



MAKING TIME IN GENERAL PRACTICE

Freeing GP capacity by reducing bureaucracy and avoidable consultations, managing the interface with hospitals and exploring new ways of working

October 2015

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FULL REPORT

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Foreword

General Practice feels under pressure as never before. Workload is increasingly driven by an unprecedented rise in the number of patients and growing complexity of their health needs, added to by growing expectations both from politicians and policy makers. Many GPs are working increasingly long hours and an increasing number are looking to leave the profession, while the numbers applying to become trainee GPs and practice nurses has fallen to a worrying level. The overall share of the NHS budget for general practice has reduced by nearly 20% over the last decade, leading commentators to describe it as a 'perfect storm'.

In addition to the pressing need to increase the GP and primary care workforce, this report looks at how the workload crisis in general practice can be tackled by **'Making Time'**. We think there are some things which are just not good enough and need to be fixed now. The complexity and confusion that has plagued central systems for paying practices and sharing information need urgent attention. Other things require the whole health system to work together more effectively. We were struck by how much time is taken in setting up and rearranging hospital appointments, as well as chasing up delays in discharge letters and the details of changes in medication. This is a key example of where GPs and their consultant colleagues and their respective teams, working together, need to agree better local systems for talking to each other and sharing information. Finally, there are things that practices can learn from each other. While many practices feel beleaguered, some are coping better than others reflecting widespread variations across general practice.

There are clear responsibilities for different parts of the healthcare system. NHS England, now increasingly working as co-commissioners of primary care with local CCGs, need to learn from other sectors where paying people is rapid, simple and straightforward. The rhetoric of 'integration' and 'whole systems working' could usefully be replaced with practical local arrangements to allow GPs and consultants to work more effectively together, rebuilding fractured relationships and a 'sense of place'. And within the GP practice, some may want to review aspects of the way they organise themselves to help reduce their own workload.

We know that there are few quick fixes but we urge NHS England to take immediate steps to streamline practice payment systems to minimise bureaucracy and maximise speed of data entry and payment, as well as providing financial incentives for practices to learn from each other and to work more effectively together.

All of the ideas highlighted in this report take time, effort and in some cases, additional resources. But taken together, they could release a lot of time and effort, freeing up GPs to deliver the job they were trained to do and care so passionately about. To focus on all the areas highlighted in this report will require a new sense of urgency at all levels of the NHS that lifting the burden on general practice is good for everyone who works in the NHS and for all of us who use it.

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Practice Management Network
for practice managers, by practice managers

Executive Summary

Background and context

This report was commissioned by NHS England as part of its wider work to deliver the New Deal, strengthening primary care and releasing capacity to introduce new care models. It summarises work carried out by the Primary Care Foundation and NHS Alliance during 2014/15 on reducing bureaucracy and shaping demand in general practice in order to make more time for GPs to do what only they can do.

It is unique in that it has quantified current pressures across England in order to prioritise recommendations for action. It reports on a survey of general practices to identify where the burden of bureaucracy lies and identifies changes in contracting and monitoring that would reduce practice time spent on bureaucracy. It details an audit of GP appointments to understand how avoidable consultations with GPs arise and where they could have been better directed. It includes recommendations for improving the primary-secondary care interface developed jointly by senior clinicians and managers from both sectors. Finally, it concludes with a series of articles and thought leadership pieces commissioned in pulling this report together.

Key Findings

Causes of bureaucracy in general practice

A survey, designed with front line practice managers and GPs as well as national stakeholders, was widely circulated to practices to identify the amount of time spent on bureaucratic tasks. The on-line questionnaire was completed by 267 practice managers between December 2014 and March 2015.

The chief sources of bureaucracy in general practice were as follows:

- Getting paid
- Processing information from hospitals and other providers
- Keeping up to date with changes
- Reporting other information
- Supporting patients to navigate the NHS

The survey results as well as interviews with practice managers have indicated that 'getting paid' has become a much bigger burden since CCGs and local authorities have been commissioning services from practices, and that the use of different systems for reporting, claiming and reconciliation has exacerbated this. They also highlighted ways in which the CQRS system for automated processing could be improved to reduce manual workload. We also asked practice managers about the most time consuming aspect of bureaucracy and 'getting paid' was clearly the single biggest issue, with 45% of all respondents identifying this area.

The next biggest bureaucratic burden, almost on a par with getting paid, related to processing information from hospitals and other providers. Managers reported this has increased in recent years.

Keeping up to date with incoming information from commissioners and other bodies, particularly at a national level, was also a significant area of burden for practices. Managers reported that this was particularly problematic when later trying to retrieve information sent by email, letter or bulletin.

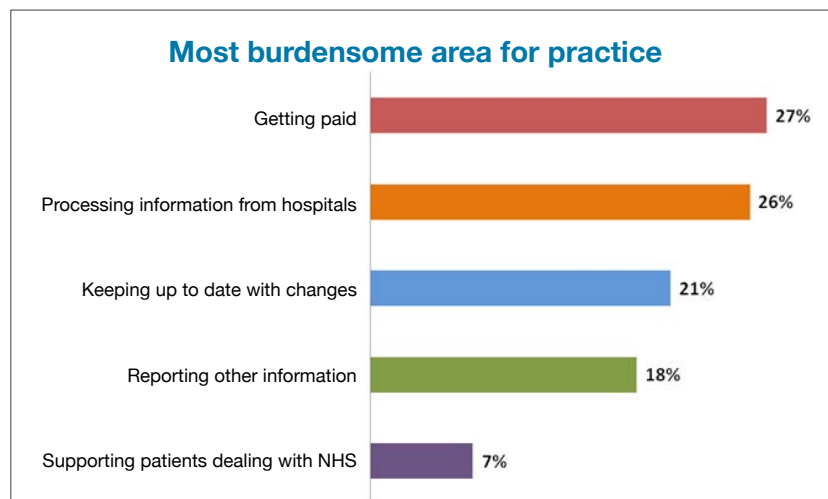


Figure 1 Sources of bureaucracy in general practice

The fourth most burdensome issue was reporting for contract monitoring or regulation. Here, interviews revealed frustration caused by multiple requests for similar information, sometimes from different teams in the same organisation (particularly NHS England), often at very short notice (eg 24 or 48 hours), and often formulated in ways which differed from how the information was stored. NHS England and CQC were described as frequently asking for information about the same aspect of the practice, but in different ways, at different times, and in a series of requests rather than a single one.

Finally, supporting patients to navigate the health and care system was also an area where practice workload was increasing.

Causes of potentially avoidable GP consultations

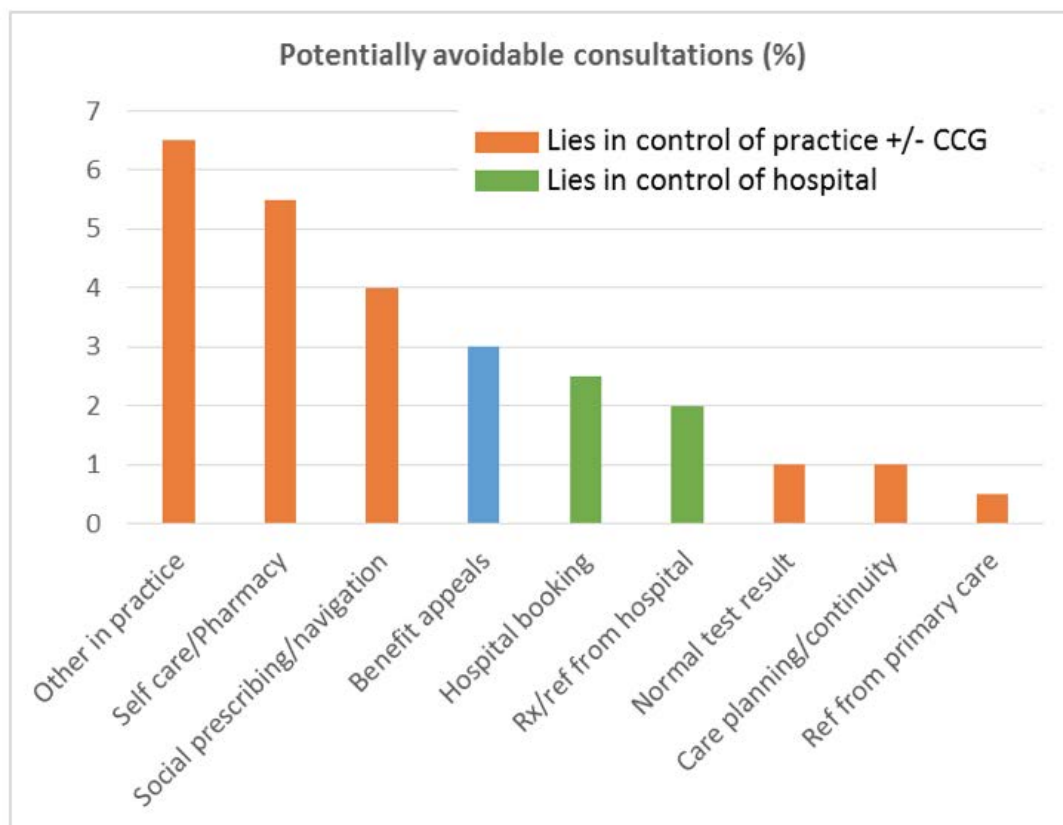


Figure 2 Causes of potentially avoidable consultations

An audit tool was developed, again with the support of front line GPs and national stakeholders, to explore how many GP appointments are potentially avoidable, either because other practitioners, within or beyond the practice, could have met their needs, or patients could have sought support in other ways. It was completed by 56 GPs between January and June 2015, reviewing a total of 5,128 appointments.

Overall, 27% of GP appointments were judged by respondents to have been potentially avoidable, with changes to the system around them. The most common potentially avoidable consultations were amendable to action by the practice, often with the support of the CCG. The biggest three categories were where the patient would have been better served by being directed to someone else in the wider primary care team, either within the practice, in the pharmacy or a so-called 'wellbeing worker' (e.g. care navigator, peer coach, health trainer or befriender). Together, these three, which could be improved by more active signposting and new support services, accounted for 16% of GP appointments. An additional 1% were to inform a patient that their test result was normal and no further action was needed. A further 1% of appointments would not have been necessary if continuity of care or a clear management plan had been established.

The second most common type of issue lay within the control of hospitals. Demand created by hospitals accounted for a total of 4.5% of appointments. The largest category, creating 2.5% of appointment, comprised problems with outpatient booking (either a lapse in the outpatient booking process, such as failure to send a follow-up appointment), or a patient failing to attend an appointment, necessitating an entirely new GP referral. The other, creating 2%, was the result of hospital staff instructing the patient to contact the GP for a prescription or other intervention which was part of their hospital care.

Discussion

1. It is clear from our findings on the scope and scale of bureaucracy in general practice that a substantial amount of time in many practices is spent on tasks that could potentially be done in other ways. It is possible to free up time that could be used to help implement local improvements. Rapid changes would also begin to address a deep sense of frustration that the system adds to the burden in practices rather than offering support.
2. Similarly, there is considerable scope for using GP time in different ways that could reduce the current workload and offer better support to patients. Our evidence is based on an audit carried out with a comparatively small number of 56 GPs and we look forward to building on this base by opening up the audit to all practices across the Country so that they can compare their use of appointments with others. The audit highlights that there are a range of opportunities for sharing and redirecting the current workload. No one practice can hope to address all of these areas but by focussing on specific types of avoidable appointment, practices could make incremental improvements reducing pressure on GPs.
3. The ability to implement common systems has been complicated by the NHS's poor record on developing integrated information systems, with policy veering from centralist solutions to local diversity. Neither has served general practice well. Much of the duplication and confusion, and the inability of clinicians across different parts of the healthcare system to talk to each other and share important patient information, stem from this failing. Increasingly, patients will demand a greater role in accessing their own notes and sharing this information with everyone involved in their care across organisational and professional boundaries. We make further recommendations about central and local responsibilities in this area and see it as a fundamental route to reducing unnecessary workload and speeding up care across the NHS.

4. We were struck by how far the links and connections between clinicians working within a health community have been frayed and broken. Traditionally, individual professional groups benefited from a common training that was supported and maintained by continuing learning and professional development. So GPs and consultants would meet up together for educational sessions and other shared events, all helping to foster what many referred to as a 'sense of place'. Many clinicians felt this common sense of purpose, collectively serving their local community, had been eroded, replaced by an often divisive loyalty to individual NHS organisations. At times of pressure and austerity, there is a danger that investment in time for clinical colleagues to talk and learn together is reduced or removed altogether, and time spent together is where local health communities can make the connections that will reduce workload on all sides. We forget that health services are always underpinned by human relationships, between clinical colleagues as well as between clinicians and patients, at our peril.

5. There are around 8,000 practices across England, many offering effective, personalised care, based on shared decision making between clinicians and patients, reflecting the needs of their local community. But too often we confuse the need for personal care with the unhelpful idea that each general practice should personalise its own business systems and processes. Each meeting between a patient and their GP or nurse should be personal and distinctive. But it is more difficult to justify each appointment system, telephone system, payment system and information system, being different. It is unacceptable that within each CCG there are such wide variations in access that have little to do with patient need but rather are more likely to be driven by the variation in approach, operational model and staffing levels across practices. The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote on improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice. This report offers a series of suggestions for how emerging practice groups and federations can create more efficient systems and free up clinical time, for example, by reducing the need for repeat visits rather than creating yet more activity in an over-heating system.

6. Many of us greatly value the contact we have with a GP, preferably someone we have known for years and understands what matters to us as we manage our health. This is particularly important to those with long term illness or who are increasingly frail who particularly benefit from continuity of care with an individual clinician who co-ordinates their care – and of much less value to those who last attended the practice several years ago for a different condition. But there are many other members of the practice team who could work in new and different ways. A large part of this is about how practices extend and develop their clinical team in a way that reduces the pressure and frequently intolerable workload, on GPs. We know that there will be pressure on recruiting GPs and practice nurses in many parts of the Country for some years to come. At the same time, new roles, including practice pharmacists, GP Assistants, Physician Assistants and Health Co-ordinators, may be able to pick up current workload in a more effective way because of their specific training or professional background, while other tasks previously seen as the responsibility of GPs can be picked up just as well by others. We recommend that NHS England should offer financial incentives to extend the practice team and that practices should be given more support to understand how different roles can lighten their load and improve care to patients.

7. This report also highlights the opportunities in looking beyond the practice to the range of support and goodwill that exists in the wider community. This is hard to do when the day-to-day pressures are so high and GPs are working increasingly long days, as well as being asked to extend their care throughout a 7-day week. The investment in time in building relationships with services outside traditional healthcare, frequently more central to promoting health in our communities, including carers and volunteers, services in the third sector, housing services and many others, is crucial. Again, it may be difficult for each practice to build these separate links, but working together as groups or federations, it may become easier to connect to others

who can do more to support patients with long-term needs and tackle loneliness and isolation. We list a number of examples of what is often called 'social prescribing', using the power and influence of the practice to improve health and well being rather than tackle illness.

8. There will also be an increasing need to support patients to help themselves. This is much more than redirecting patients around a complex and fragmented system. The NHS is responsible for making it easier to access care and services and should avoid the temptation to blame patients for its own shortcomings. But new technology offers a remarkable array of opportunities for managing our own health, through websites and Apps, patients accessing their own records, or near patient testing. Both clinicians and patients have a lot to gain, but will need to understand both the potential benefits and risks, with clinicians learning to value informed and empowered patients rather than seeing them as a threat to their authority. Again, this report reviews some of the latest innovations and explores how working together, it is possible to improve care and reduce workload in the practice.
9. This report highlights a lot of excellent innovation that could helpfully be adapted and replicated in many other practices across the Country. The '[Summary of new approaches](#)' describes the work carried out to explore some of the opportunities to work in new and different ways and provides links to further sections in the Appendix of the report.

Summary Recommendations

There are a series of recommendations arising from this report, with the top five areas listed below. We have targeted recommendations at three different audiences. First, NHS England who commissioned this report and have a key role for setting the national context. Some things can only be sorted out at the national level. Second, we see that there is a pressing need for a shared local commitment from commissioners (CCGs supported by their CSU and Local Authorities), local hospitals, community services and practices to work together to fix the obstacles that patients and clinicians encounter every day. Finally, we have a series of recommendations for individual practices, or practices working together in groups, identifying how they could learn from each other about factors which are within their own control for reducing their workload. In each case we have highlighted one or two recommendations that could have an immediate impact on reducing workload.

A. Reducing the bureaucracy in general practice must be a national priority

NHS England needs to take the lead in reducing unnecessary bureaucracy in general practice. Practice managers identify the problems with getting paid as the single biggest burden on their time and problems have got worse in the last two years following all the organisational changes. Sorting out the range of problems identified by practices and listed in this report should be an urgent priority for NHS England.

Immediate practical steps in this area include:

- ✓ NHS England must ensure that it rapidly sorts out the way practices are paid working with its new provider of primary care support services and with HSCIC who are responsible for GPES and CQRS, with regular feedback from practices to monitor progress.
- ✓ NHS England should urgently review the range of safety notices that are sent to a practice (from all sources) and consider how filtering might be improved so that practices receive those that are relevant to them without the confusion of irrelevant notices.

B. Practices should work together to free up time

There are many reasons for individual practices to start working together but we think there is a strong case simply on the basis of freeing up time in general practice. Practices working together in localities, federations, or as part of developing new models of care through Vanguards and the Prime Ministers Challenge Fund, are all exploring how they can save time through sharing tasks and responsibilities. We make clear recommendations about specific steps that could be taken in this area.

Immediate practical steps in this area include:

- ✓ Funds should be made available to all practices to free up time for GPs and other leaders in the practice to think through how they can work differently, learning the lessons from the PM's Challenge Fund sites and the Vanguard sites as they become available – creating the 'head-room' needed to plan new ways of working and clinical innovation.

C. Communication between general practice and hospitals is crucial

One of the strongest themes coming out of our research is the unnecessary extra workload created by the lack of clear systems and processes for practices and their local hospitals to communicate with each other and their shared patients. Some of this can be addressed through consistent national rules and guidelines, but probably even more important, is a shared local commitment and creating opportunities for clinicians to cut through all the unnecessary rules that get in the way of rapid and effective treatment of patients and lead to so many repeat consultations to chase up basic administrative tasks.

Immediate practical steps in this area include:

- ✓ Patients who don't attend a hospital appointment should have the right to rebook within two weeks without going back to the GP
- ✓ Commissioners should require providers across the Country to develop a local system for allowing GPs to discuss a case with a specialist and for hospital clinicians to speak direct to a GP, within hours not days.
- ✓ Discharge letters should be transferred electronically to the practice, data should be structured and presented in a consistent way and should normally be produced within 24 hours of discharge.

D. Unlocking the potential for the whole system to work together

Many of the problems encountered by practices link to difficulties faced by other partners across the local health and social care system and the wider community. Although our remit was to explore ways of reducing the pressure on general practice, many of the solutions lie in the way that all services involved in caring for patients work together. There are also substantial opportunities for practices to share their workload with other partners across the local community. Building opportunities for prescribing for health and trusting other agencies, often better at addressing many of the health needs that we face, offers the potential to both reduce workload within practices and increase confidence across the wider community. This heading also includes a wide range of recommendations for improving IT systems that would enable partners across the health system to work so much more effectively together and share information with patients.

Immediate practical steps in this area include:

- ✓ Federations should be funded to work across their practices to build practical social prescribing projects that offer real alternatives to taking up the GP's time with patients whose needs can be better met by other kinds of support in the wider community
- ✓ Work actively to support interoperability between systems providing records in primary care and those in secondary care, working with system providers.
- ✓ Commissioners need to work with their local providers to align incentives, removing the barriers for working together across a local area - including financial incentives that cut across effective collaboration.

E. Changes within individual practices

Finally, there are steps that individual practices can make to reduce their workload but these will vary for each practice. These include extending and building the practice team and ensuring that patients are, as far as is possible, reducing repeat appointments and developing the use of group consultations. Practices will need support in reviewing how they compare to others and understanding what the substantial variation across practices means for them, and in identifying what they might do to free up time. Again, we offer examples of good practice and specific recommendation, many of which may work best if carried out alongside other local practices.

Immediate practical steps in this area include:

- ✓ NHS England should offer increased funding through national incentives for practices to employ a wider range of staff within the practice team, with the decision on the type of staff and how they used being left to local discretion.
- ✓ Commissioners nationally and locally should give a high priority to supporting general practice to look at how they can free up GP time and work in new ways with partners across the healthcare system.
- ✓ By working together, practices should highlight the opportunity to reduce potentially avoidable appointments through (for example) sharing the services of support staff or commissioning new services.

Taken together, this broader perspective, acknowledging the links and connections across the health care system and the wider community, offers a comprehensive approach to reducing workload for GPs and general practice, with the knock-on effect of reducing pressure on the system as a whole.

