HASC GP Services Inquiry: Summary of Findings

The following is a summary of the key findings from the evidence gathering undertaken to date which has included an evidence session (ES27/8/14) on 27 August (attended by Area Team, Clinical Commissioning Groups, Local Medical Committee, Care Quality Commission), 12 visits to local GP practices to speak with staff, feedback received from service users (27 contributions direct to the committee including 5 from PPGs plus recent feedback gathered from NHS Choices) and desktop research undertaken:

1) Satisfaction with care provided by GPs and practice nurses remains high

- Confidence in GPs (93%) and Nurses (86%) in Buckinghamshire is high as shown in latest Patient Experience Survey results. Scores are same as England average and higher than Thames Valley Average. Table 1.
- HASC feedback examples received …..

I cannot commend the practice (all staff), but particularly my GP, enough for the help and support which I have received during this difficult period.

As someone who works in London I find the opening hours at this surgery particularly responsive to my needs - they have early opening, from 7am and also a late evening, staying open to 8pm. They are generally available to 6.30pm, meaning things like collecting a prescription when I get back from work is possible. They provide a range of health services available within the surgery, including phlebotomy.

My wife and I have both recently had appointments at this practice and can only say how well the doctors and office staff deal with patients. We have admiration for the care and attention, not just at the current time, but over many years. Appointments are given without undue delay, and urgent calls are dealt with swiftly.

They manage, in spite of the increasing pressures facing the service, to continue to maintain that precious balance of both warmth and efficiency. I have total faith in the doctors and nurses and appreciate the caring efficiency provided by the support and administrative staff.

- GP Outcomes. A*t ES27/8/14* we heard there is no single measure of GP quality and triangulation of various measures (patient survey, QOF data, Clinical systems data with complaints, anecdotal info, CCG and LMC feedback) need to be monitored to identify concerns of poor practice. Inquiry has received a summary report of GPOS data (summary report showing local practices that fall outside the national threshold for some quality indicators) as an example of how outcomes/quality is monitored.

  Area Team are requested to summarise oversight regime and process for reviewing practices where there are concerns, so this can be included in report.

2) Primary Care is under significant pressure and facing crisis

- A common theme in all the evidence gathering undertaken (ES27/8/14, visits, media & reports).
- GP account provided by Paul Roblin "Why we cant do any more in Primary Care" (issues – lack of clarity on GP role, work demands, constrained capacity, limited time to explore new initiaves, top down demands, reduced attraction of being a partner, need for more resources).
- "Are you in despair for your future in General Practice Final Report"[1] (July 2014 report based on 2,769 responses to a survey of mostly GPs). Evidence of: unsustainable workloads, GPs burnt out, with this leading to GPs taking early retirement, career break or emigrating, and a lack of newly qualified doctors becoming GPs. 80% report that one or more GPs in their practice is suffering 'burnout' due to increasing and unsustainable pressure of work. 50% of GPs indicate that they will either retire or take a career break within the next five years with a mode age band of 45 – 54. 11.6% of GPs indicate that they intend to emigrate within the next five years with a mode age band of 35 – 44. 97% feel their practice is experiencing an ever-increasing and unsustainable workload. 52% feel that the partnership model of General Practice is becoming unsustainable for the future. Some of the additional feedback themes include unrealistic patient expectations and low morale due to constant GP bashing by government and the media.
- Nationally the Royal College of GPs chairman has been prompted to say "Many GPs are routinely working 11 hour days and seeing up to 60 patients in a day to try and meet the demand…We are trying to do our very best for our patients, but there is a chronic shortage of GPs and we cannot cope with the rising demand of a growing and ageing population whilst funding and resources continue to fall"[2].
- Record numbers of family doctors in England are leaving general practice due to ballooning workloads in a 'mass exodus' that could spell disaster for the future of patient safety…..According to polling, conducted on behalf of the College, 96% of family doctors believe that working in general practice is more stressful now than it was five years ago and 22% have had to seek support, guidance or advice for work-related stress (RCGP[3]).

- Shift in activity from secondary care (such as hospitals where activity is typically more expensive, but also providers are paid per activity) to Primary Care (such as General Practice where providers are paid mostly via a block amount per patient with limited activity based payments). This shift in activity has not been followed by a shift in resource. This shift is set to continue with

[1] http://pracmanhealth.com/2014/08/15/80-of-gp-practices-have-one-or-more-gps-suffering-from-burnout/
[2] http://www.rcgp.org.uk/news/2014/august/patients-in-peril-due-to-threat-of-gp-practice-closures-says-rcgp.aspx
[3] http://www.rcgp.org.uk/news/2014/july/patient-safety-threatened-by-mass-exodus-of-gps.aspx

desire to strengthen role of community and primary care to further reduce expensive hospital based activity.

