Improving General Practice for the People of West Cheshire
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INTRODUCTION

There is a growing consensus that the current model of general practice is not working well and is struggling to meet all the challenges it faces.

The challenges are well known and are being faced by the whole of the NHS and Social Care\(^1\). They include a population who are living longer with increasingly complex health and care needs, and patients who are more demanding of information about their care and who expect better access and more involvement in their care planning.

These increasing demands are occurring against a backdrop of falling government spending on social care. General practice needs to respond to these challenges and embrace the development of a more proactive, patient centred, community based, out of hospital model of care. It also needs to adopt the rapidly developing communication and technological advances that are making these changes possible.

The scale of the challenge faced by general practice is illustrated by the figures below:

- GPs provide 90% of NHS care with only 9% of the budget\(^5\)
- Consultations in general practice have increased by 75% between 1995 and 2009\(^6\)
- There has been an increased clinical workload in general practice of over 40% since 2008\(^6\)

The Nuffield Trust and King’s Fund highlight the problem of initiating change in general practice and describe practice teams as being ‘caught on a treadmill’ of trying to meet demand whilst at the same time lacking the time to work out how to change the way they work.

\(^1\) Securing the future of general practice: new models of primary care, nuffieldtrust, July 2013
\(^2\) Primary Care: Today and Tomorrow - Improving general practice by working, Deloitte, May 2012
\(^3\) Transforming primary care: let’s start with the basics, The King’s Fund, January 2013
\(^4\) Time for radical change to shift power to patients, The King’s Fund, November 2012
\(^5\) Fairer investment needed for general practice ‘to keep NHS sustainable’, Royal College of General Practitioners, June 2013
\(^6\) Office for National Statistics, cited in Howard and others, 2013, p 6
Our role as a Clinical Commissioning Group, is to not only identify the changes that are needed, but to create the space for change to occur and to work with NHS England to facilitate it.

Evidence from health systems that have changed successfully, such as Canterbury in New Zealand, is that to bring about effective change the following enablers need to be in place:

- Creation of a vision
- Sustained investment in training and development to promote change and innovation
- New forms of contracting

The purpose of this paper is to set out the vision.

In trying to describe a vision for general practice it is crucial that we do not see change in general practice in isolation from the change required, and already happening, in the rest of the health and social care system. This paper seeks to describe how general practice in west Cheshire needs to change and modernise so that it can play a full role in the ‘West Cheshire Way’ – the vision for our local health and social care economy.

The Clinical Commissioning Group will need to consider what resources it can use to support this change and to work with NHS England to explore what contractual mechanisms are available to facilitate change.

**A NEW MODEL OF GENERAL PRACTICE FOR WESTERN CHESHIRE**

We want to build on the strengths of high quality general practice that already exist. The ideas for change within this vision are drawn from national examples of best practice but also from ideas generated locally by our GP community.

As we look to modernise general practice locally we must remember why general practice is so important to the NHS, helping it continue to be one of the most cost effective health systems in the world:

- The GP registered list provides the basis for the coordination and continuity of care. About 99% of the population are registered with a general practice in the UK.

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7 The quest for integrated health and social care, The King's Fund, September 2013
8 Mirror, mirror on the way, how the performance of the US healthcare system compares internationally, The Commonwealth Fund, 2010
The generalist skills that GPs possess means that they are able to consider the physical, psychological and social needs of patients which improves decision making especially when managing complex patients often elderly patients.

GPs manage risk and uncertainty well, often without resorting to expensive and inconvenient hospital investigations.

GPs as part of practice and community teams are experienced in the management of long term conditions.

The practice clinical IT systems are well established and can support the management of long term conditions, track changes in health status and support population health interventions like screening and immunisations. In West Cheshire all but two practices are now on, or are in the process of moving to, EMIS Web.

In order to respond to the challenges set out above and to make the changes required locally as part of the West Cheshire Way, general practice will need to change in the following areas:

- Improved access with continuity of care
- Managing demand and developing alternatives
- Integrated communication and information sharing
- The GP practice and the local community

**IMPROVED ACCESS WITH CONTINUITY OF CARE**

Access to high quality general practice is essential in a successful health care system\(^9\). There is a growing body of evidence that patients’ satisfaction with access to general practice affects attendances at A&E\(^{10,11}\). Those patients who are more satisfied are less likely to use A&E. A rise in A&E attendance may be a factor in rising emergency admissions, but the evidence also suggests that loss of continuity of care and poor quality out of hours services can lead to a higher than expected number of emergency admissions\(^{12,13}\).