Summary of New Approaches

As part of the second stage of this work we were asked to look further at new or different approaches for addressing some of the problems raised by practices. It is not intended as an exhaustive list of interventions but as a starting point for practices who are thinking about making changes to reduce the workload within the practice.

- **The Growing Role for Practice Pharmacists** (see Appendix 1)
Practice pharmacists are now seen as one solution to reducing pressure in general practice. But, says Mark Robinson, Pharmacy Lead for the NHS Alliance, GPs will miss a trick unless they also look for quality improvement when considering this new role
- **The general practice physician assistant: time to reappraise?** (see Appendix 2)
General practice has been slow to adopt the physician assistant role. Daloni Carlisle examines the latest research and asks whether the role needs reconsidering
- **Remote consultations: are they safe, effective and efficient?** (see Appendix 3)
Daloni Carlisle looks at emerging e-consultation tools in general practice
- **Group consultations: a way to spend more time with patients** (see Appendix 4)
Georgina Craig, National Director, ELC Programme, looks at the evidence for using group consultations in general practice and outlines an improvement programme
- **Support is just a click away** (see Appendix 5)
Daloni Carlisle explains why peer support is so powerful but says it must be trusted and safe for users
- **Improving communication through Simple Words** (see Appendix 6)
Georgina Craig, National Director, ELC Programme, looks at the evidence of how good communication improves outcomes not just for patients but also for GPs and describes an improvement programme
- **Can Apps support self care and can general practice respond?** (see Appendix 7)
Eddie Jahn asked GP Principals about their experience of healthcare Apps and looks at the potential gains and barriers to embedding their use in routine care
- **How online patient record access can save practices time and money** (see Appendix 8)
Brian Fisher explores the benefits of online access – and argues that not only can this save practices time and money but there are patient benefits too
- **Simplifying data collection for payment and monitoring** (see Appendix 9)
Henry Clay reviews the impact of GPES and CQRS on general practice and makes recommendations for NHS England and CCGs

Introduction

General practice is widely perceived to be in crisis and GPs' workloads to be unsustainable. Rising demand, changing patterns of work by GPs and a fall in the proportion of funds allocated to general practice in England have fed into this picture¹. While public satisfaction with general practice remains high, satisfaction with access is falling and expectations of the public and politicians continue to ratchet up the pressure. The sector can and must reform to meet evolving needs. GP capacity must be freed up.

Health Secretary Jeremy Hunt has already promised a New Deal for General Practice.

"The strategic importance of general practice to the NHS cannot be overstated. Within five years we will be looking after a million more over 70s. The number of people with three or more long term conditions is set to increase by 50% to nearly 3 million by 2018. By 2020 nearly 100,000 more people will need to be cared for at home.

Put simply, if we do not find better, smarter ways to help our growing elderly population remain healthy and independent our hospitals will be overwhelmed – which is why we need effective, strong and expanding general practice more than ever before in the history of the NHS."

Health Secretary Jeremy Hunt, June 2015

This New Deal addresses:

- Workforce
- Infrastructure
- Access with a 7 day NHS
- Assessing quality of care
- Bureaucracy and burnout.

This report was commissioned by NHS England as part of its wider work to deliver the New Deal to strengthen primary care and release capacity to introduce new care models. It summarises a number of pieces of work carried out by the Primary Care Foundation and NHS Alliance on behalf of NHS England during 2014/15.

Broadly, it looks at reducing bureaucracy and shaping demand in general practice in order to make more time for GPs to do what only they can do, and for practice managers to take a greater role in shaping the future. It is unique in that it has quantified current pressures across England in order to prioritise recommendations for action.

Part 1 reports on the evidence we gathered and makes recommendations based on:

- A survey of general practices to identify where the burden of bureaucracy lies and identify changes in contracting and monitoring that would reduce practice time spent on bureaucracy
- An audit with GP practices to understand how avoidable consultations with GPs arise and where they could have been better directed
- Detailed discussions with GPs and practice managers to understand what might work better
- Consultation with our partners to understand the burden of administration of appointments across the primary and secondary care interface.

Part 2 reports on an exercise gathering ideas and examples of innovative solutions and also makes recommendations.

Part 3 is a series of articles and thought leadership pieces commissioned as part of the evidence gathering process.

¹ www.nuffieldtrust.org.uk/sites/files/nuffield/publication/general_practice_in_crisis_3.pdf

Part 1: Gathering the evidence

Reducing the time spent on bureaucracy: a survey of general practice

Introduction

The bureaucratic burden on GPs has grown in recent years.

The NHS Five Year Forward View, published in October 2014, identified the need for a ‘new deal’ for general practice, including through addressing workload pressures². There is a consensus within the profession that bureaucracy must be reduced if general practice is not to buckle under the weight of paperwork. For example, in May 2015, the Royal College of GPs published a New Deal for General Practice³, which calls on the government to give GPs time to care, including by cutting red tape and bureaucracy.

In 2014/15 we surveyed more than 250 practice managers in England via a web-enabled questionnaire to uncover the burden of bureaucracy and elicit their thoughts about reducing this.

We asked about five key areas:

- Getting paid
- Supporting patients
- Processing information from hospitals and providers
- Reporting other information (for example to regulators, commissioners and tax authorities)
- Keeping up to date (For example with safety notices, changing policies and procedures).

We wanted to know how much time managers spent on different activities, how burdensome they felt these were and what they felt were potential solutions. We also visited a number of practices to triangulate the findings and understand what might make a difference.

Results

Overview

In brief, practice managers perceive that there is a high level of burden from bureaucratic processes and that this could be reduced substantially by employing simpler processes, streamlining and standardising communication between NHS organisations and by better use of IT and data sharing. Some of this is in hands of general practice but much lies under the influence of NHS England and CCGs.

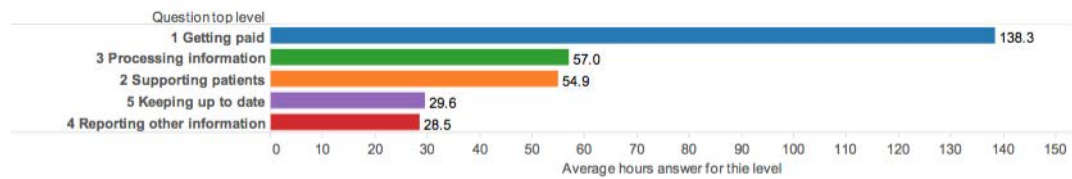
Practice managers estimated that the most time consuming area, by far, was ‘Getting paid’ with nearly 140 hours a month estimated as spent on this activity.

² www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

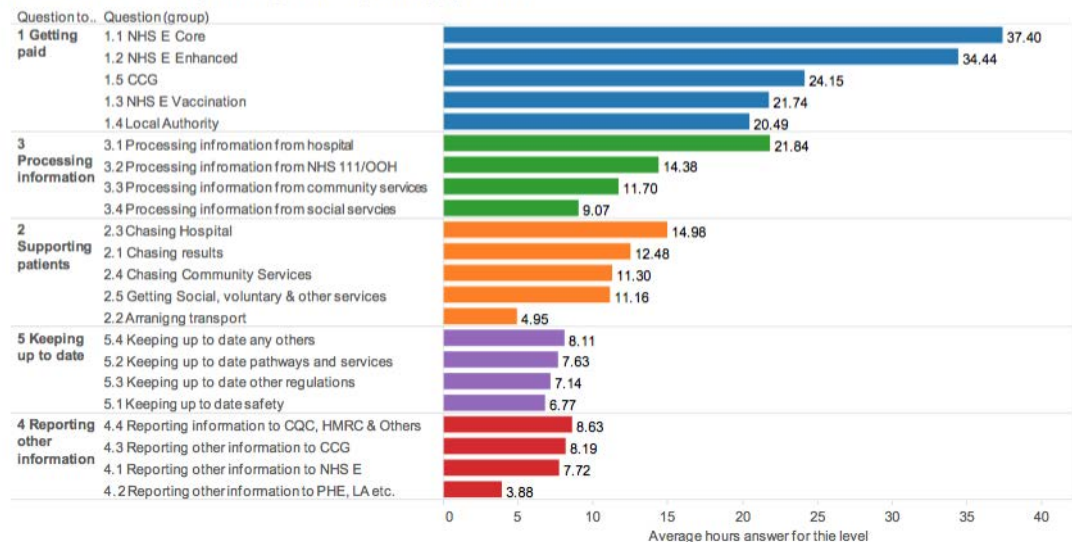
³ www.rcgp.org.uk/newdeal

Time spent by question

Top level, Average time spent by question

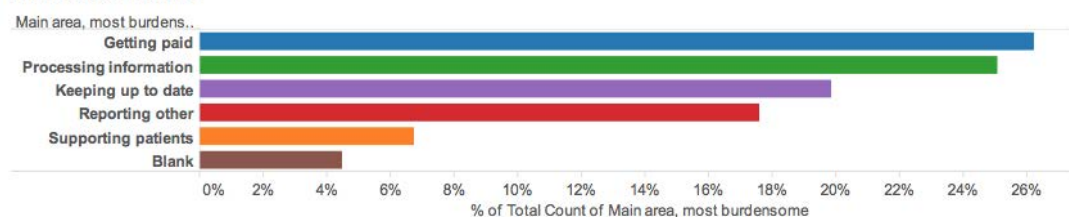


Intermediate level, Average time spent by question



But interestingly, when asked which was the most burdensome area, only just over a quarter of practice managers identified 'Getting paid' with the other areas not so far behind.

Most burdensome



In the next five pages we have included some verbatim quotes of what practice managers told us about each area and provided a graph showing how frequently each intermediate level area was identified as the most burdensome and how we categorised the verbatim responses under each heading.

Getting paid

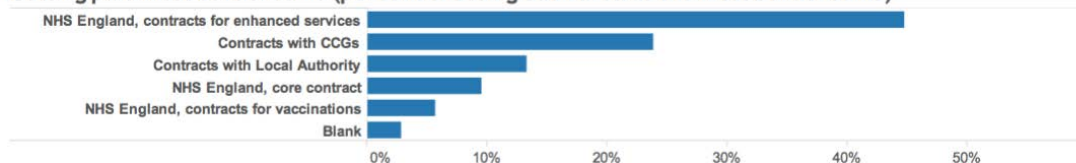
Practice managers told us the most burdensome category under this heading was contracts with NHS England for enhanced services, followed by contracts with CCGs.

Their biggest asks were to remove complexity, introduce more transparency and provide a single IT system that works. They also want to know what they are getting paid for as this is not always clear. The following comments from practice managers are typical:

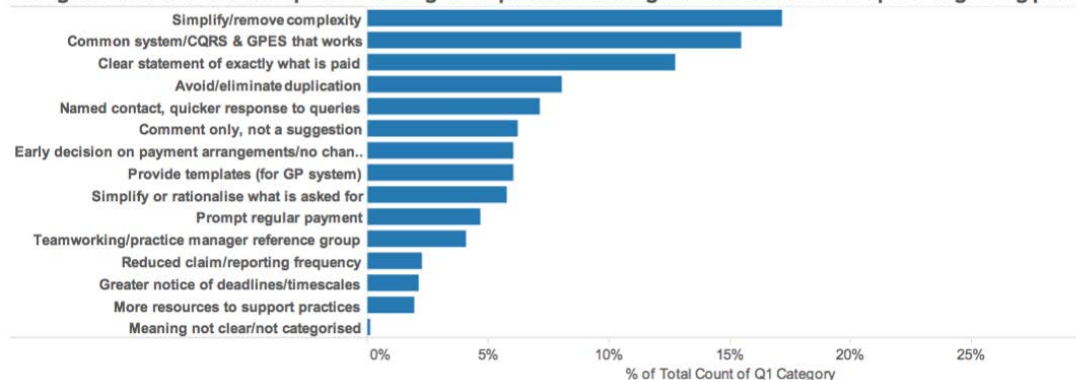
“A single process and toolkit for reporting on activity. Currently some services are reported via emailed spreadsheet, some via manual entry on CQRS and some by automated extraction (this latter requires a lot of initial setting up for practices, e.g. creating data entry templates etc.). Some services are reported monthly, some quarterly and some at the end of the year.”

“Make everything automated rather than having to submit Monthly/quarterly returns. The CQRS system is going some way to do this, but it’s still in its infancy and still has problems. For example, the extended hours enhanced service must take up thousands of hours. We have to complete a form quarterly with someone counting the number of patients attending and those that do not attend and for what purpose?”

Getting paid most burdensome (percent choosing each area as the most burdensome)



Categories for verbatim responses asking what practice managers 'would like' in respect of getting paid



Processing information

Practice managers told us that by far the most burdensome category under this heading was processing information from hospitals; out of hours and NHS 111 came in second followed by social services and community services.

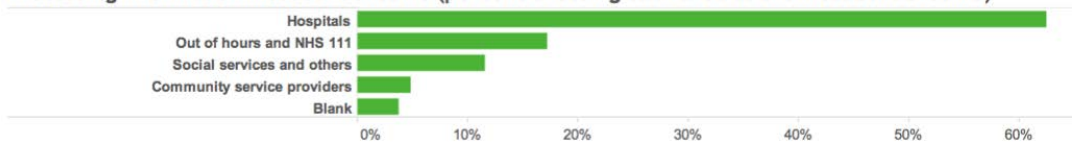
Their biggest asks were for clear summaries and a simple letter from hospitals, closely followed by electronic communication and using IT systems that talk to each other. The following comments from practice managers are typical:

“Make it compulsory for hospitals to send letters electronically in a form that can be integrated immediately into GPSOC IT systems (like pathology results currently do). Needs hospital systems to be compatible with GP IT systems and this to be mandatory in IT service provider specifications.”

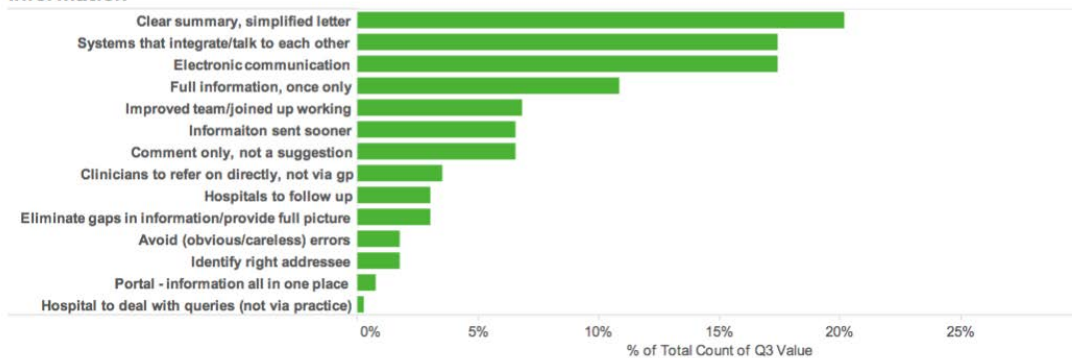
“Better information on discharge letters. Get to the main diagnosis and treatment given keep information brief.”

“Don’t generate multi-page reports for patient contacts where no advice or treatment was given. A brief summary at the front of every incoming report.”

Processing information most burdensome (percent choosing each area as the most burdensome)



Categories for verbatim responses asking what practice managers 'would like' in respect of processing information



Supporting patients

Practice managers told us the most burdensome category under this heading was arranging or following up information with the hospital.

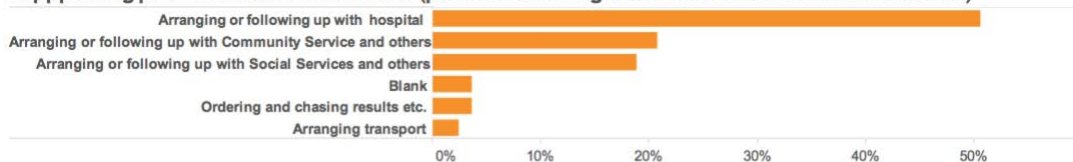
Their biggest asks were for improved IT systems and prompt response (whether to the patient or the practice). They wanted other providers to do what they should do and wanted more named contacts for following up information. The following comments from practice managers are typical:

“Chasing up appointments or letters either not dictated or awaiting to be typed despite the patient coming down to the practice having being told they need x, y or z by the consultant or hospital but we have no documentation for this.”

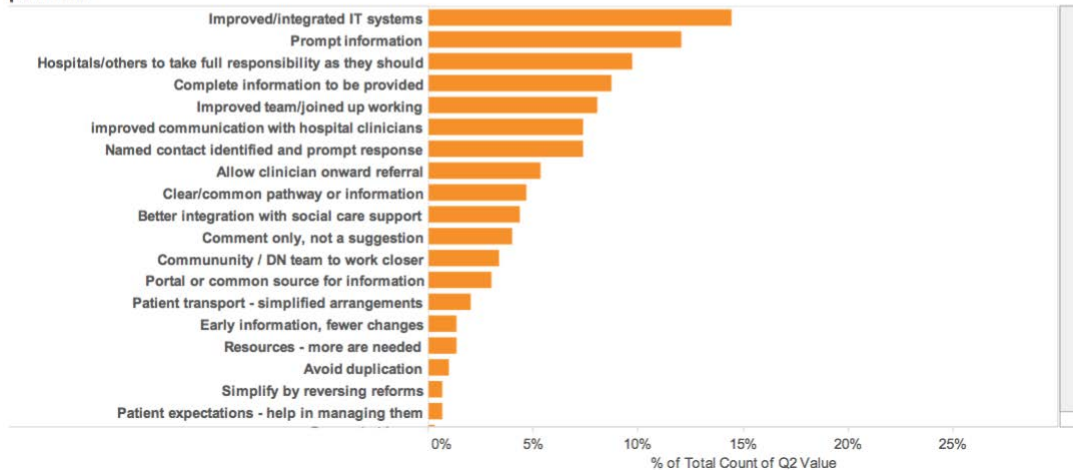
“Integrated IT systems across NHS providers allowing ordering of forms, viewing of results, e-transmission of letters joint use of practice systems by practice and community based staff.”

“For secondary care to take responsibility for their own requirements, e.g. prescribing and stop telling patients that their GP will arrange/provide.”

Supporting patients most burdensome (percent choosing each area as the most burdensome)



Categories for verbatim responses asking what practice managers 'would like' in respect of supporting patients



Reporting other information

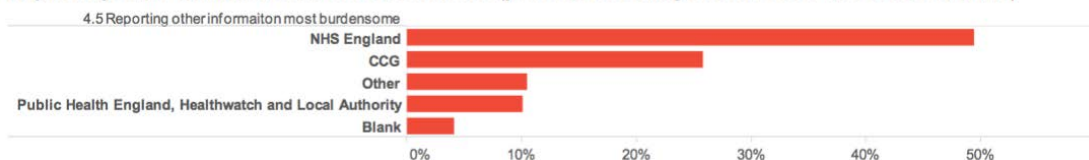
Practice managers told us the most burdensome category under this heading was reporting to NHS England, followed by reporting to CCGs.

Their biggest asks were for NHS England and CCGs to rationalise their demands for information and to give practices more notice if they needed information. They wanted simpler instructions and standardised processes for submitting information. The following comments illustrate some of this:

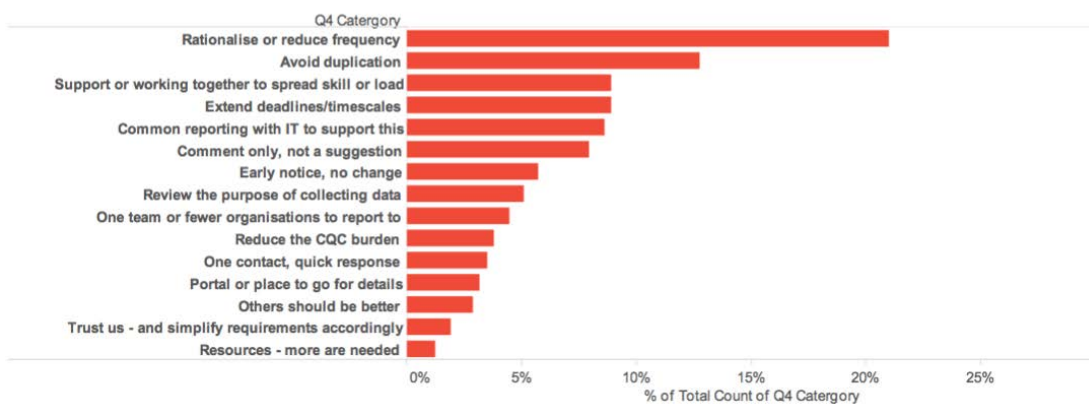
“A reduction in the number of emails from the Area Team. I’ve also lost count of the number of times these are then re-issued due to an error or correction. Email headers that give you some clue as to the urgency of the request to allow for prioritisation.”

“CQC can be over bureaucratic, instructions are often not clear so once again you are left wondering if you have done the right thing and will someone tell you if not or just penalise you in some way.”