- Average patient had 3.9 consultations each year in 1995 with this increasing to 5.5 consultations each year by 2008. There are higher consultation rates among the elderly, with a rate of 13.8 and 13.3 for males and females in the 85-89 age band. http://www.hscic.gov.uk/catalogue/PUB01077/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf The consultation rate currently is likely to be in excess of 6 per patient per year[4]. Locally we heard it is not uncommon for a practice in Aylesbury to have 700 calls for appointments in a Monday morning (G Jackson, ES27/8/14), and daily variation at some practices for appointments being from between 250-800 (ES17/8/14 LPatten), A GP we met said they see 52 face to face appointments in a day working from 8.30am-7.30pm, and many docters work past 8 or 9pm.
- General practice is becoming ever more complex with the effects of an aging population, a baby boom and more patients with mental health problems[5]. Also more proactive approach with NHS healthchecks uncovering conditions requiring follow up. Complex and multiple conditions requiring longer appointment times. More common for GPs to be working from 8am-8pm, and heard stories of GPs having to go part time just to meet the needs of the patients they were seeing adequately, due to the workload outside of appointments.
- "Between 2005-2006 and 2011-2012, the percentage share of the NHS budget spent on general practice across England, Scotland and Wales fell from 10.75 to 8.4% – a historic low" (RCGP[6]) . Which has led to calls from the Royal College of GPs for a UK wide increase in the share of funding that goes into General Practice from 8.4% to 11% of the NHS budget by 2017 to enable GPs to deliver consistent, high quality patient care and enhanced services. Global Sum allocations to individual practices is determined by the Cahill Formula with little public data available on how this works or the allocations granted. Essentially it weights the allocations according to the practice patients ages (more given to the elderly and under 5 populations) and deprivation levels, although we heard at ES27/8/14 that not enough weight is attached to the deprivation factor. The national cost for primary care provision is fixed so the formula allocations adapts to this. We have been informed funding for primary care in Buckinghamshire relative to the rest of the country is on a similar scale to CCG relative funding levels which are published, and so are among the lowest in the country. Understand that under PCT Bucks patients received 87% of the national average GP funding.

[4] Based on NHS England's own estimates, the number of consultations in general practice now stands at 340 million per year, an increase of 40m since 2008 http://www.rcgp.org.uk/news/2014/january/rcgp-response-to-daily-telegraph-article-on-gp-patient-numbers.aspx

[5] http://www.rcgp.org.uk/news/2014/january/rcgp-response-to-daily-telegraph-article-on-gp-patient-numbers.aspx

[6] http://www.rcgp.org.uk/campaign-home/about.aspx

GP and CCG work on and contribution to commissioning largely unfunded (LMC PR ES27/8/14).

- Recruitment. "By the end of 2013, there were 35,561 GPs in England. This was down on the number in post in 2009, when there were 35,917 (RCGP[7]). Cherrymead – 5 yrs ago would get 90 applications for full time GP, now only 4 for part time post, and now have salaried option to be employees without the workload and responsibility of partnership…Locum availability limted too partic at peak times of holidays and bank holiday. Locally recruitment issues also with cost of living and London weighting pull. ES27/8/14 NHS England recognises national recruitment and retention issue. Fewer trainees doctors are becoming GPs, and instead becoming consultants. Average age of a GP in Buckingahmshire is 46 (ES Annet Gammell). View of some practices that locums were very difficult to get (meadowcroft). Verney Close had spent 2.5k advertising and had 1 applicant for GP post in January. Mandeville has not been able to replace 3 GP partners, and therefore are more reliant on locums.

- Data on GPs per head of population in Buckinghamshire – illustrating GP capacity locally is in line/no worse with national and regional average. See "GP FTE STAFFING Analysis Summary ".
  Area Teams on interpretation of this data – GP numbers locally would seem in line with averages, but is there an issue with Advanced Nurse provision in Chiltern CCG?
- Lack of a full complement of GPs at a surgery seemed a factor in those under most pressure, with those with a full complement (Haddenham, Gladstone) still busy but less pressured. Meadowcroft was short of 2 Full time GPs, with only 5.5 FTEs.
- Contract inadequacies – From ES27/8/14 and GP visits we have heard the GP contract lacks specificity on what the GP role is and isn't and only states GPs must meet 'reasonable needs of patients'. Money paid does not cover the service provided…should have 5 FTE partners but cannot provide due to population based funding provided (Cherrymead). No rules on opening hours or GP numbers. Heard it is common for practices to provide above what (QOF etc) contracts dictate as a minimum (Denham).
- Paperwork and bureaucracy – such as completing QOF and other returns which are deemed 'hoops to jump through' before funding can be fully allocated. (Denham)
- Common message we heard was that GPs have limited capacity but unlimited demand. Closed lists are not only frowned we understand they also face financial restrictions if do this.
- **NHS Englands Improving General Practcie a Call to Action Phase 1 report** (March 2014, para 72-76) outlines the Batter Care Fund, CCG

[7] http://www.rcgp.org.uk/news/2014/july/patient-safety-threatened-by-mass-exodus-of-gps.aspx

strategic plans to shift activity from hospitals, NHS England planning guidance for 2014/15 providing £5 per head for transforming over 75s care, and moves to CCG co-commisisoning as examples of how resources is being shifted to Genral Practice.

Area Team able to give data on GP funding locally?

Will primary care strategy detail local primary care funding relative to other areas and a fuller analysis of GP Practice staffing provision?

3) Access to appointments and how requests are managed is a prime area of public concern and dissatisfaction

- Patient Experience data illustrates variation in satisfaction with variety of access measures (telephone access, experience of making an appointment, satisfaction with opening hours). Strong correlation (SEE Patient experience cross tabulation graphs) between patients reporting a good Overall Experience of GP and their satisfaction with tele-access, opening hours and overall experience of making an appointment. Similarly with their likelihood of recommending their practice and these factors.
- *** Note on National (MORI) Patient Experience Survey – In Bucks response rate varied between 54-23%, equating to as few as 92 responses received to as many as 139, with all but 2 practices have over 100 responses. The survey is mailed out to a sample of registered patients, so not everyone who completes will have seen GP recently. However for practices in Bucks the % of respondents who completed the survey and had seen or spoken with their GP in past 6 months varied from between 61% and 81%. Therefore the majority of respondents were basing their scores on recent experience, and the samples size for each surgery were statistically valid.*****
- We were encouraged to hear a number of practices conducted their own patient surveys in addition to the MORI national one (2014 version had 62 questions).
- Patient feedback sources of irritation include – being asked to call back at a time when appointments become available, difficulty getting through on the phone (answerphones, queues calls cut off), being faced with a choice of an urgent appointment or a 3-4 week wait.
- Telephone GP appointments- inevitably some patients will like these given the offer the opportunity to resolve an issue quickly and without the need to visit the surgery.