This suggests that general practice needs to balance the need to provide good access to those patients who require it whilst at the same time providing continuity of

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10. Access to general practice and visits to emergency departments in England: a cross sectional, population based study, T E Cowling et al, June 2013
11. Data briefing: improving GP services in England: exploring the association between quality of care and experience of patients, The King's Fund, November 2012
12. Avoiding hospital admissions, what does the research evidence say, The King's Fund, December 2012
care to patients with more complex long term conditions especially the ‘frail elderly’. The latter group also require timely home assessment so that the system delays that currently exist do not lead to deterioration in their condition with resulting increased morbidity and likelihood of hospital admission.

**Principle 1: We want to ensure that patients are consistently able to contact their GP practice easily and have a choice of ways to contact the practice.**

One of the biggest barriers to patients accessing general practice is difficulty getting through on the telephone. In West Cheshire patient satisfaction with getting through to their practices varies between 37% and 97%\(^\text{14}\). This level of variation suggests we can not only do better but also learn from each other. The new model of general practice in West Cheshire will ensure that the techniques used in the best performing practices are spread across the Clinical Commissioning Group.

Many practices offer web based booking for appointments, but not all, and those that do could probably offer more. A few practices in West Cheshire are trialling the use of text messaging to inform patients of normal results and to send patient reminders. New technologies can also offer alternatives to the traditional face to face consultations with email becoming commonplace in the UK and elsewhere\(^\text{15,16}\) and Skype consultations being piloted\(^\text{17}\).

Many practices enable patients to request prescriptions online via the practice website, again this facility needs extending along with realising the ambition of electronic prescribing.

Feedback from the September 2013 Membership Council and from the GP practice listening visits highlighted that too much GP and administrative time is taken up chasing misplaced results and correspondence from the hospital. This is time that could be spent seeing patients or answering the telephone.

**Principle 2: We want patients requiring urgent assessment to have an effective first clinical contact**

Much work has already taken place in West Cheshire to improve access for patients requiring urgent assessment. Most notably several practices have adopted the ‘Patient Access’ model, where GPs speak to all patients with a new problem who contact the practice requesting an appointment\(^\text{18}\). We need to learn from this and explore the potential to roll out across practices.

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14 GP Patient Survey Results
15 Giving patients email access to their GP, Pulse Today, May 2011
16 Redesigning primary care: the group health journey, The King’s Fund, September 2013
17 GP pilots Skype consultations with patients, GPolice, March 2013
18 Patient Access Website
There is little published evidence about the effectiveness of nurse triage in primary care although anecdotal evidence suggests that triage alone does not prevent a later face to face consultation\textsuperscript{19}. What seems to be important in improving access, whilst at the same time managing capacity, is to make the first clinical contact as effective as possible. This means ensuring that the nurse or GP making the call is in a position to deal with the patient’s problem there and then, without onward referral or a later appointment. This may be by giving advice, but it may require a prescription or other intervention. Larger practices will find it easier to provide this high level of first contact expertise so it may require practices to merge to provide the service across several sites.

**Principle 3: We want patients to have local access to GP practice services outside of core hours (Monday – Friday 8.00am – 6.30pm).**

As the NHS as a whole considers how it will begin to provider better and safer seven day care for patients, we need to think how general practice needs to change to meet this demand. GP practices currently have to be open Monday to Friday, 8.00am to 6.30pm. In West Cheshire no individual practices offer an “extended hours service” to open beyond these core hours. Instead funding has been pooled and West Cheshire Out of Hours Service provides early evening clinics on a Monday to Friday and on a Saturday morning in the three geographical areas of the Clinical Commissioning Group. Whilst pooling of the budget has given all patients access to extended hours six days a week, the number of appointments are small and their use by practices is not equitable.

Extending the opening hours of practices will require investment, which will need to come from elsewhere in the health economy. As illustrated above, the savings should be realised by reduced A&E attendances and emergency admissions. The delivery of extended hours could be by individual practices, by practices joining together to form clusters or ‘super practices’ or by investing further in the current Out of Hours provider. Again improved IT will be crucial to this development.

**Principle 4: We want to provide rapid assessment and care to patients at risk of emergency admission.**

The traditional model of general practice builds inevitable delays into the care of the most vulnerable patients. Frail older people and those with complex needs who are unable to attend surgery often deteriorate rapidly but prompt assessment and treatment can prevent emergency admission\textsuperscript{20}. It is not possible for small practices

\textsuperscript{19} The effectiveness and cost-effectiveness of telephone triage of patients requesting same day consultations in general practice: study protocol for a cluster randomised controlled trial comparing nurse-led and GP-led management systems (ESTEEM), Campbell et al, 2013

\textsuperscript{20} Breaking the mould without breaking the system, NHS Alliance, November 2011
to have a dedicated and responsive visiting service so it seems inevitable that practices need to join together to provide this service\textsuperscript{21}.