Reporting other information most burdensome (percent choosing each area as most burdensome)



Categories for verbatim responses asking what practice managers 'would like' in respect of reporting other information



Keeping up to date

Practice managers told us the most burdensome category under this heading was keeping up to date with information about local pathways and services. Behind this came safety notices followed by employment, health and safety and other regulations.

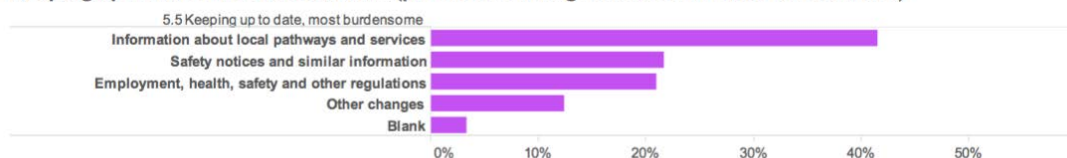
Their biggest asks were to stop sending them information that is irrelevant by filtering it first. They wanted a portal to get hold of information that is relevant and they wanted to get the right information right first time. This is typical of what they told us:

“Safety notices - often irrelevant to GPs - usually hospital or dispensing and as we are not a dispensing practice and don’t keep any drugs these are a waste of time.”

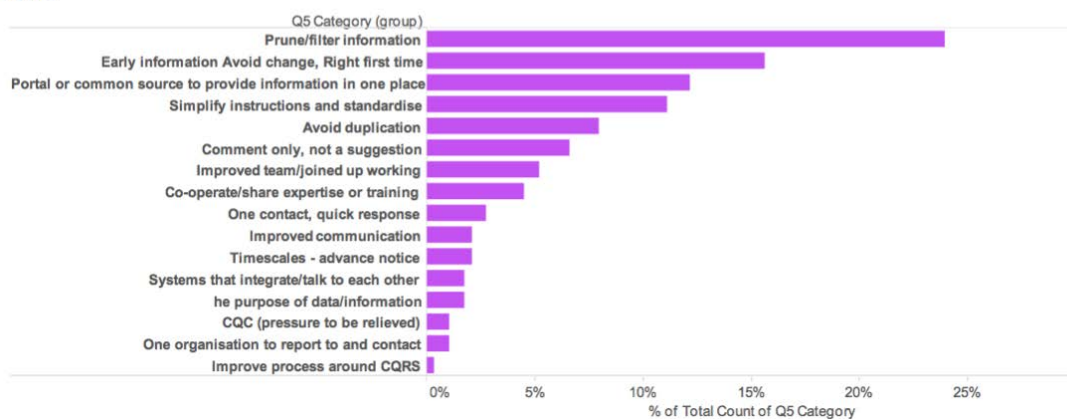
“A single point of contact to be responsible for contacting GP practices - who could ‘sense check’ communications before going out to GP practices so that we only receive what we need to receive.”

“A single place for local pathways and services which is kept up to date.”

Keeping up to date most burdensome (percent choosing each area as most burdensome)



Categories for verbatim responses asking what practice managers ‘would like’ in respect of keeping up to date



Case study

Reducing email correspondence with the CCG

West Hampshire CCG sends out a weekly email newsletter to all member GPs in a bid to reduce the continuous stream of email traffic.

It came about after GPs told the CCG they were drowning in emails, with insufficient time to wade through them and no way of telling what was important.

Called Business News, the weekly newsletter starts with a blog from CCG vice chair Dr Tim Cotton, who leads for the CCG on primary and community care, and then moves on to set out items for action or information in order of priority.

“We have tried to make it human with the personal blog introduction and then to set out clear content sections so that people can skim through to see quickly what they need to know,” says Tom Sheppard, communications officer at the CCG whose responsibility it is to collate all the information. “We have worked hard to getting the tone right. We are a membership organisation and we need to reflect that in the language we use.”

The feedback has been positive. GPs like the format, the frequency and the tone. But some still say they have not got time to read it, says Sheppard. “So we have built up relationships with practice managers who go on to filter information out to colleagues as necessary.”

It is not a revolutionary solution nor is it unique, says Sheppard. It is, however, very practical and a real help. “Our aspiration is to develop a portal for GPs where they can get all their information in one place,” he adds. “We are trying to find a way to develop this that would be secure but would not require an extra log in for GPs.”

Reducing avoidable demand for GP appointments: an audit

Introduction

Not every patient seen by a GP needs the expertise of a doctor. Many could be seen by other professionals or in other services or have their health issues resolved through high quality and timely self care advice. This part of the project set out to understand and quantify the extent to which GPs are engaged in potentially avoidable consultations.

In 2014/15 we worked with supportive GPs to develop and test an audit tool⁴⁵ that allows GPs to understand not only how many of their consultations with patients were avoidable but also the nature of these consultations. It was offered to GPs through a wide range of channels as an opportunity to reflect on their own practice and to contribute to a national piece of work looking at how to free up their time. The audit is delivered via an Excel spreadsheet that can be completed on paper or online. It was completed in practice during working sessions and the results peer reviewed and tested by experienced GPs.

The top-level data show that more than a quarter (27%) of GP consultations were identified as potentially avoidable, although there was significant variation around this figure. Even in the best of worlds the whole of this proportion is not realisable, but translating part of this number into appointments avoided will require a fundamental shift in the way practices manage demand and the way CCGs commission services. Reducing potentially avoidable appointments requires practices to give a consistent message to patients over time - it is not a quick fix.

Quantitative results: what the numbers told us

Avoidable appointments

We received over 50 responses covering almost 5,000 consultations. Of these 73% were identified as unavoidable contacts and 27% were identified as potentially avoidable contacts.

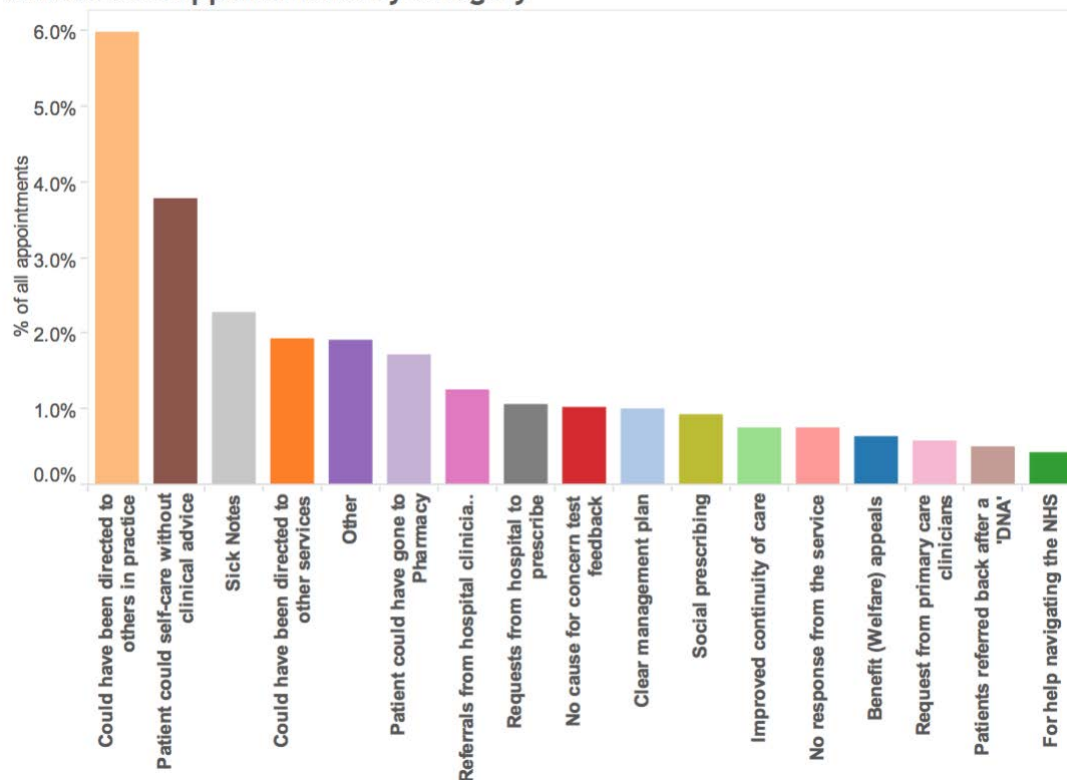
The main areas for potentially avoidable appointments were:

- Patients who could have been seen by others in the practice
- Patients who could have been seen by other services, particularly pharmacies
- Patients who could, given the right support, have been in a position to self-care
- Requests from other clinicians, including prescribing and onward referral (for example from opticians, but also from secondary care clinicians) that could have been avoided (with the practice being informed only)
- Requests for documentation (not just fit notes for employers, but for gyms, benefit appeals etc).

⁴ www.primarycarefoundation.co.uk/images/NHS_England-Audit_Tool_Paper_Version_v06012015.pdf

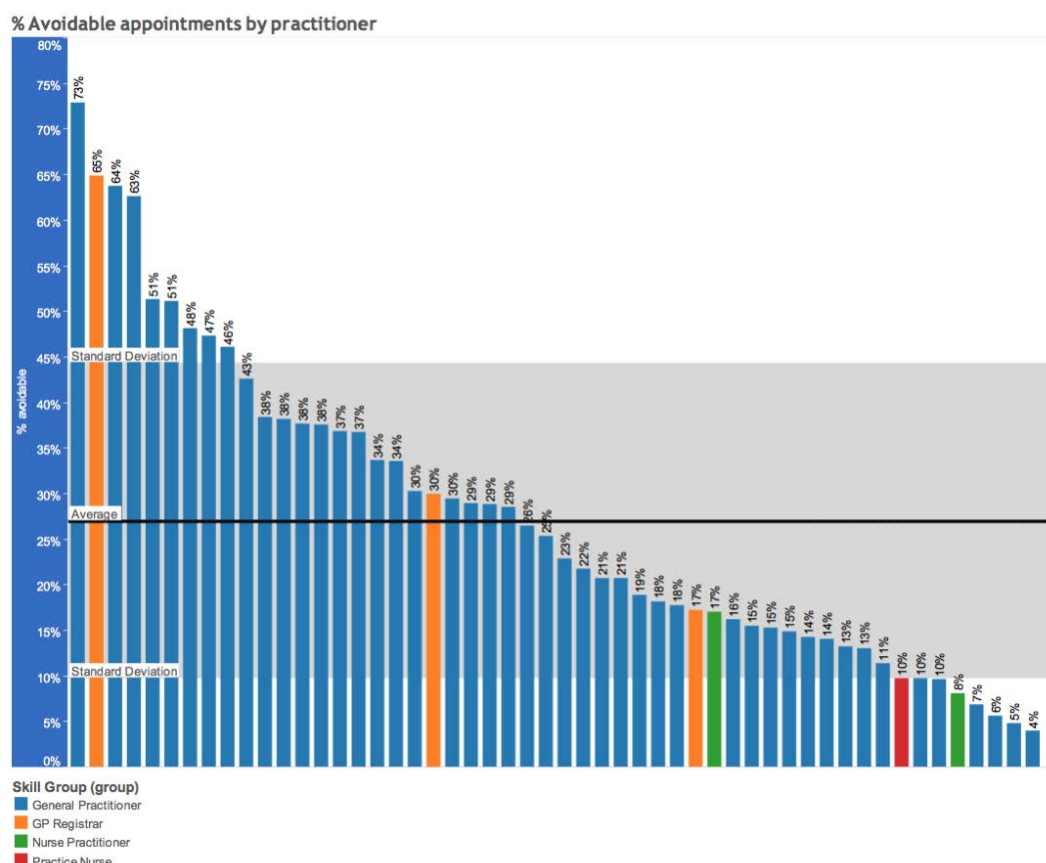
⁵ www.nhsalliance.org/reducing-workload-general-practice/

% Avoidable appointments by category



Variation

There was significant variation in perception of the GPs interviewed as to what constituted an “avoidable” appointment. The discussion (see below) indicated that although this might be influenced by such factors as the nature of the practice population, much of the variation derived from GPs’ views about the role of their practice and their views and understanding of the range of alternatives. Some GPs had committed to finding ways to re-distribute work, for example by employing other clinicians, while others maintained a more traditional approach. The proportion of reported “avoidable” appointments varied as shown below (because the level reflects so much the view of the clinician we have chosen to show the range within one standard deviation of the average, containing approximately 70% of respondents).



Qualitative results: what GPs told us

Letting go and the doctor-patient relationship

Some GPs felt that it would be disruptive to their clinical relationships with patients to point them in the direction of another clinician, and there were concerns about losing control of a patient's care to another professional as well as lack of trust in others' abilities. There was a variable appetite to challenge a patient's desire to see their doctor in favour of another health professional.

GPs found it difficult to use part of a consultation to play the "long game" and advise the patient of the most appropriate management for next time in the hope of changing behaviour. Some GPs reported the conflict between aiming for high patient satisfaction whilst directing patients to other providers of care or self-care.

On the whole, GPs were sceptical about whether offering telephone consultations was a way of avoiding an appointment or reducing workload.

Additional skills within the practice

A significant proportion of appointments GPs felt were avoidable were those that could have been managed by a prescribing nurse, but they also identified a similar number that could potentially have been managed by a pharmacist. Not all GPs interviewed had considered diversifying their clinical team in this way. Part of the difficulty is that there is (naturally) a lack of understanding about the capabilities of other clinicians where GPs do not have direct experience of working with them.

Where GPs had trainees, they felt this was a useful way of managing more minor illness. Many GPs mentioned that mental health symptoms were best managed by GPs. Although a high number of avoidable appointments were recorded for children attending with minor illness, some GPs felt as

though these patients were still best seen by a GP, for the added value of a holistic approach to family care.

Some GPs felt that they were not best placed to complete all the sick certification requests, and that there may be another system to better manage these requests. Would the follow up and certification of patient off work offer a potential for a community support service? They reported being sometimes asked to provide a certificate to a patient during the period when self-certification was appropriate and accepted by employers. These appointments could potentially be avoided if receptionists enquired about the problem and advised patients of the guidelines.

There was considerable discussion about the extent to which receptionists could or should be empowered to determine the reason for the appointment so that, with the agreement of the patient, they can steer them towards the most appropriate clinician. Some GPs and practices see this as an important part of the operational process, but others are much more wary lest the reception staff find that they are faced with a clinical judgment.

Bureaucracy

Almost all GPs commented on additional workload generated by poor organisation in secondary care, or other bureaucratic challenges. One example they gave was hospitals asking GPs to re-refer patients who had not attended an appointment. This led to time consuming work and sometimes an avoidable appointment. IT improvements had meant that there was speedier access to discharge summaries on the whole, however a lack of organisation of the discharge process continued to generate work for GPs, such as insufficient medications on discharge. GPs reported being frequently asked to chase up a follow up appointment that had not happened as expected after discharge. And nursing care including catheter changes was often not appropriately organised after discharge.

Some patients saw their GP to chase results that had been organised in hospital. There appeared to be no clear plan communicated to the patient how they would receive these results, or they had been advised to see their GP. These included scan results and histology results for instance following an endoscopy.

Electronic prescribing was reported as helpful in managing workload, and was felt to lead to higher quality medication reviews in general.

Public health measures

There was a suggestion of a public health media campaign emphasising advice for self-limiting illness, and perhaps pointing patients in the direction of a pharmacy if needed. Some GPs did not feel backed-up by the media, and commented that they felt patients were encouraged to seek help from their GPs, increasing the level of demand.

Understanding the burden of the primary-secondary care interface

Introduction

One of the findings to emerge from both the audit and the survey was the burden imposed on general practice of administering hospital appointments. We went on to explore this interface jointly with primary and secondary care doctors and managers and commissioners at a workshop in June 2015 supported by NHS Providers.

GPs and practice managers identified a number of issues but one constant theme was variability not just between hospitals but also between clinicians within hospitals. This affected, for example, the drugs provided on discharge, the speed at which discharge letters and other information was provided to general practice, and the willingness of the hospital to take responsibility for any complications from treatment that arise shortly after discharge.

Hospital consultants, with some justification, complained about the information provided to them when a practice refers a patient. They told us that the information is incomplete and non-specific. They also told us about the variation in primary care such that they cannot be sure about the safety of services to which they are discharging patients.

This is an issue that affects commissioners, sometimes in quite subtle ways. It's referred to as the "commissioning gap" in which practice 1 will take on things that practice 2 will consider to be outside their contract and vice versa. This creates an opportunity for the CCG to commission (perhaps through the federation) some way of guaranteeing a consistent set of services being available. But it is also about how in a locality it is possible to promote the use of other services and thereby relieve some of the pressure on practices.

Promoting informal communication

Our informants explained the complexities of defining this interface and the difficulties of developing hard and fast rules. One theme of discussions was that many of the problems could be overcome by relationship building rather than by process building.

"We used to have regular educational sessions at the hospital and we knew all the consultants but that's all gone now. I don't feel I know anyone anymore."

GP at workshop to explore primary-secondary care interface

"We have lost our sense of place. We all remember when we had a sense of belonging to a place. We don't have that anymore."

Hospital consultant at workshop to explore primary-secondary care interface

Case study

Bringing back education

When CCGs took over from PCTs, one of the losses was hospital-led GP education sessions. Now Northumbria NHS Trust has reintroduced them.

The day long sessions are free to GPs and funded from commercial activity by the trust. The programmes are developed with feedback from GPs but generally will include

sessions with hospital consultants on national or local projects and some elements of statutory training such as child protection.

So far, five events have run, each with 250 delegates. The next event for October 2015 had 150 people signed up before the programme had even been developed. An annual event for practice nurses is similarly highly subscribed.

Jane Weatherstone, GP Clinical Director for Northumbria NHS Trust, says: “These offer a chance for GPs to network with each other, with hospital specialists and to get their CPD and mandatory training all in a nice venue and at no cost to them.”

Supporting formal information sharing

There was broad consensus on the need for a single electronic health record shared across primary, community and secondary care with patients able to access their own information. This would enable a step change in information sharing so that standardised referral and discharge letters could feed directly and automatically into patient records. It would also support self care by giving patients with long term conditions the tools to monitor and manage their own health in partnership with their GP (see appendix 8). However, information governance was regarded as a key issue to be managed. It should not be an obstacle to providing useful information to the clinical decision-maker.

A shared electronic record may be many years away and in the meantime, there is much information that can be shared electronically, such as discharge summaries and referral letters. CCGs are in a good position to promote this through their commissioning leverage.

Booking appointments and DNAs

General practice reported to us their frustration with the process for booking appointments for patients in secondary care and the problems that arise when patients do not attend.

Too frequently the process of booking an appointment can be fraught with difficulty for the patient, frustrating for all those involved, wasteful of NHS resources and result in poor care. Though offered a choice of hospital, many patients choose their local general hospital and are told, when the referral is made, to expect the hospital to contact them. Hearing nothing for several weeks the patient may return to the practice.

Some patients report that they did not receive the letter inviting them to the hospital. Those who did receive one sometimes found that they are given very short notice; they report that it can be very difficult to get through by phone to see if the appointment might be at a different time. It is perhaps no surprise that patients become a DNA (did not attend) – leading the hospital to refer the patient back to their GP for the process to begin again. A similar cause of unnecessary workload is where a patient does not receive a follow-up appointment as planned from the hospital, often leading them to consult the GP.

Discharge letters

Discharge letters are a valuable way of communicating the opinion and views of a specialist to the GP and patient. They are more than a computer-assembled record of the treatment, tests and diagnosis code that are recorded in the patient's hospital record. They provide the view of the specialist at discharge, including any medication changes.

Delay in delivering these letters to GPs has been identified as a patient safety issue for many years

and one on which the NHS Alliance has campaigned. Targets for delivering letters to GPs within 24 hours of patient discharge have been in place for many years too. Some CCGs have begun fining hospitals for failing to meet these targets⁶. Other CCGs have worked with general practices and hospitals to improve processes⁷. Yet our informants told us that delayed discharge letters remains a real problem.

Beyond this, there was a clear dissatisfaction among GPs about the information contained in discharge letters. Often it is a summary of hospital care rather than being a letter to a GP describing the salient points for follow up.

“Primary care has quite serious differences. We need the diagnosis, what was done, what needs to be done and information about the drugs. We do not need a long letter with the important paragraph buried in the middle of page four.”
GP at workshop to explore primary-secondary care interface

There was also a particular problem around lack of discharge information for patients going to nursing or residential care, where levels of complexity are rising.

“The real push is around complex patients in nursing and residential care homes. If they had a number they could ring for information, that would be a real help.”
GP at workshop to explore primary-secondary care interface

Case Study

Improving discharge summaries

Brighton and Hove CCG and local provider Brighton and Sussex University Hospitals have developed a process to improve the transfer documentation sent by hospital to GPs. An important element of this is a specially designed form, which is based on published standards for handover documentation.