  "The triage system results in every patient who needs and appointment receiving it that same day. It filters out those calls that can be handled over the phone. This is turn cauises a few to complain because they believ that

they should always have a face to face appointment. They do not appreciate that unnecessary appointments in other surgeries are one of the main reasons why appointments are days or weeks ahead". (Cherrymead PPG).

Others wont and we had feedback from people objecting to being called back at inconvenient times at work and having to discuss private medical issues in front of colleague.

- Extended hours – Most practices HASC visited were delivering extended hours (early mornings, evenings and some Saturdays) and were trying to reserve these for workers to use. Variation in whether these would be early mornings, evenings, Saturdays or combinations of these based on demand/patient feedback. Takeup was variable with some practices reporting that appointments were not fully utilised (Gladstone) . LP at ES27/8/14 said there had been low extended hours sign up in bucks. Verney Close had done extended hours but when funding halved this became unviable, and was not being used by target cohort (workers).
- Some patient feedback that surgery extended hours needed to be publicised better so patients were more aware of the option. (Cherrymead, Amersham Healthcentre) Although we sensed that practice were keen to hold these back for workers, rather than see them filled up by people who could attend standard day time appointments.

- Some practices make it clear to patients that an urgent appointment is for a single condition only, and some have had to reduce appointment times to 7.5mins to accommodate demand. Gladstone practice of issuing an urgent/red card to patients to give to GP so they are clear appointment if urgent, which gives opportunity for education if it transpires it is not.

Appointment Management Variation

Doctor first – 100% GP Telephone triage (e.g. Cherrymead Surgery Loudwater)

Two years ago in response to 6 week appointment waits and 30min waits to get through on the telephone, this system was introduced. Doctors start day with fairly clear list and this fills up from 8am with patients called back within 2 hours where GP assesses (typically this takes 3 mins) whether they need to come in (ideally on the day, if not in 2-3 days) or not. If phones busy the patient can leave a message for a 20 minute call back. Surgery were very pleased with how system is performing, and felt they now only saw real demand rather than a filtered backlog of appointments. More time was freed up to conduct home visits to complex cases requiring more time. List of call backs will always be finished on the day, however long this takes. Feeling this method worked for this practice and its population/demands, and was less risky than before when so many patients were unable to be consulted in a timely manner. Surgery thought only 15-20 practices do this approach nationally.

Some practices locally had tried systems like this but found they weren't reducing physical appointments sufficiently so the telephone consultation was a duplication, others did not like the risks associated with not seeing patient face to face. Could also make access too easy and increase demand, as well as reduce opportunity to identify additional health issues or provide education.

Receptionist Filter (e.g. All the other surgeries visited in one form or another)

Levels of filtering can vary but as minimum involves sorting patients into urgent to be seen on the day/within 48 hrs, or non-urgents to be seen at next available appointment slot set aside for these, either with a GP or nurse depending on which is most suitable. Non-urgent appointment waits can vary depending on level demand, and how many appointment slots the practice opens up for bookings in advance. Some practices (Verney Close) only open up for the week ahead, others for 4 weeks ahead. In some cases this system can result in patients being asked to call back at a date when the next tranche of appointments become available, or are offered an appointment many weeks away. Some practices offer some flexibility/discretion to avoid this.

Alongside this method some practices also accommodate some walk in patients (Denham covers walk ins with a practice nurse in the morning), and some operate some telephone consultations for those GPs comfortable with performing these.

No standardisation of a receptionists role and some practices give them a greater role in filtering demands, LMC (PR ES27/8/14) view that sometimes role was greater than could be justified. Westongrove had an enhanced receptionist role and these were trained to signpost to other services/GP alternatives.

In some cases the two approaches were combined such as at Burnham where all 'urgents' were doctor triaged, or Poplar Grove where urgents were initially allocated on first come first served basis, and then when slots were all full any more would be GP triaged over the phone and patient given appointment if required on day.

Generally Practices would filter appointment request into the two streams of urgent or non-urgent, but some (Haddenham) had a third stream of 'soon' for 1 week wait between these.

- From our practice visits it appeared common for surgeries to close at lunchtime (e.g. Denham closed 3hrs at lunch). , which at ES27/8/14 we heard was frowned upon (at least to have no phone access over lunch), but from speaking to the practices seems necessary for GPs to catch up on various paperwork, receive test results, not to mention take some lunch. Opening hours dissatisfaction seems more connected with a lack of evening and weekend options rather than middle of day (2014 MORI Patient Experience Survey[8] indicated for those not satisfied with surgery opening times only 12% suggested lunchtime openings being more convenient, in contrast to a greater preference for weekend, evening and early mornings) so perhaps not an area of concern.

- All practices we visited gave assurance that someone who required to be seen urgently would be seen on the day or the next day, regardless of what time they phoned. This allayed some of the concerns the inquiry had having heard of waits for appointments of many weeks. This assurance was also an important factor in improving the experience of booking appointments by eliminating the '8am scrum for appointments[9].
- Overall we were encouraged by GPs adapting their systems to best meet demands / needs of their registered list (Burnham a good example of changes made in response to negative feedback, investment in systems and use of system reports to monitor ongoing effectiveness). Appeared responsive to patient feedback, systems data and sources such as Patient experience survey (not the case everywhere where some practices had little awarenss of their survey scores). Also heard at ES27/8/14 that GPs generally respond positively to data flagging up poor performance relative to peer group (so highlighting importance of NHS Choices, providing this is kept up to date, and the patient survey), and adopting new practice and innovation. However ….. is there potential for an unresponsive practice, or unchallenged practice to respond too slowly to inadequacies in their appointment management processes? July 2014 MORI Survey data release is based on data collected in 2 waves July-Sept 2013, and Jan-Mar 2014- this potentially means a lag in the experience being reported and then acted upon.