In some nearby areas an acute home visiting service provided by North West Ambulance Service gives ambulance crews an alternative to taking the patients to hospital. This service has been effective at reducing emergency admissions\textsuperscript{22}. A local acute home visiting service could develop a similar arrangement with the ambulance trust.

General practices need to use their registered list of patients to anticipate care needs and identify patients at risk of hospital admission. The development of integrated teams (nurses, therapists, social workers etc.) support our most vulnerable patients is an important part of this model and will enable more people to be cared for at home.

\textit{Principle 5: We want patients, particularly frail older people and those with long term conditions to receive continuity of care from an appropriate team of health and social care professionals.}

As highlighted earlier in this paper, in order to reduce hospital admissions continuity of care is important. One of the aims of the changes in access and managing demand, by providing alternatives to GP face to face consultations, has to be to create space for continuity for those more vulnerable patients who need it, such as the terminally ill, frail older people and those with physical or learning disabilities. This means that the appointment system, the first contact with the patient and the home visiting service should all promote continuity of care, at least over an episode of illness. This is especially important in care homes and practices will need to consider how they can provide this.

\textit{Principle 6: We need to increase the intensity of care provided to patients in Residential and Nursing Homes to ensure continuity of care and good medication management.}

This group of vulnerable patients benefit most from continuity of care, co-ordinated across health and social care. Without this they are more likely to be admitted to hospital as an emergency\textsuperscript{23}. Their care also needs planning and more consideration given to end of life care and medication reviews. In West Cheshire we have a service to support the care of patients in nursing homes, but this needs extending to include residential homes. The model in Sheffield, highlighted by the Royal College of General Practitioners provides a useful example of how this can be done\textsuperscript{23}. In

\textsuperscript{21} How our acute visiting service reduced emergency admissions by 30 percent, Pulse, March 2013
\textsuperscript{22} GP provide full time visiting service in bid to cut emergency admissions, Pulse, March 2013
\textsuperscript{23} Care Homes Case Study - Sheffield Locally Enhanced Service (LES), Royal College of General Practitioners
addition there are examples of community pharmacies being involved in regular medication reviews in a partnership with the homes and GPs.  

Managing Demand and Developing Alternatives

*Principle 7: We will help patients to self-care through use of techniques such as motivational interviewing, shared decision making and the use of shared care plans.*

There is evidence that clinical staff do not regularly support patients in developing the skills needed for self-care and self-management. In part this is due to a lack of training in what is available so a crucial element of developing a new model for general practice in West Cheshire will be a programme of training for clinicians to make them more able and willing to direct patients to self-care opportunities. As highlighted by the Health Foundation, this requires a change in the relationship between patients and clinicians and even a change in language used facilitate self-management rather than rely on the medical model of cure.

*Principle 8: We will actively develop alternatives to general practice including minor ailment scheme, social prescribing and direct access services.*

The Pharmacy First scheme was a national initiative to pay appropriately trained pharmacists to provide advice and treatment for a range of minor ailments. Its uptake nationally was patchy. A local scheme in West Cheshire was initially successful but has become less effective due to a lack of continued development and a reduction in the availability of trained pharmacists which made the service unreliable and so less effective (described in an internal Clinical Commissioning Group paper).

This scheme is being re-launched and needs to be well supported by the Clinical Commissioning Group working closely with the Area Team. Once again we need to consider carefully how information is communicated between GPs and the pharmacists.

We need to get better at providing alternatives to the medical model of care for those patients who are frequent users of primary and secondary care who have multiple physical and mental health problems that are not explained or helped well by modern biomedical techniques. Evidence suggests that ‘social prescribing’ or

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24 Improving Pharmaceutical Care in Care Homes, Royal Pharmaceutical Society Scotland, March 2012
26 Self-Management support resource centre - Health Foundation
27 Social prescribing in general practice: adding meaning to medicine, The British Journal of General Practice, June 2009
‘community referral’ can be an effective route to provide psychosocial and/or practical help for:

- Vulnerable and at risk groups, for example low-income single mothers’ recently bereaved elderly people, people with chronic physical illness, and newly arrived communities
- People with mild to moderate depression and anxiety
- People with long term and enduring mental health problems
- Frequent attenders in primary care

In areas where this is established and works well, such as Bromley by Bow Health Centre in East London, the evidence suggests that it is best delivered by a facilitator working with additional personal support for the patient, often provided by volunteers. This ‘facilitator’ role and the new development of a social prescribing data base would be another element of the new model for general practice in West Cheshire.