The form, designed to be completed by junior doctors as part of discharge processes, includes a text box entitled “clinical narrative” which asks the discharging clinician to tell the story of the admission, encouraging them to do so in a way that might be easily understood. Patients themselves receive a printed copy at discharge, aiming to reinforce the importance of making the narrative readable. The documentation also includes the list of medications on which a patient has been discharged as well as specific boxes to document any medications that have been discontinued and any changes made to dosages, flagging up those factors most important for a GP to have quick sight of.

The overall appearance and design of this summary is based on graphic design principles to enhance the impact of key messages on the clinicians completing and reviewing it. Attention was given to the coding so that as much as possible can be auto completed.

The introduction of this new form was accompanied by training for the junior doctors who would be using it, and this was backed up by a period of audit, where summaries were reviewed by consultants for quality prior to being sent – reinforcing the importance of clear and relevant documentation on those completing the form.

The form is sent by email at the point of discharge, so is received in a timely fashion by the GP practice, aiming for a seamless transfer of care. This form has led to much improved transfer communication within Brighton and Hove, and a similar template could be reproduced elsewhere, aiming for a national standard template.

⁶ www.pulsetoday.co.uk/news/commissioning-news/hospital-fined-for-failing-to-send-discharge-summaries-on-time/20005123.article#.VgFkvOlv_6s

⁷ <http://qir.bmj.com/content/2/1/u756.w1013.full>

Discharge documentation following a patient's admission to an acute setting is key in ensuring safe transfer of care back into the community. There are plentiful examples of failings in this system from colleagues across the country – many of the systems were described as not fit for purpose. There are also many examples of good practice.

Availability of results to the GP and to the patient

Hospitals carry out a range of tests on patients; GPs and patients would often like to know the results. This is a complex area fraught with technical, ethical and legal considerations and one that is addressed in NHS England's digital work streams Personalised Health and Care 2020⁸ and digital pathology work stream, Digital First⁹. It would seem from our contacts with primary care that there is a thirst among GPs for the tools described in these digital strategies – such as shared records and patient access to pathology results in long term condition management – yet there is very little knowledge of these work streams.

Onward referral

The issue of onward referral is seen as one that needs addressing following a general clampdown by CCGs on consultant-to-consultant referrals so that hospital specialists who recommend a follow up appointment with a second specialist refer the patient back to the GP first rather than referring on to the second specialist themselves.

In one scenario specialists who refer patients back to the GP unnecessarily increase the pressure on GP appointments by failing to take full responsibility for follow-up related to the original referral. This was true when there was a defined pathway across specialisms. An example might be direct referral by an oncologist to clinical genetics for genetic screening; the GP does not need to be involved.

“Patients do get annoyed by this going backwards and forwards. For example, I refer a patient to a gastroenterologist for abdominal pain who refers the patient on to a gynaecologist. I need to know but I do not need to see the patient.”

GP at workshop to explore primary-secondary care interface

The second scenario is quite the opposite – GPs who are managing patients with multiple co-morbidities did not wish hospital specialists seeing their patient for one condition (say diabetes) to refer the patient to a second specialism for another condition (say arthritis) independently. They felt that they have the continuity of care and the overview of local services.

“As GPs we have access to different pathways, for example community –based pathways, that the hospital consultant knows nothing about.”

GP at workshop to explore primary-secondary care interface

⁸ www.gov.uk/government/uploads/system/uploads/attachment_data/file/384650/NIB_Report.pdf

⁹ www.england.nhs.uk/wp-content/uploads/2014/02/pathol-dig-first.pdf

Follow up in primary care

GPs and practice managers complained about specialists who sometimes hand responsibility to the GP inappropriately. At its extreme they resented being treated as junior house-officers expected to follow up on behalf of the specialist. The specialists that we spoke to had heard such anecdotes, but none defended them - indeed they described this as insulting to GP colleagues. We suspect (and hope) that such instances are more apocryphal than real, but if they do occur GPs should have no hesitation in raising them with the medical director of the hospital.

Specialists meanwhile had their own perspective – concern about the patchiness of general practice. They told us that they cannot be sure of the quality of follow up care. This is an area where individuals will draw the line in different places as the reality is that the responsibility is often shared. A specialist discharging a patient should be asking a number of questions before deciding what sort of follow-up is necessary. For example, they should consider what further care the patient requires, whether that is available in primary care as well as being regularly and reliably managed by primary care clinicians. They also need to consider if their specialist input is required to assess the results or development of the patient's condition. They need to be sure that the handover is such that they can rely on it being delivered. But equally they should not be asking patients to return to hospital if this is not necessary - indeed the default should be that continuing care after discharge is delivered in primary care.

“There is such a range in primary care – and community care has quite simply been devastated – that I cannot be sure of the quality of the service I am handing over to.”

Hospital consultant at workshop to explore primary-secondary care interface

Discussion and Recommendations

Looked at in the round, these three pieces of work provide some common themes about where the pressure points are and how to reduce them.

Better IT systems could help

It is no surprise that IT and systems were identified as an enabler, a way to share information across boundaries and reduce bureaucracy. However, there were many barriers to this including lack of interoperability and obstructive information governance. There is no easy and quick fix - changes are needed across all systems to allow information to be shared to the benefit of patients and users - and plenty of people are working on them. Being able to view the hospital records is a start but falls a long way short of populating the patient record with full details of all of the tests and measurements, summary from the consultant's letter etc. that should be the eventual aim. It is striking how some areas have moved further than others and that commissioners, in their focus on the immediate problems, often fail to demand plans to improve systems and interfaces.

There were also some specific points about the GPES/CQRS systems for extracting data from GP systems and reporting or providing information. While much criticised, the system was also seen as providing the right long-term solution ([See appendix 9 for more detailed analysis and recommendations](#)).

The work involved in processing information about patients, particularly from hospitals, is recognised as time-consuming and also an area of risk in that some detail in a letter from a consultant might be missed because information is structured so badly. Practice managers recognise that this is another area where systems should provide a much simpler to operate solution that is safer for patients and that allows a full structured patient record to be assembled in such a way that the right information is presented to the clinician.

These are not things that practices can fix - nor can commissioners yet insist on such systems being in place before all of the technical and governance pieces are in place to allow different systems to communicate or share information. And the professions need to work with the software suppliers to agree, for example, a standard structure for a referral letter that pulls together data from the system for the consultant (as many already do, though it is perhaps not as complete as it could and should be) and structures it in a standard way with a summary highlighting any actions that the practice is to take, but with other information structured so that it can populate the record for the patient.

NHS England can help by:

- Raising the ambitions of what can and should be achieved through the use of single, shared electronic patient records.
- NHS England should continue to raise ambitions around the technology and information sharing described in Digital First.
- Continuing to support interoperability between systems providing records in primary care and those in secondary care, working with system providers.
- Working with the Royal medical colleges to develop standards for shared records.
- Providing clear guidance on what information primary care and secondary care may share from an IG perspective and how to manage IG issues in practice.
- Drafting a specimen contract that could be developed locally to specify, incentivise and performance manage information sharing.
- Making practices aware of the plans and timescales for changes and updates to GPES and CQRS to develop its full functionality, not just for payments from and information for

NHS England, but also so that it can be easily adapted for some of the more common local enhanced services or information requests.

- Supporting the development of GPES and CQRS as the default mechanism to support payments and information gathering not just nationally, but for CCGs and local authorities (see appendix 9).

Commissioners can help by:

- Promoting and incentivising electronic information sharing, working with provider organisations across health economies to develop plans for the locality.
- Providing a supporting role for organisations encountering IG barriers to information sharing where patients will benefit.
- Promoting knowledge of Digital First and associated national and local work streams so that the views of general practice are fully represented.

Practices can help themselves by:

- Making sure that they understand how best to make use of the various systems with which they interact (such as GPES and CQRS) as well as how to exploit the capability of their own IT system to support reporting and to improve the end to end work-flow within the practice.
- Working with commissioners and local care providers to explore how best to share information, tackle IG barriers and raise the ambitions for shared care records for their patients.

Keep it simple

There were numerous complaints from practice managers about commissioners requesting information late, sometimes defining the full information requirements for a service only after the service was being delivered, about how they failed to consider how some information would be collected, how little time was given to develop the necessary templates to support collecting or reporting information (let alone provided the template to practices). There were also criticisms of how much information (sometimes conflicting) was sent to them, often in dribs and drabs and how difficult it was to find the appropriate contact to answer questions. And practices reported that different groups of commissioners required similar information and they described how some requested enormous detail that meant that work was repeated. Information flows into general practice need simplifying.

NHS England can help by:

- Reviewing the range of safety notices that are sent to a practice (from all sources) and consider how filtering might be improved so that practices receive those that are relevant to them without the confusion of the irrelevant

Commissioners can help by:

- Ensuring that payment process for practices supports reconciliation so that practices can easily understand for what they have been paid over what period.
- Checking the details of payment mechanisms before settling on them, allowing all those involved time to prepare. All commissioners need to plan the process with practices and system experts before agreeing to an approach - and where needed time should be allowed for templates to be developed and made available in advance
- Standardising the mechanisms for payment, developing and then choosing from a menu of different ways in which payment can be made, i.e. by registered population, by registered population in an age band, by registered population suffering from a condition, payment for

each specific treatment/inoculation/review etc..

- Co-operate to provide information, such as templates, in one place for practices. This could be done by CCGs, by federations or across a larger area - but it requires the cooperation of all commissioners to agree to provide and maintain one up to date version of all the instructions, forms, templates, clinical criteria for referral etc. and someone to manage them and be able to advise practices.
- Agreeing a mechanism so that regular digests summarising changes and providing links to source documents and detail to replace ad hoc emails on individual changes can be provided to practices in place of numerous emails
- Co-operating so that, so far as is practical, common information is used for multiple purposes with the same break down and for the same period so as to simplify reporting for practices

Practices can help themselves by:

- Helping patients understand when to visit and who can help them, including by providing information to patients that helps them understand care processes and avoids unnecessary contact, for example, when test results will be returned.

Practices can work together to make things easier

Practice managers recognised that sometimes they found themselves reinventing the wheel. They often knew there was someone with the skills or experience who understood better what needed to be done - and they would have liked to be able to draw on that expertise. Such an initiative was seen as being something that could be taken forward by groups of practices working together, by federations of practices or by Clinical Commissioning Groups. Again there was a recognition that the new care delivery options might promote this sort of joint working between practices and there were a number of areas in which such co-operation was seen to be helpful.

Commissioners can help by:

- Supporting practices in learning from each other and developing ways of working together that reduce bureaucracy or limit the number of potentially avoidable appointments for GPs - for example by recruiting staff to work across a number of practices.
- Offer funding to all practices to free up time for GPs and other leaders in the practice to think through how they can work differently, learning the lessons from the PM's Challenge Fund sites and the Vanguard sites as they become available - creating the 'headroom' needed to plan new ways of working and clinical innovation.

Practices can help themselves by:

- Using their collective voice within the CCG to influence all commissioners (not just the CCG) to minimise the demand on practices - highlighting good and bad examples to make the point.
- Working together on common problems, for example on templates for returns that trigger payment, HR or system support. This might be formally through a federation of practices or other joint vehicle or informally via practice manager networks.
- Sharing lessons and experience as they adopt new ways of working. Even within this report there are a host of ideas and suggestions that an individual practice would find impossible to experiment with and develop - but practices should learn from each other the practical tips and wrinkles that make them work.
- Highlighting to CCGs and federations the opportunity to reduce potentially avoidable appointments through (for example) sharing the services of support staff or commissioning new services.

Manage the primary-secondary care interface

Practice managers and GPs identified a number of issues associated with the interface between primary and secondary care. They complained of variability not just between hospitals, but also between clinicians within hospitals over, for example, drugs provided on discharge, the speed at which discharge letters and other information is provided to general practice, the willingness of the hospital to take responsibility for any complications from treatment that arise shortly after discharge. These difficulties were confirmed in our further work to explore this boundary and we make recommendations below.

NHS England can help by:

- Drafting specimen contract terms that could be deployed locally to specify, incentivise and performance manage booking appointments and managing DNAs. This could define a default position whereby patients who have missed an appointment are notified promptly and given the opportunity to rebook during a period of 10 working days grace without having to return to their GP.
- Drafting specimen contract terms that could be deployed locally to specify, incentivise and performance manage discharge letters. This could define as a default position an expectation that discharge letters should be transferred electronically to the practice, that data should be structured and presented in a consistent way and that they should normally be produced within 24 hours of discharge. We appreciate that an ambition to achieve electronic transfer of discharge notes by October 2015 has been set out and this needs to be pursued with vigour.
- Working with the Royal Colleges of GPs and Physicians and IT system providers to develop standard templates for discharge and referral letters that are practical and oriented to the real world of clinical practice.
- Ensuring that the recommendation for all GPs to receive electronic discharge summaries by October 2015, as outlined in summer 2015, is delivered.
- Monitoring the uptake and use of the new e-referrals service that replaced Choose and Book to ensure it delivers the expected benefits.

Commissioners can help by:

- Agreeing local protocols to allow GPs to discuss a case with a specialist, preferably by telephone and preferably on a telephone number where either party can be sure of an answer.
- Working with hospitals and general practices to provide joint education sessions for primary and secondary care doctors.
- Work with hospitals to streamline the process by which appointments are booked with the hospital. Processes need to be robust and clear for patients, with good telephone access allowing them to book an appointment at a suitable time.
- Reviewing with practices where there are delays in receiving discharge letters.
- Working jointly with hospitals and general practice to improve processes and content of discharge letters.
- Examining processes for residential and nursing homes to receive discharge information.
- Issuing clear guidelines that describe the circumstances in which a specialist is expected to refer onwards to other specialist colleagues or seek to triage these referrals for appropriateness. This seems largely to revolve around whether the onward referral is related to the original referral.
- Addressing the commissioning gap by working with general practices and secondary care providers to understand where transfer of care to primary care is falling down and consider new models of care to resolve this.
- Ensuring that specialists referring a patient back to primary care can be assured that the

necessary follow-up will reliably be actioned. Without this assurance clinicians will, in the best interest of patients be much more likely to plan follow-ups in secondary care or build in a review to double-check.

Practices can help themselves by:

- Feeding back to hospitals, specialist clinicians, CCGs, employers and other organisations when information is incomplete, unnecessary or inappropriate.
- Working with IT system providers to consider how discharge letters and other information received from hospitals, health and care providers are built into the end to end work flows within the practice (see also Case study: Reducing the GP workload: the clinical personal assistant)
- Reviewing the workflow associated with referral to other services to ensure that this is both efficient for them and effective in providing all of the information needed within the recipient organisation

Give practices headroom to innovate

The quantitative results of the audit show that many appointments in general practice are potentially avoidable. The qualitative results highlight the difficulties GPs face in practice in creating alternatives, encouraging patients to use them and making sure that they meet the need and expectation of the patient. There is both a lack of confidence and lack of knowledge about alternative healthcare professionals and how they could fit into an extended skill mix within a practice team. Similarly, there is a lack of confidence that new ways of consulting with patients can provide realistic alternatives to face-to-face consultations.

Finding alternative ways to meet the demand will require practices to work in new ways and we have outlined some of these in the next section of this report: What can we do differently? No single practice can look at all the areas or implement all the solutions we suggest but working in groups or federations and employing tried and tested quality improvement tools should allow change to take place at scale. Similarly, practices will rightly look towards national bodies to create the pipelines and regulatory support for new healthcare professionals and new types of consultation. We have made more specific recommendations at the end of the next section.

The issue of whether practices have the headroom currently to take this on is real; as the RCGP has pointed out in its New Deal report earlier this year, GPs need time and funding to innovate¹⁰. But, challenging though it is, practices will have to find headroom to innovate – time that will potentially repay itself. Commissioners should support them as indicated above and NHS England should ensure that not only are the lessons from the PM's Challenge Fund sites shared but also that practices have some headroom to think about how they might take them up locally

NHS England can help by:

- Ensuring that not only are the lessons from the PM's Challenge Fund sites shared but also that practices have some headroom to think about how they might take them up locally

¹⁰ www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/PPF/A-Blueprint-for-building-the-new-deal-for-general-practice-in-England.ashx

Commissioners can help by:

- Supporting general practice to create the headspace and funding to innovate

Practices can help themselves by:

- Practices can challenge themselves to find headroom to innovate – time that will potentially repay itself

Part 2: What we can we do differently?

Look at the skill mix

The greatest opportunity for relieving pressure on GPs is by extending and making fuller use of the wider practice team. There is considerable variation across practices with some making extensive use of a broad skill mix while others retain a traditional medical model of general practice. This is a decision for the practice - but it has clear implications for the numbers of registered patient per GP.

New roles may offer fresh ways of sharing the workload in a way that reduces pressure on GPs and improves the overall quality of care for patients. Opportunities include:

- Highlighting the benefits of a broader skill mix within the practice, or potentially, across practices. Some examples are included in the case studies and appendices in this report; more may be expected to be reported from the Prime Minister's Challenge Fund¹¹ sites.
- Providing increased funding for practices to employ members of the practice clinical team, whether this is traditional roles such as practice nurses or nurse practitioners, or new roles such as practice pharmacist or GP assistant.

Join forces

New ways of working are explicitly promoted in the Five Year Forward View and practices are already looking at how they can federate or find other models that offer to remove some bureaucracy (See case study: efficient rostering across a federation). In a number of areas, practices are now being managed by acute or community trusts (see case studies: community trust takes over general practice and new ways of managing general practice).

Case study

Efficient rostering across a federation: Network Locum

Agency Fees are a problem throughout the NHS – no less for Primary Care providers than for other parts of the system. Network Locum have been connecting Providers and GPs directly with each other using technology since they were founded. A relative new comer to the locum market, they provide a web-enabled staffing solution set up by GPs for GPs. Its aims are to reduce the agency fees paid by practices, reduce the bureaucracy involved in paying locums, provide continuity for practices by helping them use regular, trusted locums and improve the experience of locum GPs.

Network Locum had an existing relationship with practices in Southwark and when they were approached to support one of the GP Federations with staffing to provide extended hours services from one site their solution improved visibility and helped match the rota to local GP's calendars. This innovation fitted exactly with the vision of the federation and commissioner in engaging local GPs to deliver additional levels of access to Southwark patients seven days a week, 8am to 8pm.

Network Locum's CEO Melissa Morris, a former NHS manager, explains the approach. She started by setting out with the seven-day service manager the shifts that needed filling in

¹¹ www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/

the six months from June to December. “We provided a free tool that allowed the provider to build an on-line ‘bank’ of local GPs. When GPs from the practices who were interested in working in the extended hours project were asked about their availability 80% of the slots up to December were filled almost immediately with local doctors.” No agency fees were payable in respect of the local doctors, although Network Locum charged a fee for each out of borough placement and the federation were able to vet GPs before allocating them slots. When it comes to payment, all this is done automatically. The system generates the invoices and the NHS pension contribution form, dramatically reducing paperwork for practices.

Network Locum is already working with 1,000 practices and some NHS acute trusts who use GP locums to run urgent care centres. <https://networklocum.com/about/>

Case study

Community trust takes over general practice

In February 2015, Derbyshire Community Health Services NHS Foundation Trust took over the running of Creswell and Langwith Medical Practice on a caretaker basis with just one day's notice.

A combination of factors including failure to attract staff to the practice, which serves a former mining community, led to a crisis that threatened to close the practice doors at short notice.

So Hardwick CCG called in the community provider to make sure that didn't happen. It's been so successful that the trust is continuing to run the practice and will now oversee its transformation into one of a new breed of multi-specialty primary care providers, offering patients direct access to advanced nurse practitioners, musculoskeletal physiotherapy and an in-house pharmacist.

William Jones, an executive director at Derbyshire Community Health Services NHS Foundation Trust, says there are many benefits to the arrangement. The trust has provided stability, clinical leadership, infrastructure, investment, a vision for the future and aligned primary and community care both for patients and clinicians.

Dr Bola Owolabi, clinical director for the north of the county with Derbyshire Community Health Services NHS Foundation Trust, says: “Having the backing of the community trust's organisational structure means that GPs can focus on patient care as the business aspects of the practice are taken care of. A big attraction has been the innovative multi-specialist team approach and offering a portfolio career with opportunities across DCHS' other services, such as sexual health, musculoskeletal services, geriatric medicine, rehabilitation and endoscopy via the planned care services provided at Ilkeston Community Hospital's diagnostic and treatment centre.”

Case study

New ways of managing general practice

Northumbria NHS Trust set up a new company to run general practices in April 2015. It is a development that has the potential both to reduce bureaucracy and improve the primary-secondary care interface.

The development came about after a number of practices approached the trust for help with back office functions such as pay roll, HR and premises. It already runs two practices with a third about to join. The GPs are salaried.

Already working practices are changing, with clinical pharmacists from the acute trust now working alongside GPs in general practices.