- Patient feedback quotes:

[8] http://gp-survey-production.s3.amazonaws.com/archive/2014/July/1301375001_Y8W2%20National%20Summary%20Report_FINAL%20v1.pdf

[9] A finding of a Barnet Healthwatch study into GP appointment management published in 2013: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/288446/PatientRepresentativeGroupSubmissionsFinal.pdf

"*I would certainly regard Milbarn as one of the better GP surgeries I have experienced in the past 30 years. I would also say that it takes quality improvement seriously too*".

"The Doctors are first class, the Nurses very kind and helpful and the same can be said for all the Staff. The practice is well managed so that we can invariably see a doctor on the day in question or very soon thereafter".

- National patient experience data – gives an indication of patient appointment preferences. Based on their last GP contact 77% wanted to see a GP, 18% wanted to see a nurse and very few (6%) wanted to speak to a GP on the phone. 42% wanted to see or speak to someone on the same day, and 36% in the next few days. Just 6% wanted an appointment for the following week or later (7% had no preference). Also showed growing preference for booking appointments online (up from 29% in June 2012 to 34% June 2014).
- LMC PR advised at ES27/8/14 that a reasonable wait for a non-urgent appointment should be no more than 2 weeks, and AG advised there should not be an option of same day or two weeks depending on whether it was urgent or not. Some practices we visited admitted that some routine appointments could take 4 weeks even when the patient had no preference on the GP they were booked with.

- The health regulator **Monitor published a discussion document following their call for evidence on GP services (Feb 2014)** which picked up a number of the issues our report has identified locally. It proposes to undertake further work to "Understand variations in access and quality in general practice: in order for commissioners and policy makers to successfully address national variations in access and quality, it is necessary that they understand the extent, causes and distribution of these variations. Building on existing data from NHS England it will intend to develop a detailed picture of the nature and extent of supply and demand for GP services (p11)"
- CQC inspection regime of GPs does include "checking whether a GP practice assesses and responds to the needs of the local population, including in relation to access to appointments. It will also include checking how the practice responds to feedback from people, for example through having an effective Patient Participation Group"[10]. But these inspections will be

[10] Page 9: http://www.cqc.org.uk/sites/default/files/documents/20131211_-_gp_signposting_statement_-_final.pdf

infrequent, and it is unclear from their GP inspection handbook[11] on how they would assess appointment access.

Question for the Area Team – How would inadequate timely appointment access be identified and addressed?

CCG role/support to facilitate sharing best practice, support for service improvement.

Should Area Team/CCG generate data/analysis in useable format for practices (e.g.on supply of appointments categorised by phone/48hr, advance, specific GP. Waiting times. How GPs are managing demands) - Much of this guidance is included in the 2009 DoH publication "Improving GP access and responsiveness[12]" aimed at the role of PCTs. Does new guidance exist / does the Area Team still use this? Whose role is it to monitor appointment capacity and waiting times?

4)……clarity of what good looks like (particularly on appointment access)

- **Will Primary Care Strategy to do this?**
- The Kings Fund/Nuffield Trust Report on *Securing the Future of General Practice*[13] (2013) provides a set of 12 design principles for future models of primary care and illustrate what 'good' primary care would look like:
  1. A senior clinician, capable of making decisions about the correct course of action, is available to patients as early in the process as possible. Providing more effective triage and decision making. (**Does this require GP Telephone consultations/triage?)**
  2. Access to primary care advice and support that is underpinned by systematic use of the latest electronic communications technology
  3. Minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations.
  4. Patients are offered continuity of relationship where this is important, and access at the right time when it is required.
  5. Care is proactive and population-based where possible, especially in relation to long-term conditions.
  6. Care for frail people with multi-morbidity is tailored to the individual needs of patients in this group, in particular people in residential or nursing homes.

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[11] http://www.cqc.org.uk/sites/default/files/20141008_gp_practices_and_ooh_provider_handbook_main_final.pdf October 2014

[12] http://www.productiveprimarycare.co.uk/Data/Sites/1/dh_accessguide.pdf

[13] http://www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice-_full_report_0.pdf

7. Where possible, patients are supported to identify their own goals and manage their own condition and care.
8. primary care is delivered by a multidisciplinary team in which full use is made of all the team members,and the form of the clinical encounter is tailored to the need of the patient.
9. Primary care practitioners have immediate access to common diagnostics, guided by clinical eligibility criteria.
10. Single electronic patient record that is accessible by relevant organisations and can be read and, perhaps in future be added to, by the patient.
11. Primary care organisations make information about the quality and outcomes of care publicly available in real time.
12. Primary care has professional and expert management, leadership and organisational support.