In West Cheshire at present access to physiotherapy and mental health therapy is by referral from a GP. It does not have to be like this and there are examples in other parts of the country where direct access works well. Whilst offering direct access would improve access and reduce demand on GP services it would need careful development with the current providers, agreed clinical pathways and improved communication.

**Principle 9: We will commission new technology to support patients to self-care and self-monitor their conditions.**

There is a continuing and rapid growth in the use of online and mobile technology to support patients to manage both immediate health concerns and long term conditions. An example of this is the NHS symptom checker and other online and mobile apps. An important element of training clinicians in support self-care will be increasing their awareness and use of these new technologies. We also need to get better at working with our health and social care partners in using telecare and telehealth to support patients in managing their own conditions in their own homes. These technologies exist and have been introduced already in this area, but in order to maximise their benefit general practice needs to become a more involved partner.

We cannot make the changes we want to make in general practice without involving patients from the outset and whilst the traditional methods of engagement such as

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28 Social prescribing for mental health - a guide to commissioning and delivery, Care Services Improvement Partnership
29 Physio Hull
30 Musculoskeletal physiotherapy: patient self-referral, Chartered Society of Physiotherapy, August 2012
31 Newham IAPT - Our Health - East of England
32 NHS Direct - Health and symptom checkers on your mobile
practice Patient Participation Groups are important we will need to get much better at involving all patients so we will need to use social media more effectively. Social media can also be used to help patients improve their own health and wellbeing through innovations such as Puffell and to manage their long term conditions.

**Principle 10: We will build on existing technology and invest in additional technology to enable the other principles to be achieved and improve communication between general practice and other partners in care delivery.**

Running through all the changes described above is the requirement for much better communication and agreed pathways of care between general practice and all its partners in health and social care. Improved and joined up information technology and shared communication underpins the West Cheshire Way vision and it is especially important that the developments in information technology needed for general practice are considered within this overall strategy.

**THE GP PRACTICE AND THE LOCAL COMMUNITY**

**Principle 11: We will ensure that GP practices become community resources to improve the health and wellbeing of local people.**

One of the aims of the West Cheshire Way is to support people in their community. The GP practice and the GP registered list is a vital element in achieving this. GP practices can play a much greater role in promoting the health and wellbeing of the community. There are examples across the country where this is happening, such as Bromley by Bow. The new model of general practice for West Cheshire will allow practices to develop in this way by encouraging partnerships with other local public, private and voluntary sector organisations.

**Principle 12: We will involve patients in the design and development of the new model of primary care.**

In planning and delivering a new model the patients of the communities involved need to be part of the process from the outset. The necessary changes will not be successful without this close and continuous involvement. One of the reasons for the success of the reforms to the health and social care model in Canterbury, New Zealand was that a key measure of success was whether it reduced the time patients spent waiting. The overall aim of changing the way care is provided is not what makes the system better for practice staff, nurses or doctors, but what makes it

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33 Welcome :: Puffell
34 Bromley by Bow Centre
35 The quest for integrated health and social care, The King's Fund, September 2012
work better for patients. The only way of finding this out is to involve patients in the design and delivery of the new model.

CONCLUSION

The changes set out above propose a different way of delivering primary care. It builds on the strengths of general practice with its bio-psychological model of care based on a registered list of patients, but it goes beyond this through partnership with other providers of health and social care. The overarching aim of the changes is to make the service work better for patients and to join it up with the rest of the health and social care so that patients are unaware of the organisational make-up of the care they receive. The changes will allow practices to provide rapid and easy access for patients with urgent needs, whilst providing continuity of care for more vulnerable groups of patients.

The practice needs to become a ‘hub’ in the community that brings together other public, private and voluntary organisations to improve the health and wellbeing of the local population and in doing so supports a growing programme of self-care.

It is unlikely that individual practices will have the resources and capacity to make all the changes described above so it seems likely that practices will need to come together either as a federation or by mergers to deliver the scale of change necessary. There are examples in other parts of the country where this is happening.

The changes required in general practice are part of much wider changes occurring across health and social care in West Cheshire as described in the West Cheshire Way vision. Running through all these changes is the need to improve communication. This means using the technology we already have better and being better at sharing information. It also means embracing technologies that can empower patients to care for themselves better and also support truly integrated patient centred care.

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36 The Vitality Partnership
37 Primary care quality and safety systems in the English National Health Service: a case study of a new type of primary care provider, Journal of Health Services Research and Policy, September 2013
38 Suffolk GP Federation