Jane Weatherstone, GP Clinical Director for Northumbria NHS Trust, says: “It is bringing some of the efficiencies that a large organisation has and some of the relationships that will help things run more smoothly.”

The bureaucratic burden on the practices is certainly reduced because all the HR, pay roll and other administration is taken off them. However, it is too early to say whether it will cut the burden for individual GPs.

With primary and secondary care clinicians on the company board, the development also offers benefits around the primary-secondary care interface, says Dr Weatherstone. The company's general manager has a secondary care background.

“We are starting to change some of the traditional boundaries,” says Dr Weatherstone. “We do expect to see more practices joining us and for them to start changing more of these boundaries.”

Extend the practice team

There are several roles that can help reduce pressure on GPs by directing patients to more appropriate healthcare providers. These roles include:

- Practice pharmacist – [see appendix 1](#)
- Nurse practitioner
- Paramedic
- Physician assistant – [see appendix 2](#)
- Health advisors or community co-ordinators
- Wellbeing coaches or health trainers¹²
- Clinical personal assistant - see case study below.

Whilst in larger practices there may be an opportunity to deploy some of these skills full time, many of them will be most effective if they operate across a number of practices.

¹² <http://healthtrainersengland.com>

Case study

Reducing the GP workload: the clinical personal assistant

Ten practices in Brighton and Hove are now deploying a new clinical personal assistant role to reduce the bureaucratic burden on GPs.

It's an idea that has been backed by the RCGP, which in 2014, called for a medical assistant role, trained in 12 weeks to take on some of the GPs' administrative burden. This is very different to the physician assistant or physician associates who take on a clinical role.

The Primary Care Clinical PA (PCCPA) is a band 4 administrative worker trained to support GPs by processing letters coming into the practice. By using a clear and agreed workflow, the PCCPAs can carry out delegated work where it safe to do so, leaving GPs to deal with those letters requiring medical input or oversight.

In a pilot scheme, the PCCPA role was estimated to save each GP in the practice 40 minutes per day but to require three additional hours of administrative time per week per 5,000 registered patients.

The role was first tested at Pulborough Medical Group practice by GP Jonathan Serjeant and has since been developed under the Extended Primary and Integrated Care arm of the Prime Minister's Challenge Fund. It has been rolled out to ten practices in the Brighton and Hove Integrated Care System.

The agreed workflow sets out how letters are dealt with; the workflow can be tailored to each practice's requirement.

In one example, PCCPAs open all letters and automatically forward to a GP where it involves a child under 5, a serious or complex diagnosis or other issues around safeguarding or mental capacity. Typically, this is a third of letters coming into the practice. For the remaining letters, the PCCPA takes a variety of actions. This might be entering read codes and other data into the practice system; booking a follow up appointment with the patient; booking follow up blood tests with the patients; or following the agreed DNA process for patients who missed appointments. GPs do not see these letters.

Deploying the PCCPA role at practice level requires training for the admin staff who are to take it on; a lead GP to provide governance and audit; and GPs willing to consider working in a new way.

For more information contact Melanie Teulet, Primary Care Development Manager, Brighton and Hove Integrated Care Service. melanie.teulet@nhs.net

The role of practice pharmacist has widespread support¹³, with the RCGP recently calling for funding and support to roll it out nationally. Other roles have been around for a long time without gaining much traction, for example the physician assistant, despite research showing that they can reduce cost per consultation without increasing the rate of re-consultation for the same problem. Health secretary Jeremy Hunt has announced plans to make 2,000 PAs available to general practice by 2020¹⁴.

A newer role is the practice-attached paramedic or emergency care practitioner. This role is now being tested in a number of the Multispecialty Community Provider vanguards, including Kent and Derbyshire.

¹³ www.nhsalliance.org/wp-content/uploads/2014/12/NHS-Alliance-Pharmacists-in-general-practice.pdf

¹⁴ www.gov.uk/government/speeches/new-deal-for-general-practice

In Whitstable, Kent, a paramedic team is now based in a GP practice. They have their own vehicle with onboard diagnostics and access to electronic patient records. When patients call the surgeries at 8am requesting home visits, GPs screen the calls and refer the most urgent to the paramedics who can make a visit quickly. The less urgent wait until a GP can visit later in the day. In the first five weeks of the pilot in spring 2015, paramedics were able to see, treat and complete two thirds of patients referred to them. The volume of 999 calls was down 10% over the period

Manage demand

Many practices work hard at managing demand and matching the service that they provide to meet that demand. There are practical measures that GPs and practices can take within the practice environment. They are well-known – although not universally employed – and include:

- Checking the balance of same day and book ahead slots - and in particular looking for signs that patients are defaulting into the 'same day' slots because they were unable to get an appointment at a convenient time a few days ahead. This can increase the burden, reduce continuity and might have been more easily handled (with greater flexibility as to when they are fitted in) had the patient been able to book a time that suited
- Reviewing how frequently the average patient has a clinical consultation (face to face or by phone) with the practice in a year. Some practices find that there is enormous pressure on appointments, but the solution comes from looking at what it is about the way the practice works that means that patients are coming back so often compared to the norm. This may highlight the opportunity to deal with multiple problems in one go, to rationalise review periods or to promote continuity
- Dealing with demand differently, for example through group consultations, redirecting patients to other members of the practice team, planning shorter online or phone consultations, particularly if a follow-up consultation is necessary, providing direct access to services such as physio, offering patients the option to book online appointments and offering patients the option to obtain repeat prescriptions online
- Looking to improve personal productivity through a well designed environment with information readily to hand, streamlined processes that exploit the potential of the IT system to the full and with practitioners who are well trained and confident in their use of the computer and systems

Alternatives such as telephone consultations or e-consultations can help practices manage demand, although there is some controversy over whether providing these alternatives either stimulates new demand¹⁵ or simply redistributes it¹⁶, providing no savings of either time or money.

The controversy has not stopped pioneering practices testing out new types of consultation or entrepreneurs developing and marketing new solutions and a number of providers are already offering alternatives. They include WebGP and AskmyGP, which offer to enable e-consultations with the patient's own GP and charge practices a fee per head, and Dr Ed and Dr Thom/The OnLine Doctor offering privately funded e-consultations with a GP (see appendix 3).

¹⁵ www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140630_meeting_need_or_fuelling_demand.pdf

¹⁶ http://medicine.exeter.ac.uk/news/title_405113_en.html

Case study

Alternative ways to access GPs: Care UK's SuperPractice

The SuperPractice is one of the projects stimulated by the Prime Minister's Challenge Fund. Its premise lies in that the nine geographically spread practices run by Care UK can deliver improved patient experience and greater practice efficiency by providing certain services in the same way to all of them.

A key efficiency gain has been to release some GPs for some of their time to staff a central telephone resource.

Patients calling their own practice can opt for a telephone consultation and then are routed automatically to the hub where a GP, who can access their notes, deals with their call. The centre is open to patients 24/7.

Care UK has shown:

- 90% of all phone consultations are completed within 4 hours
- Face to face consultation wait times have reduced from many days to just hours in participating practices
- Patient contacts have risen by just under 10%, but the entire system is cost neutral and the practices feel much more in control and relaxed
- Local walk in services have experienced marked reductions in volume returning benefits to commissioners.

The technical challenges are around being able to route callers from any practice to a hub, and within that hub to be able to view patient notes from all practice systems used.

Case study

Alternative ways to access GPs: WebGP from The Hurley Group.

WebGP is a patient portal that sits within patients' own practice web site. Patients can carry out simple transactions on line such as book an appointment but beyond this, they can work through a symptom checker and choose from multiple options as to how to fulfil their need. They can:

Self manage

Use sign-posts to alternate services

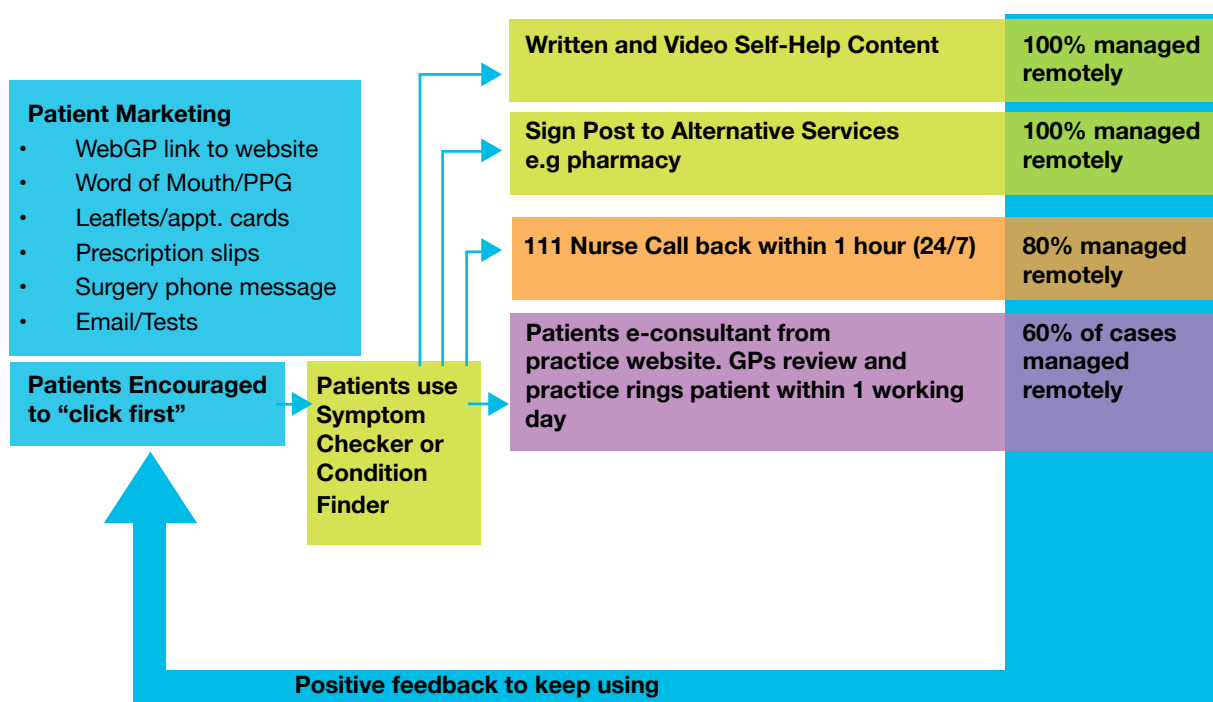
Request a nurse call back

E-consult with a GP

Request an appointment.

The system creates a summary medical history that takes less than 3 minutes to analyse and allows the GP to further stratify the patients' needs, 60% of which do not require a face to face consultation.

Practice decides to Proceed with WebGP:



The system has been tested by 20 practices with over 130,000 patients and has been shown to reduce GP workload and deliver cost savings.

Support patients to help themselves

There is an emerging body of evidence about the benefits of supporting patients to manage their own health both to the individual's wellbeing and in reducing demand on health services. At one end of the spectrum are information sites for lay people. Some are very general, covering a range of conditions, such as the BMA's self help site¹⁷ or NHS Choices¹⁸ which now receives 1.7m visits a day, over half of them by people looking for health advice from the Health A-Z service. Others offer more specific advice, for example national charities such as the British Heart Foundation, Macmillan Cancer Support and Diabetes UK. Beyond information provision, there are other more active ways in which general practice can support patients to help themselves, such as the generic programmes designed to support self care, including Self Management UK¹⁹ and the Expert Patient Programme²⁰.

Peer support

In 2015, National Voices and Nesta published the first systematic review of peer support in the UK²¹. It said there is evidence that peer support can help people feel more knowledgeable, confident and happy, and less isolated and alone. It also showed that there is a limited understanding of the different forms of peer support, how best to deliver support and the forms of training and infrastructure to get the most impact from it; so, further evidence is needed to fully understand the impact it has on the health service and individuals with long-term health conditions.

Examples of peer support include group consultations (see appendix 4 for a summary of the evidence and case study), online support groups run by charities (see appendix 5 for a case study), local groups and 'buddy' schemes in which practices connect the patient with someone else with a similar condition.

¹⁷ <http://bma.org.uk/working-for-change/improving-and-protecting-health/self-care>

¹⁸ www.nhs.uk/Pages/HomePage.aspx

¹⁹ <http://selfmanagementuk.org>

²⁰ www.expertpatients.co.uk

²¹ www.nationalvoices.org.uk/peer-support-valued-wider-impact-needs-further-evidence-finds-new-report

Case study

Peer support: Big White Wall

Big White Wall is an anonymous on line community for people who are anxious, down or not coping. Users can express their feelings, conduct validated tests that can enable them to identify their needs and track progress, and receive guided support programmes including live professional support. Professional moderators provide governance, prevent misuse, inform and can intervene in an emergency.

- 95% of BWW users feedback to say they feel better for using the service
- 73% of users say they discussed things about their health for the first time ever using BWW
- On average the amount saved in reducing appointments and other costed health interventions is £37,000 per 100 patients. This does not include social care and an individual's work place savings
- 67% of people affected by mental health related sickness absence reported that BWW reduced their time off work
- 80% of BWW users self manage

BWW is CQC registered. It also has the potential to share data (at the users' control) with professionals such as GPs, and provide a huge anonymised data resource to research. Users can subscribe as individual but in many cases may be referred by GPs, with commissioners paying a population subscription. Employers can also subscribe. An estimated 30% of general practice consultations have a mental health component.

Improving doctor-patient communication

There is an emerging body of evidence that improving communication between doctors and patients improves not only satisfaction but also outcomes. These are skills that can be taught (See [appendix 6 for a summary of the evidence and case study](#)).

Using Apps in healthcare

A quick reading of current articles in healthcare IT and new appointments in US medical education would lead a casual reader to believe that the age of the app in self care is upon us, with patients ready to provide data from their wearable devices directly into their electronic healthcare record. NHS England is reportedly planning to enable patients to feed in personal data from fitness apps to their health record by 2018²² and has set out plans to rebrand NHS Choices as a national hub for digital services, including a health app library²³.

English general practice, however, remains cautious about the value of apps, though the Prime Minister's Challenge Fund initiative may highlight practical opportunities. Issues of quality assurance, information governance and workflows in general practice remain to be addressed before apps for self care can have a major impact on work reduction in the UK (See [appendix 7](#)).

²² www.digitalhealth.net/news/29974/

²³ www.digitalhealth.net/news/29959/

Giving patients access to their own medical records

Anyone in England who wants it can now have access to their GP record. This offers significant opportunities for practices and patients. The 2015 GP Contract makes it compulsory for practices to enable patients to see only the equivalent of the Summary Care Record (SCR), which shares allergies, medication, name, address, date of birth and NHS Number. The SCR gives people little useful information and is really designed for clinicians, not patients. From 2016 practices will be expected to share with patients the full record. However, practices can choose to offer more comprehensive access right now.

Advocates argue that sharing records can have significant benefits, including reducing the demand for appointments in general practice by promoting self care (see appendix 8 for a summary of the evidence).

Case study

Online access

Manor House is a large practice in the Manchester area. The practice decided to make record access available to their patients because they felt it was a basic right and that it would make life easier for patients and staff.

They initially took time to screen every record before sharing with the patient, but after some weeks they realised this was unnecessary and allowed full access routinely. Receptionists, the practice manager and GPs handled any queries as necessary.

Once the receptionists and practice manager had made the small changes needed to incorporate record access into their work, the process was examined as part of a research project. Patients were asked whether record access increased or decreased the number of calls and appointments they made over the previous year. We also asked for their comments on those changes.

The 94 patients with record access who responded showed that 110 appointments and 325 telephone calls were saved with a per-patient saving of £29.08 once all the backroom costs are taken into account. There were similar results at a different practice with a different population.

If 30% of patients used record access at least twice a year, these figures suggest that a 10,000 patient practice would save 4,747 appointments and 8,020 telephone calls per year. Assuming a consultation rate of 5.3 annually, that equates to a release of about 11% of appointments per year, with significant resource savings for patients and the environment.

* For more information contact Dr Brian Fisher, Co-director of PAERS brian@paers.net

Social prescribing

Social Prescribing involves linking people to activities in the community that they might benefit from, connecting them to non-medical sources of support. The evidence to support it is mixed. Many small scale studies of social prescribing schemes describe the benefits of a range of interventions for people experiencing a range of common mental health problems, long term physical health problems and social deprivation^{24,25}.

Advocates suggest that at its best, social prescribing can:

- Support people to overcome chronic illness and unhealthy lifestyles
- Enable people to learn new skills
- Support people to become less grant dependent and to find work
- Provide the tools to create an enterprising community
- Deliver better social and clinical outcomes for people with LTCs and their carers
- Allow more cost efficient and effective use of NHS and social care resources
- Provide a wider, more diverse and responsive local provider base.

However, a recent evaluation by the University of York²⁶ has called into question the quality of the evidence, suggesting there is little good quality evidence to inform the commissioning of a social prescribing programme while evidence about the cost effectiveness of social prescribing schemes is lacking.

Nevertheless, policy makers are keen to see more practices offering social packages of support to patients. It is an element of Health Secretary Jeremy Hunt's New Deal for General Practice²⁷.

"Around a fifth of GPs' time is spent dealing with patients' social problems including debt, social isolation, housing, work, relationships and unemployment - yet 50% of GPs have no contact whatsoever with local social care providers."

So we need to empower general practice by breaking down the barriers with other sectors, whether social care, community care or mental health providers, so that social prescribing becomes as normal a part of your job as medical prescribing is today."

Jeremy Hunt, June 19 2015

Social prescribing is an area that appears to offer potential, albeit one in which practices and CCGs need to find what type of social prescribing is most beneficial. It is an area in which training and experimentation seems to be worthwhile.

Case study

Training for social prescribing

In our experience, many GPs not already offering social prescribing would like to start but feel they lack the skills and/or resources. Now social prescribing organisations have stepped into the gap and begun offering training courses for commissioners and GPs.

They include:

- Bromley by Bow Centre in Tower Hamlet, London offers training seminars
- Wellbeing Enterprises, a CIC based in Merseyside has a number of training modules
- Green Dreams a CIC working with 13 GP practices in East Lancashire and offers e-training

²⁴ www.nesta.org.uk/sites/default/files/more_than_medicine.pdf

²⁵ www.evidence.nhs.uk/search?q=%2522%2520social+prescribing%2522

²⁶ www.york.ac.uk/media/crd/Ev%20briefing_social_prescribing.pdf

²⁷ www.gov.uk/government/speeches/new-deal-for-general-practice

Health and housing

More recently, the NHS Alliance has advocated for better links between health and housing, arguing that housing organisations could save the NHS billions of pounds a year. Ensuring people have a safe and warm home to return to after a hospital stay would help swifter discharges, while a reduction in emergency admissions and GP appointments could be achieved through preventative measures²⁸.

The most conservative estimates claim that inadequate or inappropriate housing costs the NHS £1.4bn a year. Many GPs are familiar with the diverse housing problems faced by their patients; for example, the need for home adaptations or a move to specialist accommodation following a stroke or the onset of dementia. However, they probably don't know where they can access housing guidance to inform their decisions – hence the need for closer collaboration between GPs and housing associations. NHS Alliance is working with the housing sector to develop a brand new online resource to support this. The website www.housingforhealth.net will allow housing and health professionals to network and share learning and good practice, and aims to review and update evidence as it becomes available.

Case study

Health and housing: supporting hospital discharge

The time following hospital discharge may be especially difficult for some older patients and those with complex needs. They sometimes need extra support to adapt to living independently at home again.

Staffordshire Housing Group and their partners address this by offering short-term intensive practical and emotional support, including:

- Health, such as attending follow-up appointments, taking medication
- Housing, such as making housing applications, arranging viewings and house-moves, sourcing furniture and household goods
- Finance and household management, such as accessing benefits and social care funds, managing bills and bank accounts
- Navigation through other community-based services
- Emotional support, encompassing a meet-and-greet service and help with confidence, motivation and social isolation issues, as well as with anxiety and depression.

The project evaluation covering the period July-December 2014 shows that 92% of service users did not have to be readmitted to hospital during their support period and continued to live independently at home. Service users also report improvements in their mental health, confidence and motivation. The post-discharge support may result in decreased demand for long-term health and social services.

The project is funded by Stoke-on-Trent CCG; it was initially commissioned for one year in July 2014 and has now been extended until March 2016.