5) GP practice buildings and how improvements are delivered

- General concern emerged from visits over how GP Practice built environment capacity and quality would adapt now in some cases, but in the future for most cases, to rising demands and changing service requirements. Uncertainty over who is responsible for this now, and this was much clearer with PCT where there was a premises manager post (V Close).
- This appears to be a national issue – A BMA General Practice Committee has warned that four out of 10 GP practices nationally do not have adequate facilities to deliver safe patient care[14] with the Royal College of GPs responding that “over the last ten years the UK has had one of the largest hospital building programmes in the world, but this has not been matched for practice premises”.
- LMC PR ES27/8/14: Government only paying lip service to the need for funding for GP premises.
- On a number of our visits the GP practices informed us that the practice building was designed for much smaller practice populations than currently was serving (Meadowcroft 10k now 14k, Verney Close, Denham, Kingswood 7k now 10k)
- From visits we came across a variety in practice building ownership (owned outright by partners, leased from landlord, PFI, or in case of Gladstone where they had no involvement in property payments) and solutions where building capacity had been increased (practice partners financed, developer/landlord financed) . Overall there seemed a lack of clarity of how much oversight there was of the condition and capacity of practice buildings, strategies and plans to

[14] http://www.rcgp.org.uk/news/2014/july/state-of-gp-practices-another-symptom-of-chronic-lack-of-funding-in-general-practice.aspx

address these, responsibility for this and how contributions from the planning process are collected for GP practice facilities.

- Kingswood HW referred to an annual premises improvement fund administered by Area Team where bids were invited.

Area Team requested to clarify these uncertainties.

- Notional Rent (based on district valuer assessment) process is seen as a constraint of GP practice building improvements. Area Team have a fixed budget for this to cover payments to GPs for their premises. If notional rent cannot increase to cover improvement costs GPs are unable to finance these. Uncertainties on notional rent value could impact on length of lease practices can commit to[15].
- Also an issue when Practice leases property, but then sub-lets for an additional service provider to come in. Notional rent will reduce to reflect this, but if sub letter goes practice is left with a shortfall – so discourages those practices that do not own property to bring other service providers in/co locate (Cherrymead).
- Planning process – uncertainty over how S106 monies are gathered and distributed. **Is this working effectively?** Also burden on GPs from unequal distribution of Care Homes (both initial S106 for development, and for ongoing cost burden – Westongrove, and similar message from Gladstone although they were aware of a method to claim additional monies for care home registered patients.
  Are all practices aware of this?
- **Monitor published a discussion document following their call for evidence on GP services** (Feb 2014) highlighted issue of reduced incentives for investment by GPs in their premises and restricted funding for this (p12-13).
- **NHS Englands Improving General Practice a Call to Action Phase 1 report** (March 2014, para 92-99) accepts investment in primary care facilities has lagged behind resulting in inadequate practice buildings and facilities. Report puts onus on CCGs to address this in via their strategic plans for developing primary and community based services (with Health & Wellbeing Board) and by rationalising existing community based estates. NHS England will also publish a new framework on decisions regarding GP premises reimbursement, and work with Government on the current reimbursement system to promise value for money and innovation.

Questions to Area Team on notional rent pot in Bucks – is it fully utilised, how can more be found to fund GP Practice Improvements?

[15] Evidence on Notional Rent issue drawn from Information Daily podcast on GP services: http://www.theinformationdaily.com/2014/09/30/realitybites07

What knowledge/data is there of the state of premises in Bucks (condition and capacity)?

Will co-commissioning and greater CCG involvement resolve issue (utilising money saved from activity shift from hospitals to GPs to cover notional rent increases)? Are CCGs prepared to undertake new responsibilities in this area and what will Primary Care Strategy cover this / commit to it?

6) Social Care Access to relieve GP demands

- Positive feedback received that this has improved in recent years. MAG Meetings were regarded as very positive, which are multidisciplinary (GPs, Adults Social Care, Community Healthcare, Mental Health community nurses) meetings with individual practices to discuss small number of particular patients. Helps to take demand from GPs for patients whose needs are best met elsewhere. Prevention Matters officer in practices too has been beneficial, but felt these were very busy (Kingsmead).
- However concerns remain over ease at arranging rapid response services to prevent people having to be sent to hospital rather than more appropriate alternatives (Poplar G) such as social care or community hospital care, which is seen as labour intensive by GPs.
- Also – capacity of ASC for people in need of some form of supported/cared for accommodation (Kingsmead) contributes to stress and worry and inadequate housing also impacts physical and mental health…lack of suitable accommodation to meet patient need/choice
- Buckinghamshire Healthcare NHS Trust Adult Community Healthcare Team (ACHT) rapid response service is the route for GPs to access non-acute hospital services urgently (single point of contact for GP for both health and social care access) but bizarrely is reliant on fax communication, with GPs often not knowing if communication has been received by ACHT.
- This is an area of focus for the Better Care Fund with an appreciation as part of this that it does not work as well as it should. The BCF detailed business case is likely to have more detail on this as an area of priority improvement than other elements.

  As commissioners of the ACHT service what is the CCG view on the current effectiveness of the rapid response service including its reliance on faxes?

  What will Primary Care Strategy include on this aligned with BCF work?

7) Patient / service users education and GPs not unified on their role to educate/push back on demand

- Near universal message from practice visits was that managing down patient expectations and demand fuelled by these, the media and government would make the biggest difference to GPs.
- As with secondary care passing demand down to GPs, do GPs need to do more to push demands out of GP Practices?
- Heard of some cases where patients would visit practice over 100 times in the year (Burnham), but practice was relaxed about these individuals. Burnham informed us that they currently had 260 Did Not Attends / month, which followed a 45% reduction from the introduction of text message reminders.
- Varying GP views. Cherrymead – feel patients don't waste time and understand what GP is for. Not service abusers but heavy users. Other surgeries felt some service users were presenting unnecessarily to a GP and taking capacity away from those more in need of an appointment. There was a view that leaflets and posters (such as Choose well) do not work, and that it is important for a GP who is trusted by the patient to play a role in educating and giving more targeted messages, which could include communicating better the costs of appointments and demands on the system (Denham). Kingsmead said it was difficult for GP to tell someone they had wasted their time and must do so opportunistically and phrase it carefully.