Contact

Nicola Lowry nicola.lowry@archnorthstaffs.org.uk 01782 20447

²⁸ www.nhsalliance.org/mediacentre/health-must-begin-at-home-stronger-collaboration-with-housing-could-save-the-nhs-billions-of-pounds-a-year/

Recommendations

National bodies including NHS England and Health Education England can help by:

- Developing the pipelines and associated support (such as job descriptions, career pathways and professional regulation frameworks) for delivering new workers for general practice, including physicians assistants and new types of administrative support workers
- Sharing the lessons on new ways of working from the Prime Minister's Challenge Fund sites
- Developing a "how to..." guide for practices wishing to introduce social prescribing
- Developing the existing national library of Apps and broadening it to include kite marking for standards

Commissioners, federations and groups of practices can help by:

- Supporting and promoting initiatives to share new skills across practices
- Promoting the sharing of lessons locally so that practices can learn from each other - with individuals being supported to develop and test new ways of working and then to spread them
- Maintaining a directory of support services or organisations that patients can be referred to

Practices can help themselves by:

- Exploring their skill mix to find opportunities for introducing new roles that will relieve the pressure on GPs
- Remaining alert to and seeking opportunities to learn from the experience of other practices about the wide range of alternative ways that practices can develop their operational and clinical processes and practice
- Exploring new ways of consulting with patients, whether by phone, e-consult or group consultation
- Exploring how to introduce social prescribing
- Exploring new partnerships with other organisations, such as housing, that will help relieve the pressure on general practice

About us

Primary Care Foundation

The Primary Care Foundation was established in 2006 to support the development of best practice in primary and urgent care.

We do this by:

- Using information to create understanding that drives improvements in care
- Seeking to reduce unnecessary variation, both across organisations and between individual clinicians
- Developing practical tools that can be widely applied across the urgent care system
- Applying our understanding of national policy in urgent care to support local changes

The Primary Care Foundation is interested in all aspects of urgent and primary care, from general practice through to A&E and hospital care. This includes working with all partners of the urgent healthcare system, either separately or together, to make improvements in patient care. We specialise in carrying out reviews, based on analysing a range of data sources and examining local practice, that make local and national recommendations. We also look for opportunities to share learning, building resources that can solve problems more widely across the NHS. The foundation has worked with over 1,300 practices in the last 4 years on managing access and urgent care, using a specially designed web-based tool to prepare reports for practices, and as part of this we have we regularly discuss with practices the options to manage unnecessary demands on consultation time.

Working with the Department of Health in 2009 & 2010 we delivered two major reports on Access and Urgent care in General Practice and A&E and Primary Care. We also produced a discussion paper on Urgent Care Centres. In all of our work we look to keep the main professional bodies on board and supportive of the final conclusions. The Primary Care Foundation was also selected back in 2007 by the Department of Health to run a benchmark of out of hours services across England which was directly funded by over 100 PCTs. We are now looking at extending and updating this service to offer a wider urgent care benchmark.

NHS Alliance

NHS Alliance uniquely brings together clinicians of every kind, and managers and patients. It also brings together providers in primary care – whether they are general practice, NHS Trust, social enterprise or independent – all with a mission to improve and do their very best for each and every patient. Its strong values over the past fifteen years have given it the ear of government, while its tireless work in patient and public involvement has provided a voice for patients. This ethic extends from the NHS Alliance National Executive, who all give their time for free to the frontline clinician or manager, whose ambition is to improve the service they offer. Everyone in Alliance has a day job – that is its strength as the voice of the working frontline – the people doing it.

NHS Alliance has also recently established Accelerate, a new delivery arm, providing project support for policy makers and front line services. We recognise the lack of time and space to work through ideas and the value of a thinking and doing teams, building on the Alliance's strong local and national networks to build teams of bespoke clinical and managerial leaders, offering a fresh perspective on the problems they face in their own day-to-day work. We have recently developed a joint initiative with NAPO for the New Models of Care Team to support vanguard sites to develop the best possible clinical leadership.

Acknowledgements

With thanks to:

Everyone on our **National Steering Group**, both at two face to face meetings and in many other emails and phone calls. Members of the group included: **Chaand Nagpaul**, GP and Chair of the General Practitioners Committee of the BMA; **David Paynton**, GP and National Clinical Lead, RCGP; **Rebecca Rosen**, GP and senior fellow of the Nuffield Trust; **Tim Cotton**, GP & Clinical Director, West Hampshire CCG for NHS Clinical Commissioners; **Michael Dixon**, GP and Chair, NHS Alliance; **Peter Swinyard**, National Chairman, Family Doctors Association; **Russell Vine**, Head of Practice Managers Network; **Jeremy Taylor**, Chief Executive, National Voices; **Nav Chana**, GP and Chairman, National Association of Primary Care; **Murray King**, Associate Director of Primary Care Strategy Development, Hastings & Rother CCG, for NHS Clinical Commissioners.

All our colleagues who developed additional sections and case studies that have been used throughout the report and printed in full in the Appendices - **Edmund Jahn, Georgina Craig, Merron Simpson, Brian Fisher, Mark Robinson**.

For the additional support from three GPs, **Terry Kemple**, Bristol GP & President Elect RCGP, **Zoe Schaedel**, a Brighton GP; and **Brian Fisher**, a GP in Lewisham, who tested out the findings from the GP audit with local colleagues, reviewing their results as part of a peer review process.

Sarah White & Louise Coleman and colleagues at CFEP UK Surveys for support in the design, analysis and reporting on both the questionnaire for Practice Managers on bureaucracy in General Practice and the GP Audit of appointments.

Miriam Deakin & Chris Bright from NHS Providers for all their support in setting up a joint workshop for leaders from FTs and GPs to discuss issues arising from our research and to all the participants for their time and ideas.

Colleagues at **Salix & Co** especially **Sarah Wrixon, Stewart Laing & Lucy Simpson** for advice and support with communications and presenting the findings both as a report and as a web based resource for practices.

Everyone who completed the GP audit of potentially avoidable appointments and the Questionnaire on bureaucracy in general practice, as well as many others – too many to name – who helped on the way, including **Jonathan Serjeant, Sion Gibby, Barbara Young, Caroline Kerby, Ken Aswani, Ray Montague**.

Finally, we appreciate the consistent support and guidance from **Robert Varnam** and **Faye Sims** as the sponsors of this work from NHS England.

And as always, while we acknowledge all the help and support, the final content is our responsibility alone.

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Appendix 1

The Growing Role for Practice Pharmacists

Practice pharmacists are now seen as one solution to reducing pressure in general practice. But, says Mark Robinson, Pharmacy Lead for the NHS Alliance, GPs will miss a trick unless they also look for quality improvement when considering this new role

GPs are in short supply. Meanwhile, there is an oversupply of pharmacists. Now a new role is under consideration: the practice pharmacist. It has been tested in a number of practices in over many years but has recently been revisited in a policy context, including by the NHS Alliance, the Royal Pharmaceutical Society and now the Royal College of GPs.

For example, in March 2015¹ the RCGP and RPS launched joint proposals on the role, describing pharmacists as a “hidden army” ready to ride to the rescue of general practice. The role had the potential to relieve pressure in general practice and improve patient care, they argued. It was not about having a pharmacy premises within a surgery, but about making full use of the pharmacist’s clinical skills to help patients and the over-stretched GP workforce. Having a pharmacist as part of the team could make a huge difference both to patients and clinical colleagues. Practice pharmacists can consult with and treat patients directly, relieving GPs of casework and enabling them to focus their skills where they are most needed, for example on diagnosing and treating patients with complex conditions. As part of the multidisciplinary team, practice pharmacists can advise other professionals about medicines, resolve problems with prescriptions and reduce prescribing errors. They can work with GPs to resolve day-to-day medicine issues and with practice teams to provide advice on medicines to care homes, as well as visiting patients in their own homes when needed.

Clearly there is an immediate opportunity for practices to review their current skill mix and consider the employment of a pharmacist within the practice. There is also a danger of considering the role in the narrow context of reducing GP workload rather than improving the quality of care. There are many opportunities for practice pharmacists and these must be matched to the experience and qualifications of the pharmacist and linked to practice plans for the pharmacist’s professional development.

Medicines Reconciliation

GP practices may have to deal with hundreds of letters/communications and discharge reports each day. Administrative staff can manage many of these but those describing changes in medicines currently require the attention of a doctor. There are examples where practice pharmacists are responsible for updating the medicines in patient records. Experience from practice pharmacists has highlighted the discrepancies that require either a discussions with the patient or a call to the hospital or out-patient service to clarify intentions. With the introduction of electronic discharge letters from hospitals it is even more important that General Practice has a system that is fast, reliable and robust.

Medication Review

Many patients are on multiple medication for multiple co-morbidities. Polypharmacy is a particular concern in the elderly patients and those considered frail. Pharmacists are able to deliver medication reviews for the practice and put in place action plans to reduce the risk of emergency admission of patients to hospital.

Prescription Management.

An average GP authorises 200 repeat prescriptions each week. It is essential that the system is

¹ www.rcgp.org.uk/news/2015/march/pharmacists-set-to-work-in-gp-surgeries.aspx

both accurate and efficient. NICE described a scheme within Walsall CCG which demonstrated that a pharmacist-led repeat prescription management system increased the quality of prescribing, reduced waste and saved GP time.

GPs are currently asked to deal with a wide variety of supply shortages and prescription issues which a practice pharmacist would be better placed to manage. The role of pharmacists within prescription management can include the additional management of high-risk medicines, management of patients under shared care and the delivery of medication reviews.

Prescription safety/concordance

Practice pharmacists are well placed to support routine monitoring and efficacy of prescribed medicines and how patients take them to ensure optimal results. They can support formulary adherence to local area prescribing committees, ensuring that GPs and patients are prescribing safely and defensibly and the review and assessment of new medicines for the practice.

Acute common conditions

An estimated 57million appointments a year are used by people with common conditions or medicines-related problems. Pharmacists may have considerable experience of managing these within a community pharmacy setting. Some pharmacists are already offering an alternative to Nurse Practitioners and GPs for patients with such conditions. They have a potential role to play, diverting patients from GPs to a more suitable professional where reception staff are able to triage patients from a list of symptoms/conditions to see the practice pharmacist. There are examples of pharmacists working in walk in centres and in out of hours services delivering an identical service.

Practice pharmacists have an additional role in signposting patients to their community pharmacy within minor ailment programmes.

Chronic disease management

Approximately 50% of all GP appointments are for patients with long term conditions. There are examples of pharmacists with specialist training and independent prescriber status running chronic disease programs in association with the practice nurse. This model, described in the Nurse Prescriber Journal brings together different skills and knowledge to provide a service to a wider range of practice patients. Pharmacists are often involved within respiratory, cardiovascular and diabetes clinics, but there are many other examples.

Practice performance

Many practice pharmacists have a role within audit and service management to ensure that the practice achieves QoF, LES and DES payments.

Role in primary care practice research

Pharmacists are well placed to engage in this activity which can improve the care of patients and assist the practice in ensuring some income generation.

Conclusion

Practice pharmacists should be seen as making a positive contribution to a general practice and patient care, rather than a simple mechanism of reducing GP workload and keeping practices afloat. Work by the Royal Pharmaceutical Society and the NHS Alliance in 2014 has highlighted barriers to their employment. There remain gaps in GPs' understanding of the role of the practice pharmacist as well as how practices can make best use of this role. In addition, there is work to be done to help general practice understand and plan skill mix to include practice pharmacists and to support their professional development. Work is required at a professional level to map out competencies and qualifications required by practice pharmacists².

² www.nhsalliance.org/wp-content/uploads/2014/12/NHS-Alliance-Pharmacists-in-general-practice.pdf

Appendix 2

The general practice physician assistant: time to reappraise?

General practice has been slow to adopt the physician assistant role. Daloni Carlisle examines the latest research and asks whether the role needs reconsidering

The physician assistant or physician associate role has been around for at least 50 years including in English general practice on a very small scale since 2003. The rising workload and shortage of GPs in England is now prompting renewed interest.

It's odd that general practice has moved so slowly with this development given its origins. "The first programmes were set up in 2008 to address the shortage of GPs in some areas," says Jeannie Watkins, senior lecturer for PA studies at St George's University London. "But they were quickly snapped up by the acute trusts."

Professor Drennan, Associate Dean for Research and Professor of Health Care and Policy Research at St George's University of London, adds: "It's not that general practice has not taken up the role with enthusiasm," she says. "It's more that there is not the supply of PAs to meet demand."

Ms Watkins, who worked as a PA in general practice for six and a half years until 2014 and now runs a PA recruitment agency as well as undertaking a role as the UK Association of Physician Associates' Director at Large, runs through the time line for PAs in general practice.

The first PAs to work in UK general practice, in 2003, were US-trained and joined practices in the Black Country struggling to recruit GPs; they set up the UKAPA in 2005. In 2006, the Department of Health developed a competency and curriculum framework and by 2008 a number of university medical schools had established PA training programmes.

By 2010, the UK Association of Physician Assistants (UKAPA) believed there were 25 PAs working in general practice. An online survey of 16 of these found they were most frequently employed to see patients with same day booked appointments. Some also reviewed test results, seven undertook booked appointments with patients with long term conditions, and individuals undertook home visits, cryotherapy, teaching, clinical audit and supervision of other staff such as HCAs¹.

Today there are seven medical schools running two-year post-graduate courses² with more about to start. The training is generic and based on the medical model with 1600 hours of clinical practice, including general practice.

"Courses do vary in their emphasis," says Ms Watkins. "For example at St George's we are quite primary care focused." Most trainees go on to work in acute hospitals, one mental hospital has piloted the role but still very few general practices employ PAs.

Demand for places is high – last year there were 170 applicants for 66 places at St George's. While that is small compared to the numbers applying for medical school, Ms Watkins points out

¹ Drennan VM, Chattopadhyay K, Halter M, Brearley S, de Lusignan S, Gabe J, et al. Physician assistants in English primary care teams: a survey. *J Interprof Care* 2012;26:416–18
<http://www.ncbi.nlm.nih.gov/pubmed/22574762>

² NHS Careers www.nhscareers.nhs.uk/explore-by-career/wider-healthcare-team/careers-in-the-wider-healthcare-team/clinical-support-staff/physician-associate/

that students are self funding at a cost of £9,000 a year for tuition. There are no student loans and no grants.

“This certainly detracts people from applying,” says Ms Watkins. “UKAPA is working with Health Education England to push for career loans to be made available.”

The PA role in general practice has been researched – although not well and mostly in the US. Last year, Professor Drennan and colleagues published a major study funded by the National Institute for Health. It looked at the published papers on PAs in primary care including research studies, academic studies, newspaper articles and policy documents. Researchers also carried out an observational study of 12 practices, half of which employed PAs.

Broadly, the pre-existing research shows that physician assistants are acceptable to patients (particularly where they had a choice between PA and GP), effective and efficient in complementing the work of GPs³.

The detailed case study of 12 general practices showed that PAs tended to see people booked in for same day appointments and worked at the younger end of the demographic compared to GPs. In some practices the PAs were deployed to maximise practice income, for example by maintaining patient registers, a role that had not been observed before.

Researchers looked in detail at over 2000 of these same day consultations, looking for differences between GP and PA consultations. They found no difference in the rates at which patients came back to the surgery within 14 days for the same or a linked problem. While the PA tended to spend longer with patients than the GP, the cost per consultation was £6.22 lower.

The conclusion: PAs offer a potentially acceptable and efficient addition to the general practice workforce.

However, the study highlighted some caveats. GPs and nurses without experience of working with PAs often held negative views; the views of patients largely had not been sought; and mention of the role of the PA in general practice was, by and large, absent from English health policy. Little thought had been given to their regulation or the potential for prescribing rights and there is some evidence that PAs require a high level of supervision.

It identified gaps in the research too. There was little research comparing PAs with nurse practitioners or on which patients PAs should see. There was scant work on their impact on healthcare utilisation and almost nothing on workforce planning and skill mix. There was no research on the potential role for PAs in primary care led urgent care.

Several questions arise. Do GPs really want to employ PAs? HEE certainly thinks so and has announced plans to create an extra 200 training posts for general practice PAs in 2015. In a statement, HEE said: “Increasingly, we will need to invest in entirely new roles and professions, such as physicians assistants, to help deliver more holistic care across different teams and settings.”

The RCGP and BMA have cautiously welcomed the role as having potential to provide some valuable support.

³ Drennan VM et al. Investigating the contribution of physician assistants to primary care in England: a mixed-methods study. Health Services Delivery Research, Southampton (UK): NIHR Journals Library, 2014, May.

Accessed at www.ncbi.nlm.nih.gov/pubmed/25642506 May 2015

⁴ Physician Assistant Managed Voluntary Register <http://www.ukiubpae.sgul.ac.uk/the-managed-voluntary-register-mvr-and-the-mvr-commission>

Simon de Lusignan, Professor of Primary Care at the University of Surrey and a co-author of the NIHR study, says GPs won't take on PAs without (a) some good science to back up the observational studies and (b) some financial incentives to produce that science.

He says: "If we said to practices that we will subsidise a PA to create a layer of appointments for people with long term conditions who were previously seen in acute care, and in return you provide a weekly data extract to monitor how it is working, then we would start to get some science and start to develop the role."

But there are other barriers. Ms Watkins says lack of registration of PAs is a major barrier to employment in general practice. The UKAPA (soon to become the Faculty of PAs in the Royal College of Physicians) runs a voluntary register⁴, which is useful but inadequate, she says. "We cannot protect the title," says Watkins. "Anyone can call themselves a PA. For example, a foreign doctor can come here and work as a PA when there might be good questions to ask about why they are not applying for GMC registration."

It's not for want of trying. Ms Watkins says: "We have been approaching the government on this for seven years. We had applied to the Health and Care Professionals Council but last year the government said it would not regulate any more professional groups and our application was stopped."

"The government has said we should be looking at the Professional Standards Authority but we are too risky to be rubber stamped." The RCP, the Association of Medical Royal Colleges and HEE are all pressing for regulation. "Jeremy Hunt knows about this."

Without registration, PAs cannot get prescribing rights. While this is a barrier to employment in general practice, says Ms Watkins, it is perhaps not the big issue that some make it. "It was not as if I spent my days as a general practice PA writing prescriptions," she says.

Another area ripe for research is where the PA-nurse practitioner boundary lies. Professor Drennan's research in the case study sites found that it was well delineated but you don't have to search far on Twitter to find a good deal of hostility to PAs from primary care NPs.

Ms Watkins (who is also a nurse) says the roles are complementary. "When I was in practice, I worked alongside nurse practitioners. We were both prescribing – my prescribing rights were based on my being a nurse. I would diagnose a patient with diabetes and then refer to her because that's where her expertise lay. There is overlap, but it is all about making best use of your skill mix."

Professor Drennan says: "I think that there are two sets of views among GPs about PAs. The first says 'I can see that having a PA who is trained in the medical model can be an advantage and free me to see the more complex patients. They get it. The other looks back at poor experiences of working with nurse practitioners which generated more work for them and says 'it's quicker for me to do the work than to delegate'."

She thinks general practice should be looking again at the PA model – especially as the supply improves over the next few years.

"They can contribute to the staff mix in general practice in ways that are safe and efficient and very clearly are about working with the case mix that is younger and comes for same day appointments, leaving GPs free to work with the more complex patients."

"Maybe nurse practitioners can also do this – but where are they going to come from? It comes back to the supply issue. So the PA is another pool of people. They are not in competition with PAs but are seen by practices employing them as very clearly another pair of hands and one that can swivel to cover for nurses as well as doctors."

What is a physician assistant?

Physician associates support doctors in the diagnosis and management of patients. They are trained to perform a number of roles including:

- taking medical histories
- performing examinations
- diagnosing illnesses
- analysing test results
- developing management plans.

They work under the direct supervision of a doctor
(NHS Careers)

The physician assistant is a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.
(DH, RCGP, RCP The Competence and Curriculum Framework for the Physician Assistant. 2006)

PAs are paid on band 6 to 7 of Agenda for Change, with salaries ranging from £24,000 to £38,000

Summary and recommendations

- PAs are an additional pool of professionals who may help general practice to meet demand
- General practice PAs primarily consult with younger patients attending for same day appointments. They can do this as effectively but at lower cost than GPs
- General practice PAs also carry out roles that generate income for practices
- GPs are split in their perceptions about PAs, with some very enthusiastic and others sceptical. However, the supply chain is not there to meet demand
- Embedding the role in general practice is time consuming and work intensive and requires a transformation approach.
- GPs should be aware that PAs require a high level of supervision if they are to deliver the envisaged efficiencies, patient satisfaction and productivity gains
- HEE should continue to work on the supply chain for PAs
- NHS England and HEE along with the DH should consider again how PAs can be enabled to register as professionals and work towards obtaining prescribing rights

Appendix 3

Remote consultations: are they safe, effective and efficient?

Daloni Carlisle looks at emerging e-consultation tools in general practice.

Around 250 years ago, a certain Dr William Cullen, Physician in Edinburgh, was busy carrying out remote consultations with his patients.

You can see more than 20,000 of his letters transcribed on the [Royal College of Physicians' website](#)¹ today. Here there are cases that will sound all too familiar, such as Dr Cullen writing to a woman upset that her own doctor had prescribed weight loss and exercise. He reiterates the advice. Plus ça change. Today tech savvy GPs are looking at “new” ways to consult with patients. This time it is not by letter but via the web.

Broadly, there are two models now operating in England. One invites people to use a website to avoid a GP visit and obtain a private prescription for medication via the internet; [DrEd](#) from Day Lewis Pharmacy and [OnLine Doctor](#) from Lloyds Pharmacy are examples. The other links a web-based history taking directly to the patient's own GP and aims to promote self care and more efficient, productive use of GPs' time and include [ASkmyGP](#) and [WebGP](#).

Harry Longman, an engineer turned primary care access champion, is behind [AskmyGP](#)² and the Bramley Surgery.

In this model, GP surgeries subscribe to a service currently pitched at £2 per registered patient per year. Patients access the online tool via their practice website. Their first choice is whether they want self care advice from NHS Choices, a repeat prescription or help from the practice.

Choosing help from the practice brings up a free text box where patients can state their reason before being led through a questionnaire about their symptoms. It is essentially a clinical history completed by the patient online.

This history goes over to the GP surgery in short form, where it can be integrated into GP workflow, allowing doctors to triage and decide whether to telephone the patient, ask reception to call and book an appointment, or issue a prescription via the pharmacy.

“This is demand led,” says Longman. “Doctors are very scared of that and worry that if they are dealing with all the demand they will be swamped. But the truth is that demand is predictable and stable and when you meet it, there is less work.”

He argues that current access problems drive people to behave in ways that create bottlenecks – the 8am rush or making a repeat consultation two weeks hence “just in case”. He says: “The response we want is for people to think ‘I know the doctor is there when they need them and I will call them then and not before’.”

AskmyGP's online history-taking tool has taken 20 years to develop and contains 80,000 questions. It is based on the US [Instant Medical History](#)³ software developed at the Mayo Clinic and which currently has over 700,000 uses a day although generally in long-term condition management and administered in the clinic waiting room rather than remotely.

¹ <http://cullenproject.ac.uk>

² <http://askmygp.uk>

³ www.medicalhistory.com/home/index.asp

Longman estimates that it cuts consultation time from ten to six minutes. “It recognises thousands of conditions and is tolerant of misspelling,” he says. “The questions are fully branched. It will never give a diagnosis and will never tell a patient to see a doctor or call an ambulance. I would not trust a computer to do that. By doing this history taking online, it saves the doctor time and it saves the patient time.”

AskmyGP is GPSoc compliant and while it can feed in directly to the patient record, in many practices this may require a short manual step by reception.

It's been [piloted at one practice](#) so far, the Rydal Group Practice in north London with just over 1,700 uses. Patients love it and in three months it shifted 30% of demand from phone to the online service. Nearly 90% of use was in hours. Around one third of patients were asked to make an appointment, one third called back by phone and one third issued with a prescription via the pharmacy.

Digital exclusion is often used as an argument against using such tools but Longman says this is fallacious. “We do not want anybody to be digitally excluded and there is always the telephone option,” he says.

Popular it may be but Dr Ed Diggines, partner at the Rydal Group Practice, remains unconvinced that AskmyGP answers his needs.

His practice had been using more telephone services in order to meet demand and had tinkered with online access for patients. “The length of telephone consultations and the details the receptionists needed to get to support them was increasing and that meant people were struggling to get through even more,” he says. “So we moved to a web-based call back option, using the practice system where patients could log on and give us a brief description of their problem and request a call back.”

This stumbled with the security – patients did not like having to use a password. The practice helped test AskmyGP and advised on its design – recommending that the free text box come before the questionnaire – before agreeing to pilot it in early 2015.

At present, he says the –history gathered through the algorithmic questionnaire does not add enough value to the e-consultation to warrant investment in the overall service. “It's a clever bit of software but it's the free text that I look at,” he says. “We are a small practice and the cost of AskmyGP to us would be £25,000 a year, most of it to recoup the software licences and development. That's not something we can afford for the value it would deliver.

“Yes, the algorithm has value – for example by patients before they attend for long term condition reviews. I think its ultimate value would be to turn it into a two-way portal where GPs can respond to patients in an interlocked, safe system.”

WebGP operates on a similar model in that it plugs into the patient's own GP surgery acting as a “Virtual General Practice”. It was developed by a group of senior GPs and academics who worked alongside software programmers, website user experience experts and the Design Council to build the platform. An additional group of 30 GPs were involved in road testing and trying to break each questionnaire.

Its offering is somewhat broader than AskmyGP and for just 75p per patient per year includes:

- Symptom checkers to help patients confirm their GP is the right service for their situation
- Self-help guides and videos about the commonest general practice conditions
- Sign-posting to alternate offers e.g. pharmacy and online counselling
- 24/7 phone advice within one hour by requesting a call back using a web form on the

practice website (arranged through the local 111 provider)

- E-consults in which patients use their practice website to submit condition-based questionnaires to their own GP for a response within one working day, potentially avoiding the need to attend the practice.

It has been trialled by the [Hurley Group](http://hurleygroup.co.uk)⁴ (a London based primary care provider organisation) in 20 London GP practices, with 130,000 patients taking part over six months.

The trial showed some encouraging results for GP workload. Half of patients who consulted online were managed remotely and one in three site visitors used self-help tools. Nearly one in five patients who had planned to book an appointment went on to self manage. GP consultations aided by the online history were quicker and GPs saw only those patients who needed a face-to-face consultation.

GPs felt they had more time to deal with complex patients with long term conditions as a result of saving time and were reassured by the clinical governance, which insists that all e-consultations are reviewed by a doctor and every patient gets a call back to verify identity and close the communication loop.

It generated efficiencies and cost reductions, with savings accruing to both the GP practice and the commissioners. In short, patients liked it, GPs liked it, and commissioners liked it. Now academics at South London's Academic Health Science Network are about to start to look in detail at the data the system is generating and explore facets such as digital dis-inhibition – the phenomenon by which patients lose their embarrassment and reticence about personal problems when they are online versus face to face with a clinician.

Dr Arvind Madan, CEO of the Hurley Group and a GP at Docklands Medical Practice, says a critical factor in GPs using e-consultation systems is the clinical governance; WebGP is the only UK system to have the confidence of the medical defense organisations, he says.

One measure built into WebGP are so-called “red flag” questions that prompt the system to make an emergency call. “If a patient reports that they have a temperature and that they have been to a malaria zone, it will tell them they need to go to A&E,” explains Dr Madan. “It includes e-triage and from a clinical governance perspective, that’s very important.”

He does not agree with Dr Diggins that the e-history adds no value. “Yes, the free text saying ‘I have hurt my back digging the garden’ tells you the patient needs painkillers. But the e-history will tell you whether the patient can feel both legs or has control over their bladder and bowels and therefore how you need to respond.”

As a practicing GP, Dr Madan says he would not be without WebGP. “For many years, I was a ten session a week jobbing GP and so often my consulting room door would close and the patient would wander down the corridor thinking ‘did I really need to come here for that?’ I’d be thinking the same. With WebGP we can pick off the minor problems before they even get to our door. So no, I would not be without it.”

Lloyds Pharmacy operates a system on a different model in its [OnLine Doctor](https://onlinedoctor.lloydspharmacy.com/uk/drthom)⁵ site, formerly known as Dr Thom.

Started in 2002 by an obstetrician selling Chlamydia testing kits directly to the public, it was

⁴ <http://hurleygroup.co.uk>

⁵ <https://onlinedoctor.lloydspharmacy.com/uk/drthom>

acquired by Lloyds pharmacy in chunks from 2008 to 2011. In April 2012 it was rebranded as the Lloyds Pharmacy OnLine Doctor.

Rachel Carrell, Managing Director, explains how it works. “A really simple example is this. Suppose you have a diagnosis of asthma and you’ve lost your inhaler. You can make an appointment with your GP – or you can go online, fill out a questionnaire with the same questions your doctor would ask, have that reviewed by one of our doctors who can then issue a prescription so you can pick up the inhaler at a pharmacy or have it posted to you.”

It’s a private prescription and there is no link to the patient’s own GP. This, she says, is key for its main use: 85% of the workload is sexual health services. “We are very discrete. But we are also very convenient and very fast.

The service uses a proprietary software system and has three or four doctors on duty at any one time. They review the questionnaires and either issue a prescription or, if there are further questions to be asked, contact the patient via secure SMS service or telephone.

According to Carrell, it is a super efficient system that has proved its value not just in the UK but also in Australia and Ireland where a combined 1m plus patients have used it.

She says: “Typically, a GP can see six patients an hour. Our doctors are processing up to 100 patients an hour. The reason that is possible is because they are doing the simple stuff that can be done at a distance and because we have spent years building up a system where everything that can be automated is automated.”

Yes, says Carrell, this is very different to either WebGP or AskmyGP. “Their big advantage is they can deal with a lot more conditions,” she says. “We deal with just 20. But our advantage is we are very fast and very convenient for the right people.”

However, she thinks there is scope for Lloyds OnLine Doctor to work with the NHS and is exploring possibilities with a Leicester practice now.

Conclusions:

- There is an emerging body of evidence that multi channel patient contact and communication channels from telephone to internet to smart phone Apps can deliver efficiency gains and improve quality in general practice. Much of this comes from those who have developed solutions for general practice. There is a need for more rigorous, independent research.
- While these solutions have moved beyond proof of concept and into pilot projects, it is not clear yet whether they yield their promised return on investment or offer a value for money solution for general practice. The business case needs to be developed with more rigour.
- There is also a deal of skepticism from GPs about the real value of these systems and their potential impact on workflow and workload. There is need for clear understanding of how implementing a system is a transformation project rather than an IT project.
- It is not clear what standards new solutions are working to and what regulators govern which aspect of their operation. Many report being regulated by multiple organisations, sometimes with overlapping or contradictory requirements. Clinical governance is a work in progress, a real cause of concern for practicing GPs. There is a need for clarity of regulation and clearer understanding of clinical governance.
- Thought should be given as to what incentives should be used and how and when they be introduced, to help start to shift patients into using more efficient and effective relationships

with general practice. From managing their own appointments on line, through to completing an automated self assessment on line before contacting the practice.

- The patient should be able to hold and manage their own patient health record and be responsible for that, with the support and professional stewardship of their GP, much more completely than is the case now; just as they hold responsibility for their own financial records but need professional help with those from time to time.
- Protection needs to be built in so that changes making general practice process more efficient, and enabling new technologies to benefit patients, do not adversely impact the minority without access to the technology.

Appendix 4

Group consultations: a way to spend more time with patients

Georgina Craig, National Director, ELC Programme, looks at the evidence for using group consultations in general practice and outlines an improvement programme

What's the problem?

Evidence suggests that one-to-one consultations may not be working for GPs nor for patients¹. Ten-minute appointments are a high pressure way of working and organising care in this way may impact on job satisfaction and GPs' personal wellbeing; both antecedents to a good patient experience². Burnout puts GPs at risk of depersonalisation and alienates them from their patients³. Basically, no one is winning.

To sustain primary care and the clinical teams who provide it, we need to find new and better ways of delivering care that energise clinicians and leave people feeling better able to cope, care for themselves and keep well. When we achieve this, people will self-care with confidence and may need their practice team less. Group consultations for some patients may be a way forward.

What do people want?

People and families⁴ - especially those living with long term health issues who visit the GP more often - tell us that they want to:

- Talk to someone who understands their situation; who has been there and overcome the difficulties they face. Talking to their peers gives people hope, inspiration and reassures them that their life can get better. It also means they feel less alone. This is especially important when people receive life changing news like diagnosis of a new long term condition.
- Have a closer relationship and spend longer with their GP; have more time to discuss the issues that are on their mind. Having a close relationship with their GP gives people confidence to self care and reassures them.
- Have regular follow up and review from their practice. Proactive follow up reduces anxiety and worry and makes people feel safe and reassured. This is especially true of medicines because people worry about a lot about whether their medicines are working and about symptoms that could be side effects.
- Take control of their health issues and feel able to cope – especially when things change or get worse. This is because people want to be as self-reliant as they can be. People want to avoid ending up in hospital if they possibly can.

¹ Fischer M and Ereaut G (2012) When Doctors and Patients Talk: Making Sense of the Consultation. London: The Health Foundation

² Maben J et al (2012). Patients experience of care and the influence of staff motivation, affect and wellbeing. National Institute for Health Research Service Delivery and Organisation Programme

³ Orton P, Orton C, Pereira Gray D (2012) Depersonalised doctors: a cross-sectional study of 564 doctors, 760 consultations and 1876 patient reports in UK general practice. BMJ Open; 2: e000274. doi: 10.1136/ bmjopen-2011-000274

⁴ Experience Led Commissioning. (2014) Insights into peoples experiences of primary care. GCA Limited

Frontline professionals - including GPs⁵ - tell us that:

- Repeating the same story to people day after day wears them down - especially when nothing changes. This leads to burn out.
- Ten minutes is not long enough to have the kind of discussions people want to have. This leaves professionals feeling frustrated and powerless because can't deliver the kind of care they want to.
- They too would like closer relationships with people and families, but there is no time.
- They believe that confidentiality stands in the way of linking up those with the same condition or similar experiences within the practice.

What's the solution?

Driven by the desire to change and overcome this dissatisfaction, pioneering clinicians are leading the development of group consultations in UK primary care.

Also known as shared medical appointments, group medical appointments and group appointments, group consultations are personal medical consultations delivered by a clinician in a supportive peer group setting, with all patients listening in and learning. They are not an addition to one-to-one appointments - they replace them. They are not group therapy or education sessions, although they do educate both the participating patients and the clinicians. In brief, this is how group consultations work.

There are three key roles:

- **Group Consultation Clinical Expert:** this is the consultant, GP or nurse who is consulting with the group of 12-15 people
- **Group Consultation Process Facilitator:** this person is skilled in 'holding the space' and supporting a group of people to work together. They run the group consultation and free the clinical expert up to concentrate on giving clinical advice and consulting. They are usually non-clinical
- **Group Consultation Co-ordinator:** the pivotal administration role within the practice, the co-ordinator is key to the success of group consultations. They ensure that all appropriate test results are available for the clinical expert; remind patients to attend; and ensure confidentiality agreements are signed and filed every time.

This is how group consultations run:

- Group consultations last around 90 - 120 minutes. The clinical expert is only there for 60 minutes of this time.
- The clinical expert decides who participates and personally invites people to opt for group consultations, explaining the benefits (getting to spend an hour with your own GP). Participation is voluntary. The person can say no. Family carers can attend too.
- Prior to the group consultation, the co-ordinator makes sure that patients have had all the right monitoring tests done so they 'know their numbers' e.g. HbA1c, cholesterol, blood pressure, peak flow. They write up the numbers on a board or poster in the room so everyone can see each others' numbers.
- The process facilitator opens the group consultation and make sure that everyone has thought about and prepared at most two questions that they want to discuss with the clinical expert.
- The clinical expert joins 20 minutes or so into the group consultation. He or she reviews the list of questions and peoples' test results. The process facilitator also briefs him or her and highlights the common issues within the group.
- The clinical expert holds brief individual consultations with each of the participants. Patients take it in turn and raise their clinical issues. This process lasts around 60 minutes. As the

⁵ Experience Led Care. (2015) Simple Words Insights. GCA Ltd

clinical expert responds to each person's questions, everyone listens and learns. Patients can also chip in and share their experiences and advice about practical 'non medical' issues and solutions. Of course, sometimes people's questions are answered before it gets to their turn. That is why they prepare more than one question. Working this way means the clinical expert avoids repetition and reinforces key points. It also enables people to see that others share their concerns and challenges, which is very reassuring. When patients join in and share what has worked for them, the group benefits simultaneously the wisdom of both their peers and the clinical expert, which enhances the value of both elements.

- The process facilitator ensures the conversation remains positive and focused on learning AND that the clinical expert stays on time, with everyone feeling listened to and involved.
- If someone needs to speak to the clinical expert alone about an issue they do not want to share in the group or needs to have a physical examination, this happens after the 60 minute group session is over - or the person can book an appointment shortly after if it is non urgent.
- After the clinical expert leaves, the process facilitator supports the group to reflect and set personal goals for the next consultation if a series is planned. They summarise with the groups' goals and remind the group what will happen at the next session and when it is, building on what the clinical expert has discussed with each individual. The process facilitator reminds the group that they will be sharing their progress towards their personal goals at the next session and is available to signpost people to support that may need to get started e.g. weight management support; exercise programmes; education or further peer support.

Whilst there are no hard and fast rules, group consultations usually run for six months by which time people are often ready to move on and support themselves; sometimes maintaining contact and becoming a self-managing group. However, they can also be used to consult for acute symptoms as well as chronic conditions.

What are the potential efficiency gains?

As well as being a very rewarding way to practice that builds on the mounting evidence base that supports person-centred care and peer support, working this way creates very significant efficiency gains:

- The specialist, GP or nurse can see up to 12 patients in 60 minutes, which potentially doubles access to routine care and follow up appointments
- Many of the patients who attend group consultations may be attending the practice several times a month. Now they only attend once a month This saves them and the practice time and appointments
- The process nudges systematic follow up and review of people, which enhances quality of care
- The process builds confidence and embeds a goal orientated approach to self management
- The process supports peer connection so that people benefit from its benefits.

Evidence base

Evidence to support group consultations Evidence from the UK

Part of major practice redesign programme focused on improving population health outcomes and care for people with long-term conditions (LTCs), the Smethwick practice team introduced group consultations with an ethnically diverse community. The team provided group consultations alongside case and care management for:

- Back pain
- Diabetes and hypertension
- Asthma
- Health and confidence
- Acute minor illness.

The practice realised these benefits:

- Improved access to GP/nurse care for people living with LTC (framed as a 'two hour appointment with the doctor')
- More choice for patients; some preferred a group approach
- Reassurance and increased personal confidence amongst patients and families
- Peer led learning, support and challenge to support behaviour change and self care
- Improved care experience
- Expanded capability and capacity; ability to do more with the same resources.

Independent evaluation⁶ of the programme showed that group consultations contributed significantly to delivery of £2.5 million of quantifiable savings; freed practice capacity and created space for quality improvement. In those who benefited from group consultations, at 12 months, 69% participants had improved their body mass index (average reduction from 35.4 to 34) and 84% had an improved blood pressure control compared to baseline. Participants fed-back that group consultations added value and reported improved confidence to self-care.

Nesta⁷ funded a programme of work in 2012/13 that looked to evaluate innovations in delivery of people powered health. Their programme supported pain specialists to run group consultations that meant consultants saw 15 people in the time they would normally see nine. Audit of Croydon's Service User Network (SUN), which applies group consultations within the care of people with mental health issues found that hospital bed day use decreased after six months of participation in SUN with a total decrease from 330 days to 162 days in the group audited; a 30% reduction.

Evidence from the USA

Studies⁸ demonstrate that 'shared medical appointments' (SMAs) led by doctor and nurse practitioners enhance patient experience, improve clinical outcomes and reduce hospital admissions and A&E attendance.

Thirteen randomised trials evaluated the effects of SMAs on outcomes for patients with diabetes. Broadly, they show that SMAs consistently and sustainably improve blood glucose measures in patients taking part and increase their reported health-related quality of life. Patients may be less likely to be admitted to hospital or attend the ED. The impact on costs was unclear.

Evaluation⁹ has also found that SMAs can increase access and reduce backlog without increasing clinic time and support stressed clinicians to move forward.

Noffsinger¹⁰ evaluated the productivity and efficiency gains for clinicians resulting from group consultations. He calculated a 300% increase in productivity and suggested that applying group consultations could reduce the need to hire additional clinical staff.

Are group consultations replicable?

Building on this success and as part of their Prime Minister's Challenge Fund work programme,

⁶ PHD cic, (2011) Redesigning primary care: outcomes in Smethwick <http://path-finderhd.com>

⁷ Nesta. (2013) Redefining consultations: changing relationships at the heart of healthcare.

https://www.nesta.org.uk/sites/default/files/redefining_consultations.pdf

⁸ Edelman D, Mc Duffie JR, Oddone E, Glerisch JM, Nagi A, Williams JW Jr, Shared Medical Appointments for Chronic Medical Conditions: A Systematic Review, VAESP Project #09-010; 2012 <http://www.ncbi.nlm.nih.gov/books/NBK99785/>

⁹ Cabral J. *A new paradigm: shared appointments in diabetes*. Cleveland Clinic, USA

<https://professional.diabetes.org/admin/UserFiles/CE/South%20Florida/Workshop%20D-3%20Team%20Approach%20to%20Diabetes.pdf>¹⁰ Noffsinger, E (2013). *The ABC of group visits*. Springer USA

<http://www.springer.com/gp/book/9781461435259>

GP practices in Slough are working in partnership with The Experience Led Care Programme to pilot a programme to embed group consultations at scale in general practice. Through face to face training, online learning and on the job coaching, practice teams have learnt how to set up, run and consult using group consultations.