- Common message was that the threshold for seeking GP intervention had reduced over the years and people were often seeking an appointment too early. We heard that young people were more demanding and 'want' to be seen rather than 'need' to be seen in some cases, with the elderly more stoic prepared to give it a few days or weeks before contacting. Also the capacity for self-care had reduced and in some cases this was down to a breakdown in the family unit/ support network. There was a view that increased demand was less fuelled by demography and more by user expectations (fuelled by media and government). Improving access unchecked potentially will just fuel greater demands, whereas constrained access can be a limiter on demand (Denham).
- Need for a greater push nationally of the 111 service to educate people on how to access the NHS front door.
- Another common message from inquiry is that is important that GP services respond to peoples needs and not their wants.
- Self-care promotion is required, and has seen positive press coverage in Wycombe from A Gammel on this (Haddenham), and the surgery had a self-care information area in their waiting room, and ran health education events (e.g. on diabetes).
- Meadowcroft had an initiative of health educators in the community who try and advise and signpost patients, and to improve patient understanding of services available and how to use (? Unclear if this was just for ethnic and/or immigrant communities).

- LMC (PR ES27/8/14) accepted public dismay at 8am rush for appointments and long non-urgent waiting lists, but average patient does not realise this is an result of resource provided for the service not matching the totality of the demands on it and there is a need to get this message to patients.
- Issue of GPs willingness / role in being harder on patients to manage demand better. **Is it right GPs should call for more limited NHS resource if unwilling to tackle misuse of the service? Who should take a lead on GP demand management and educating public on raising awareness of service pressures, appropriate service level expectations, using alternatives to GPs?**
- LMC PR – Does not recognise 'time wasters' and need for practices skill mix to meet this demand constructively, to avoid poor feedback.
- Patient expectations – expect to see 'their' named GP within a short timescale (sometimes unrealistic but in some cases you could see that this option could be reasonable such as people with complex histories or multiple condition so for some people should this be facilitated more?), Longer appointment times (again in some cases could be unrealistic or unnecessary but in others could be worthwhile and we heard that some surgeries do accommodate this).
- The government's "named GP" policy will be extended to all patients, including children, under the new 2015/16 GP contract (HSJ 30/9/14), which could only fuel the patient expectation to see particular named GPs. **Should Primary Care Strategy outline a more coordinated approach and expectation on how GP demand is managed, and the role of GPs in this. Is there a need for better data collection on DNAs and 'unnecessary GP appointments' and guidance to practices on actions to take?**

8) Patient Participation Group value variation

- From our visits we found variation in the level of PPG development, as well as practice views on their effectiveness and value.
- Practices have received a payment (Directed Enhanced Services/DES) to set up PPGs, although some practices already had these set up in some form. Terms of the DES last year required a survey of PPG/practice users, and this year still requires the practices to collect feedback so essentially a survey is required (alongside national survey and Friends and Family Test – really necessary for these multiple feedback methods???)

Patient Participation Group (PPG) Variation

Largely Positive views received from the practices on PPGs of some (e.g. Cherrymead, Burnham) - Comments including: proactive, constructive, good skills in the group. Input into changes to website and newsletter and adding value. PPG Online forums and blogs. Fill in various surveys and practices could point to improvements (in physical environment and admin processes)implemented from PPG feedback. Some do have young people involved (Burnham).

Use of social media (poplar) and fund raising. Seen as worthwhile and worth effort to set up and coordinate. Are of real value and a critical friend. Have grown up discussion. Fund raise and provide physical help on some tasks too at surgery. Also a route for patient feedback anonymously. (Haddenham)

In some cases PPGS recently set up, in others they have been established a long time and were previously 'friend groups' (westongrove). A view that some practices could use more than currently do, but time/resource precludes this (bedgrove).

Common issues of how representative groups are of practice population with fewer young people generally involved. (Cherrymead) Risk that you only hear from a small motivated group. Verney Close 16 members only 2 are under 60.

Difficult to engage ethnic groups, and have invested much time but to little effect.

Some were entirely virtual, whereas others would have physical meetings occasionally.

We also received feedback direct from some PPGs which demonstrated the positive contributions they were making to the practice. (Whitehill PPG, Amersham Health centre, Cherrymead, Hawthornden Surgery, Tower House Steward).

Were some negative views – that it was a box ticking exercise and if funding for it ceased it may get dropped given practices have other means of collating feedback via complaints, NHS Choices and staff feel for issues that could act on patient voice rather than a formal imposed structure.

Mixed view on whether further support would be worthwile. Some thopught yes to increase coverage and representativeness (Verney C) , others queried if would be a worth the resource entailed.

Some doubted the practices ability to respond to all feedback (Kigsmead) so what was value in gathering more.

- Terms of DES PPG payment/standard and is this enough to ensure PPGs are effective (size, representativeness, activity)?
- National support group (http://www.napp.org.uk/), National Association for Patient Participation exists to provides some support, resource and guidance.

Is there adequate oversight of how good/effective / well developed PPGs are, and awareness of those which require more effort to become effective? What are the possible approaches for developing these and whose role is it?

9) Area Team oversight and support

- At the ES27/8/14 we heard that the Area Team Primary Care Team were a busy and stretched team, and includes primary care quality hub which feeds into the Thames Valley Quality Surveillance Group. Team is aware of the pressure GPs are under having heard this from GPs and from what is summarised in *NHS Call to Action*. Also heard from LMC Paul Roblin who is involved in GP performance activity that it is difficult to gather sufficient evidence to employ contract clauses/penalties and there is less resource now for monitoring and managing contracts. Paul also cautioned that whilst performance is generally good you need to be aware of burnt out GPs to identify where support and respite is required. Area Team and CCG suggested the better approach was often to deploy softer quality monitoring by working cooperatively with practices on areas of poor performance (such as telephone capacity, and appointment management) rather than resorting to strict contract management.
- **Monitor published a discussion document following their call for evidence on GP services** (Feb 2014) concurs that very little contract management may be taking place during transition to new commissioning arrangements and Area Teams are too remote and/or insufficiently resourced to perform this role.
- Views nationally that oversight is less now, and Area Team is more remote the previous Primary Care Trust was. This is a factor presumably in push for co-commissioning and the CCGs assuming greater role. One practice we visited commented that had very little contact with Area Team and they are remote. Don't feel they appreciate the DES impact on staff resources.
- Area Team oversight capacity likely to be restricted further in future with NHS England's proposed restructure, which will see the 24 area teams outside London merged into just 12. It is understood that, while the number of area team directors will reduce, NHS England will retain some staff presence in each of the existing 24 areas. Thames Valley area team will merge with

Bath, Gloucestershire, Swindon and Wiltshire area teams (Health Service Journal, 1/10/14).

- CCGs have a statutory responsibility to improve the quality of primary care (although they do not commission this or performance manage it).
- Some concerns raised over whether the Area Team were clear on their role? (Haddenham), and there seems to be a need to clarify what areas of oversight and monitoring are felt to be deficient currently, so there is no false sense of security.
- Co-commisoning locally and how is issue addresses if appetite for this is low given lack of resources following the activity. Area Team accepted their capacity is limited and a focus on quality is a priority for CCG joint working.
- NHS England has invited expressions of interest for co-commissioning from CCGs with three levels on offer (1 – CCG involvement in discussions on Area Team commissioning, 2 - formal committees/partnerships for collective decisions, 3 – more formal devolution of decision making to CCGs). Greater concerns at Conflict of Interest if go fully to level 3.
- Possible issue of lack of data standardisation in GP practices to enable CCG or Area Team to pull data off EMIS remotely for appointment analysis (V Close).
- The health secretary has commissioned Health Education England to conduct an area by area examination of general practice capacity, after admitting current assessments involved guesswork (HSJ, 2/10/14) which would look where more GPs were required.

Questions for both AT and CCG – Data and oversight of supply and demand in GP practice. Supply of appointments / GP vacancies. Demand for consultations and nature of these consultations.

Prospects of AT resources shifting to CCG for extra oversight and commissioning activity?

Will Primary Care Strategy clarify Area Team and CCG roles in oversight and monitoring?

10) Community healthcare/ district nurses support for GPs

- Issue was raised on a number of visits with a desire to revert back to district nurses based in GP practices as part of a wider primary care team (HCAs, nurses, GPs) OR at least a return to this level of personal familiarity and communications (Westongrove, Burnham). Concern current model not patient centred and centralised to save cost.
- There is potential for the Better Care Fund to address some of the current deficiencies with the links between community healthcare, district nurses and GP Practices, with this likely to be through working with current provider Buckinghamshire Healthcare NHS Trust on this.

Question AT and CCG on their views on deficiencies with current District Nurse set up. Is there enough nurses in post to give them the time to communicate better with GPs? What is likely to change over what timescale to address these issues?
What will Primary Care Strategy say on this, and how the service will be improved as part of the Better Care Fund?

11) Pharmacy links with GPs

- Concerns from some practices (Mandeville) that there is variation in how set up/suitable some pharmacies are to provide the additional services GPs would like to redirect patients to, to reduce demand. Also that the electronic prescription service does not work with some larger providers such as Boots and Tesco, impacting on quality of service to patients.
- Pharmaceutical Needs Assessment (PNA) being produced currently but it is understood that this will not cover issues such as how different pharmacies may not link up as well with GP services as others. Which may have implications to patient convenience/satisfaction and the potential to move activity away from GPs and into pharmacies.
- Understand GP practice dispensing is quite unusual now, and this is not likely to increase in future.

Area Team and CCG view on whether pharmacy variation is a concern, and what could/should be done to identify way forward.
Will Primary Care Strategy include anything on this given the PNA is not expected to?

12) GP Services adapting for the future

- **NHS England's Improving General Practice a Call to Action Phase 1 report** (March 2014) outlines reasons for why General Practice needs to change: Demographic change, the need to secure better outcomes, financial constraints, impacts on other parts of the system/secondary care, and workforce (GP workforce has only grown at half the rate of other medical specialities and not kept up with population growth in past 10 years). In order to meet the ambitions laid out against this background NHS England believes general practice will need to operate at greater scale and in greater collaboration with other providers and professionals. This will not necessarily require changes in organisation form and merges but through practices working in partnership through networking and federations. More evidence on

the case for this change is outlines in the Kings Fund/Nuffield Trust Report on *Securing the Future of General Practice*[16] (2013).

- In recent years GP service provision has had to change with the demands faced. There is evidence of more patients being seen by nurses rather than GPs (in 1995 21% of consultations were undertaken by nurses, by 2008 this was 34% although increased recording on computers of nurse appointments could be a factor in this), and with more consultations conducted over the telephone and fewer home visits (in 1995 3% of consultations were on the telephone and 9% were home visits, by 2008 12% were on the telephone and 4% home visits)[17]. Practices we visited were using various grades of nurse and HCAs.
- Overall view from visits was that there was sufficient opportunity to share best practice, but perhaps this is not fully utilised. There are CCG locality practice managers meetings (discuss referral rates, A&E use, benchmark etc.) and there has been initiatives to create headroom for practices to step back and look at how they deliver their service effectively. In some cases this was linked with Productive General Practice[18] national support package, which is the case of Gladstone surgery they replicated elements of via an away day. Productive General Practice has online resources from NHS Institute for Improvement and Development/ NHS Improving Quality. This package of tools is licenced out (at a cost) providing a change management framework for adapting GP services to demands and enhance service. There is a specific guide on website for how CCGs should lead roll out of this framework.

- There was a feeling from CCG that meetings are not fully embraced (N Lester ES27/8/14), but that this is a new culture and ten yrs ago practices had very little contact with each other. Gladstone view that attending meetings is time consuming and a big demand. Sharing good practice is not resourced, and is GP goodwill to cover this (ES27/8/14 CN). Issue perhaps of GPs not having capacity to share best practice as much as would like, particularly in smaller or more pressured practices.
- Mixed view from practices on support desired to adapt systems to better meet demands with some welcoming CCG support in this and best practice sharing (Poplar G), whilst others less convinced of the need (Gladstone). Some would like analytical reports/data which is too time consuming to produce at practice (Verney C). Over 75s fund by AV CCG seemed a positive step in

[16] http://www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice-_full_report_0.pdf
[17] http://www.hscic.gov.uk/catalogue/PUB01077/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf
[18] http://www.institute.nhs.uk/productive_general_practice/general/productive_general_practice_homepage.html

fostering practice partnership work (Poplar G, Mandevile), where business cases/bids were invited from groups of practices.
What is tipping point for radical changes? Risk that practices only consider radical change when at breaking point and when they have the least capacity to explore innovation and opportunities.

- Does model of primary care in deprived areas need to be different to other areas, with wider network of support/resources from other agencies (social care, unemployment agencies etc)?
- Recruitment issues are limiting practice ability to employ various skill mix to take demand from GPs (meadowcroft). Nurse practitioners in short supply (LMC PR), although physios and councillors can also help reduce demand. Meadowcroft have struggled to recruit long term condition nurses and have had to train these up themselves.
  What Solutions are there to this and is there potential for innovation?
- LMC (PR 27/8/14) was sceptical of benefits of federations working at scale. GPs have suspicions and will be labour intensive to set up, with many risks and unknown workloads. Other GPs (Meadowcroft) also felt they would make efficiencies on admin but sceptical on whether they will resolve demand issues. **NHS Englands Improving General Practcie a Call to Action Phase 1 report** (March 2014, Appendix A) includes some examples of how wider primary care delivered at scale could improve access and resilience, as well as support integrated care.
- Likelihood of further use of technology in the future to meet demands such as Skype/video consultations, use of patients smart phones/apps, patients recording and submitting own test results, e-consulting (westongrove).
- Key problem is practice staff finding time from the 'day job' due to workload and recruitment issues to take the time to plan changes. **NHS Englands Improving General Practice a Call to Action Phase 1 report** (March 2014) commits to a study in April 2015 on how more time can be freed up in General Practice to provide more proactive, person-centred care and improve access.
- Diff appointment systems could preclude mergers (Cherrymead would not want to lose Dr First and other practices may not be keen).
- There is potential that if GPs do not evolve themselves and come together in partnership, private companies could enter the market and do this for them.

Are local GPs ready to shake up how they are organised, given the model of service delivery is considered to be largely unchanged in 60 years?

What role should Area Team and CCGs play in supporting and/or facilitating this. What already happening (over 75s fund for example), what is proposed, and is the pace of change sufficient?

How far should Primary Care Strategy go steering/pushing GP Practices on the changes required?

- Some of the patient feedback we received suggested a local desire for More services provided locally, District nursing , health visitors, Midwifery, Chiropody (podiatry), Phlebotomy. Extra services such as advice on social care issues, benefits, advice and support on health issues.
- GP desire for national changes to funding and commissioning – more money to pay for the services actually needed/provided and commissioning for this.

Other issues

- Need for more electronic communications between GPs and Hospitals (patient records, referrals, discharge papers etc). Generally GPs well placed for this and it is the hospitals that are using antiquated systems/processes Discharge paperwork and delayed receipt of these. Could all be solved with a move to electronic. Outpatient letters are now electronic but not urgent discharges. Better communications between hospital and GP particularly on handovers of complex patients would be positive.
  Perhaps warrents coverage in Primary Care Strategy.
- Awareness of Out of Hours provision and how to access, when to call 111 or 999. Some Practices reported their own GPs may have uncertainty on OOHs and minor injury pathways.
- Scepticism on Friends and Family Test value (must be available to each patient and submit returns monthly) which will allow a simple comparison between practices to support choice, but will provide less valuable feedback to practices to identify issues and improvements required (cherrymead)

- Bureaucracy /inefficiency in the fragmented system – Denham example of dermatological patient being referred to hospital for one condition, an additional condition being identified at the hospital but the patient being sent back to the GP for a re-referral to get second issue resolved, which provides the hospital with an increased payment. Example of inefficiency and non-patient centred care. Also instances of patients being sent to GP with a letter requesting a medication to be prescribed so this does not come out of the hospitals drug budget.
  Did hear 2014 contract changes were positive in that they emphasis more care in the surgery and less box ticking. (Denham).
  LMC (PR ES27/8/14) - Paperwork now burdensome, and distracts from day job. GMS Funding Changes letter 12/8/14 proposes to reduce QOF and move associated resource into global sum to reduce admin burden and give GPs more flexibility.
- Counselling provision could be better for adults and children to take some GP demand, but there are no NHS counselling services available (Meadowcroft).
- 7 day working proposals - availability of staff to cover this? May force some practices to federate/merge to cover this (Haddenham). Scepticism of the

benefit of this and could come at a cost to service level and continuity of care, spread GPs to thin (westongrove).