Practices are targeting consultations at a wide range of patients, including:

- Diabetes
- People with BMI over 35
- Asthma
- COPD
-

South East Asian families with young children (unplanned / urgent care)

One practice is working with the local IAPT service, which is already commissioned to provide group well-being sessions for people who live with long-term health issues. IAPT experts are acting as process facilitators and able to bring also their specialist skills around building mental wellbeing to the table.

Moving forward, Slough CCG wants to explore how to spread the use of group consultations at scale across the patch. Neighbouring CCGs are also looking at supporting the approach as well. Spread is likely to include a 'train the trainer' model. The plan is also to explore with specialists how primary care based group consultations could substitute for outpatient clinics, with the GP present and benefiting from time spent with specialists and joint review so they learn and transfer specialist knowledge – a further potential benefit of group consultations. Slough GPs are already conducting one to one consultations jointly with specialists so this is the next logical step and will reap huge time efficiencies as well. Slough is currently seeking funding for an independent evaluation that fully scopes the business case for a whole scale move towards group consultations in UK primary care.

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Appendix 5

Support is just a click away

Daloni Carlisle explains why peer support is so powerful but says it must be trusted and safe for users

“Anyway I just need advice on trying to stop myself reading something into everything before I go mad!”

This cry for help came across the internet one evening in April. It reached me via my email inbox on my mobile and came from a woman newly diagnosed with womb cancer. She was scared, struggling to understand not just her diagnosis but also the care process. She’d convinced herself that an off the cuff remark from a radiographer had sinister connotations.

So the womb cancer support community immediately swung into action. We shared our experiences and knowledge; we reassured and made suggestions about things that had helped us and that she might try.

Slowly, she began to unburden her fears and what was going on in her head. Twenty seven hours later she posted this: “What a relief it has been to find so many caring people on this site. Yesterday I felt so alone and now I know that I can log on at anytime and find help.”

There’s no one who understands the impact of a cancer diagnosis like someone who’d been there. There is no one who can offer support and practical ideas about how to get through it like someone who’s done it.

I’m saying that from experience. In the weeks and months after I was diagnosed with womb cancer in February 2014, Macmillan’s Womb Cancer Support group was very important to me. I can’t remember exactly when in my cancer journey I came across it. I knew that Macmillan provided information about cancer and indeed it was the one source that my clinical nurse specialist advised I look at. “Don’t go on the internet,” she had warned me early on. “You’ll only scare yourself. But if you must, go to Macmillan.”

So, it was on one of my forays into the internet to find out how to prepare for surgery or what to expect from chemotherapy that I came across Macmillan Community. Here I found an online community of women who knew exactly what I was going through. Some of them were ahead of me, others some at the same stage. Here was a group of women who would share their experiences and with whom I could share anything.

It was on the main site that I found the terrifying lists of side effects from chemotherapy; it was on the online community that I discovered how many women have a pattern of side effects and can plan for good and bad days so that chemo doesn’t entirely rule their lives. They were ready to give me a virtual hug when I sent out an electronic howl of despair. They gave me an electronic cheer when I completed a phase of my treatment. Soon, I started to support other women who were sharing their fears, triumphs and worries.

Macmillan’s community has seen me through cancer treatment and helped me both to understand and to articulate some important ideas. Early on, one woman advised me to look on the journey as an adventure. It was a hard notion to get to grips with but one that has been enormously helpful in trying to regain some autonomy.

I was able to articulate how I coped: I handed over my medical care to the medics but saw my role as keeping myself as well as possible through exercise, healthy eating and meditation.

We exchanged tips on keeping busy through the hours of sitting on the sofa. I knitted; others crocheted. We have had conversations not possible elsewhere about our sex lives and our partners.

After a few months I began to reach out and support the women coming along behind me. I must have done a good job because Macmillan's online team asked me to take on the voluntary role more formally. I'm now a community champion, a role that I enjoy enormously. I've done the training – which was both easy and incredibly useful. I know how out of control newly diagnosed women feel – and it is great to be there to help and support them in the same way I was helped and supported. It is also good for me to turn this experience into something useful that can help others.

I've since discovered that being part of the community makes me a Clanger. No, don't laugh – this is serious and evidence based. In 2008, the government's [Foresight project](#) reviewed the evidence for what keeps us mentally well, and came up with the acronym **CLANG**:

Connect with others and gain the emotional ballast of being part of a community.

Learn and feed your curiosity.

Be **active** every day in mind and body.

Notice the world around you and discover the joy of being as well as doing.

Give back to others.

I'd say being part of a Macmillan community definitely counts as clanging.

But are such forums unequivocally A Good Thing? I know that there are lots of stories out there of damaging online communities where one group of people gang up on an individual or where a particular view of treatment gains orthodoxy and no dissent is brooked.

I've never experienced anything like that in the womb cancer community. Here we share our experiences and let each woman take what she wants from them. We sometimes encourage women to seek help – suggesting that they might call their GP if an appointment hasn't come through or that they call the helpline if they are struggling with emotions. We support each other to come to the treatment decisions that are right for each individual and do not judge. I have made a number of wonderful friends – most of them online but one I have met up with in person. We have a lot in common.

So for me, this is a safe community. I think that's because of the safety nets built in by Macmillan with clear guidelines, moderators always alert and ready to react if they are breached and training for the community champs.

But never, in all my dealings with doctors and nurses has any health professional suggested that the online community might be worth exploring. Is this because you don't know about them? Maybe it is because there is no "evidence base" or because you perceive them to be unsafe? Whatever the reason, I'd suggest you might want to start having a look around. More and more charities run such communities and more and more of your patients are using them.

Appendix 6

Improving communication through Simple Words

Georgina Craig, National Director, ELC Programme, looks at the evidence of how good communication improves outcomes not just for patients but also for GPs and describes an improvement programme

What's the problem?

If communication between patients and GPs and nurses is not as good as it can be, the NHS will not realise the benefits of investment in capacity and improving access in primary care – and outcomes will not improve.

People and family carers tell us¹ that they want different conversations with their GPs; ones where they understand what the GP is saying and what they can do to take control. They tell us that consultations can be really difficult and confusing - and that doctors often do not explain medical things in words and terms they understand. They find this frustrating, with some even suspecting it is a deliberate ploy to 'blind us with science'.

GPs tell us² these conversations are often challenging for them too. They invoke strong emotions, including: frustration, anxiety, fear, resentment and anger. This significant emotional labour is contributing to clinician burn out; a growing phenomenon in primary care³. Burnout in turn leads to depersonalisation, which compromises outcomes for both doctors and their patients. Clinician wellbeing is the foundation stone of primary care efficiency and care quality.

Research suggests we can improve communication between GPs and patients in many consultations and that when communication improves, so do outcomes.

What's the evidence of impact?

Human connection and shared goals

Studies have shown that doctors miss 50% of psychosocial and psychiatric problems⁴; interrupt patients an average of 18 seconds into the patient's description of the presenting problem; that 54% of patient problems and 45% of patient concerns are neither elicited by the physician nor disclosed by the patient⁵; that patients and physicians do not agree on the main presenting problem in 50% of visits⁶ and that the patient is often dissatisfied with the information provided to them by physicians.

¹ Experience Led Commissioning. (2015) National Simple Words Insights. The ELC Programme

² *ibid* 1

³ Orton P, Orton C, Pereira Gray D (2012) Depersonalised doctors: a cross-sectional study of 564 doctors, 760 consultations and 1876 patient reports in UK general practice. *BMJ Open*; 2: e000274. doi: 10.1136/ bmjopen-2011-000274

⁴ Davenport S, Goldberg D, Millar T. (1987) 'How psychiatric disorders are missed during medical consultations'. *Lancet*; 2: 439-440

⁵ Stewart M, McWhinney I, Buck C. (1979) 'The doctor/patient relationship and its effect upon outcome'. *JR Col Gen Pract*; 29: 77-82

⁶ Starfield B, Wray C, Hess K et al (1981). 'The influence of patient-practitioner agreement on outcome of care'. *Am J Public Health*; 71: 127-131

A review of the impact of clinician's communication skills⁷ on patient outcomes found a correlation between effective physician-patient communication and outcomes. The main impacts, in descending order were: improved emotional health; symptom resolution; improved function and physiological measures i.e. blood pressure and blood sugar level and pain control. Key elements of effective communication identified as impacting on outcomes were:

- **A positive experience of history-taking:** with evidence that outcomes improve when the doctor asks a wide range of questions, not only about the physical aspects of the patient's problem, but also about his or her feelings and concerns; understanding of the problem; expectations of therapy and perceptions of how the problem affects function were key
- **Involvement in care planning:** with evidence that outcomes are better when patients feel like active participants in care and that their problem has been discussed fully; share in decision making and are encouraged to ask questions; clear written information supplements the spoken word and the doctor provides emotional support.
- **Consensus at the end:** this is a key variable. Consultations that end with agreement between the patient and doctor about the nature of the problem and the agreed course of action lead to better outcomes.

The focus on building a caring, respectful, empowering context and recognition of a different balance of power and control is both implicit and explicit in this research.

Remembering the message

Research shows⁸ that people forget immediately between 40-80% of information doctors communicate and half of what they remember incorrect⁹.

Ley¹⁰ has shown that understanding and remembering information, as well feeling satisfied with the outcomes of care is central to improving adherence; a key outcome of effective medical communication.

The reasons people forget information fall into three main categories:

- **Factors related to the clinician** e.g. using medical language the person does not understand
- **How information is shared** e.g. speaking rather than writing down or using visuals or pictographs to support communication. The more complex the information is, the less people remember¹¹
- **Factors related to the patient** e.g. their state of mind, levels of anxiety and stress; age and education and pre-existing personal theories, knowledge or beliefs. The older people are, the less they retain and people tend to forget information that does not fit with their existing map of the world¹².

What's the solution?

In 2014, a programme began in Slough to improve the outcomes for patients and for GPs of conversations that they currently find challenging.

⁷ Stewart M. (1995) 'Effective physician patient communication and health outcomes: a review'. Can Med Assoc J MAY; 152 (9) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1337906/pdf/cmaj00069-0061.pdf>

⁸ Kessels, P. (2003) 'Patient's memory for medical information'. Journal of the Royal Society of Medicine: (96) 219 - 222

⁹ Godwin Y. (2000) 'Do they listen? A review of information retained by patients following consent for reduction mammoplasty'. Br J Plast Surg; 53: 121-5

¹⁰ Ley P. (1988) 'Communicating with Patients: Improving Communication, Satisfaction and Compliance'. New York: Croom Helm

¹¹ McGuire L. (1996) 'Remembering what the doctor said: organization and older adults' memory for medical information'. Exp Aging Res; 22: 403-28

¹² Ley P. (1979) 'Memory for medical information'. Br J Soc Clin Psychol; 18: 245-55

Working in partnership with local GPs and patients, the co design team explored with each party the ten conversations that each found the most frustrating and wished they could change and improve.

People told us they need:

- GPs and patients to connect on a human level and work together to towards shared goals
- Patients to understand and remember what their doctor said to them
- Patients to respond to the consultation in a positive way and find the energy and confidence to take action and control of their health issues
- Consultations that energise clinicians and build resilience.

GPs and patients then came together to share their perspectives and imagine better outcomes; the changes needed to improve these conversations.

The co design team has turned this insight into a practice-based improvement programme for GPs and other primary care clinicians. The programme supports clinicians to come together and reflect both collectively and individually on their current consultations; work with patients to explore how they perceive those same conversations and to redesign the ones that both patients and clinicians agree matter most. Practices then apply for accreditation as 'Simple Words' practices.

The tricky conversations

Seven conversations emerged as in need of improvement.

These are all included in the modular programme:

1. **Life changing news, including:** a new diagnosis of a long-term condition; prescribing medicines for life; sharing news about a potentially life limiting condition e.g. cancer and the need for rapid investigation of symptoms that may signal a serious condition. There was a mismatch between what doctors saw as life changing news and what patients thought, with in particular news about diagnosis of common long term conditions and prescribing medicines experienced as life changing news for patients.
2. **Getting to the bottom of the story, including:** uncovering hidden agendas; supporting people to share symptoms and concerns they may not be telling GP about; making progress with frequent attenders where the root cause is unclear and there may be psychological issues. This was an issue for both doctors and patients.
3. **Explaining medical terms in simple words, including:** simple explanations of long term health conditions; treatments and tests; explaining test results. This was only raised by patients – and it was the issue they focused on most. Doctors felt they were doing a good job, explaining medical terms in simple words; although they recognised that they might have underestimated how it affects patients once they heard their stories.
4. **Agreeing the right treatment for the individual, including:** dealing with requests for specialist referral that the GP may not feel is clinically necessary This was an issue for both.
5. Conversations around medicines, including: antibiotic and generic prescribing and discussions about side effects and benefits of treatment; ending consultations with a prescription. This was a significant issue for both doctors and patients; although they had different ideas about what was challenging within this conversation.
6. **Health related behaviour, including:** supporting people to recognise and responsibility for self care and self manage their long term condition; broaching the subject of planning for the future e.g. Do Not Attempt Resuscitate (DNAR) and advanced care planning. This was a bigger issue for doctors than patients.
7. **The way people use services, including:** addressing inappropriate A&E use; over-frequent attendance and frequent do not attendance; dealing with people who are genuinely late for their GP appointment. This was a big issue for doctors and not really a problem identified by patients; although they empathised with how it affects doctors once they heard doctors' stories.

These conversations align closely with research findings and contextualise these conversations in the real world of modern primary care. Slough's experiences show that the very same patient-doctor communication challenges remain alive and kicking in UK primary care over 25 years since some of the research was published.

The Slough community is now working together with The Experience Led Care team to develop the online training and an accompanying improvement programme that practices will implement to transform these conversations. Through online learning and group reflective practice with clinical peers and patients, the programme takes clinicians on a journey to improving both their own wellbeing and their personal impact in consultations, with the aim of improving outcomes for patients and making general practice more rewarding. The plan is that all practices in Slough will complete this programme in the next six months.

Is it replicable?

The Simple Words Programme is designed to be replicable at scale. Reflective practice and learning happens at one protected practice session, online and through peer led workshops at practice level. The co design team is training 'Simple Words Champions' in each practice who will support the programme and facilitate discussions between patients and doctors to agree priorities for improvement.

The programme is already spreading to other areas of the country. Work is planned on a version of Simple Words for hospital practice. The team is also looking at what Simple Words for patients and families would entail.

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Appendix 7

Can Apps support selfcare and can general practice respond?

Eddie Jahn asked GP Principals about their experience of healthcare Apps and looks at the potential gains and barriers to embedding their use in routine care

Interviewing GP Principals about the use and impact of Apps for self care and support of patients, two contrasting statements shone through. First, they viewed increasing use by patients of health related Apps as “inevitable”. Second, they currently have very little interaction with patients using Apps. Is this indicative of a dyke about to burst across general practice letting the seas flood in, or more of a natural delay between innovation of new technologies and implementation? The truth is probably a bit of both; but what is behind the dam is a lot more than just new smart Apps...

Rebalancing the patient – professional relationship

New technology has brought huge quantities of information close at hand and the means to do something with that information. Retail, finance and leisure have grasped and delivered on these capabilities. Many people now expect such capability and have the means to use it. In 2014, [market regulator Ofcom](#) estimated that 61% of people had a smart phone, an increase of 10% on a year previously. Many existing businesses have faced radical overhaul to deal with these new capabilities. Many new businesses, previously unimaginable, have sprung up. In healthcare that revolution is beginning to happen – just not at the patient-professional interface.

Yet not a single GP interviewed in depth for this paper regularly recommended the use of Apps for their patients. Indeed the answers varied only between “once or twice” to “never”. Few could name any Apps that helped them in their practice, although on prompting most did recognise that they had been using an eyesight checker or a risk calibration tool, or the online British National Formulary, or even a new EMIS App showing a cut down version of their practice’s patient administration system.

All the GPs also said that they had seen patients who were using an App of some sort for their health and well being, but the numbers were very small compared to those who researched a condition on the internet.

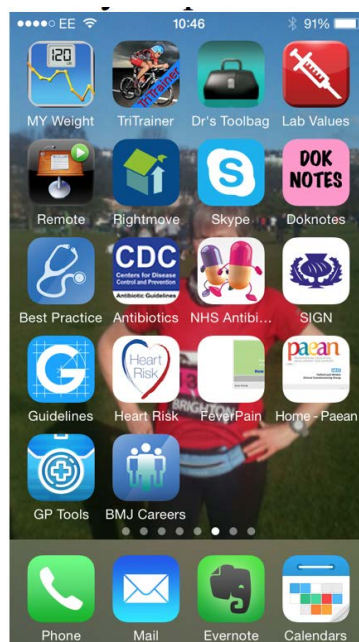
Which Health App?

The fact remains that the Apps are available and out there. There are not only multiple hearing check Apps available but also a hearing aid App. One GP asked if there was a pulse App available whilst being interviewed. Ten minutes after the end of the interview he emailed back to name the one he’d found and that it seemed to be accurate. Apps range from single purpose to all-embracing long term condition management Apps, for example for diabetes or heart conditions. Health App functionality can include one or several of the following and are for patient or professional or both (the list is not exhaustive):

- Health and Fitness
- Chronic condition self care management
- Mutual or peer support network
- Vital sign monitoring
- Local services directory
- Medicines management
- Practice transactions (appointment booking, repeat prescription ordering etc)
- Generic symptom checker
- Research and development
- General Practice systems (EMIS, System1 etc)

- Diagnostic / treatment aids
- Subscription GP services
- Personal experience recording (aka Trip Advisor)
- Professional development record

Does your phone look like this?



(Kindly reproduced from Dr David Lee)

The quantity available is daunting. Which of the 82 symptom checkers available do I choose? And therein lies the first of many problems for patients and general practice alike:

- Is an App based on good evidence?
- Is it tested, safe and effective?
- What are my responsibilities and liability?
- Will it help improve a condition or worsen it?
- Will it increase or decrease effort on my part?
- Will I understand the information it produces?
- Is the information produced integrated into the patient's health records – and if so, how?
- Is any information held safely and in confidence?

Assuring quality

There are ways out of this though. For a start, we need some kind of kite marking to assess Apps against the criteria above. There is room for [NHS Choices to develop its App Library](#) from the useful start containing 374 Apps currently, into something far more effective. If not done formally through an arm of the NHS, perhaps a site like [patientslikeme.com](#) will gain the levels of information needed in feedback to start to stratify Apps effectiveness.

In summary, a good App is:

- Well researched
- Recognised by patient, professional and institutional interests as being clinically effective and safe and providing a good experience
- Recognised by regulators
- Empowers patients to care for themselves as much as possible
- Extends the scope of how a person's care needs are provided
- Enables information sharing with professionals under the control of the user
- Secure and confidential
- Advances the understanding of how best to both care for a condition (or conditions)
- Enables quick access to care in any emergency

- Helps parents, carers etc who are affected by the condition to assist and/or cope as well
- Engages with general practice as a partner with the patient.

Beyond App quality, there are two other key tests for general practice in terms of the impact of Apps on practice workload. Firstly has the practice an effective system to manage and stratify demand? There is no point for patients to be empowered and holding large quantities of information about their condition to then bump up against an antiquated system where they know more or less what they need, (a simple email answered, or a quick phone chat to verify something...) but have to wait days or weeks for an appointment and then be referred for tests that their smart phone has already done for them.

The second test for a practice in terms of workload is whether the App empowers patients to manage more of their own care. This is where we can start to “rebalance” the patient professional relationship into a more modern framework.

Good health Apps personalise healthcare and provide new means for patients to look after themselves. The patient becomes informed, empowered and autonomous. The professional becomes a coach, a partner, a provider of boundaries and an enabler of a team’s resources. This shift has been going on since the start of the information age and will continue to quicken as patients become more empowered and informed by modern technology.

The trick for general practice is to harness the change, massively strengthening its role and purpose. General practice is local, holds the fundamental patient health record and holds a one-to-one relationship (registration) with every citizen. No other professional can shift to hold the ground as the birth to death health coach, enabler and support professional to all patients.

Disrupting practice

Many Apps are in this way typical of “disruptive” technologies. They redefine how a system works, and if the existing system refuses to change or cannot change in time, then change happens to it. This sounds both threatening and thrilling, and it is. The worst that can happen is if people ignore the power of Apps and think that healthcare will not be affected as other services are. If that is the case then parallel whole systems will emerge. Alternatives are already in the wings, such as [Babylon Health](#), which offers users a private video consult with a doctor, followed by prescription or referral to a specialist. These may satisfy the innovators and early movers to new technologies and systems but could ultimately cause large sections of the population to “channel shift” should general practice procrastinate.

One final caveat: technology literacy is not evenly spread. Ofcom’s 2014 study of nearly 2,000 adults and 800 children, found that six year olds claim to have the same understanding of communications technology as 45 year olds. As age goes up, digital literacy (as measured by the Digital Quotient or DQ score) goes down. More than 60% of people aged 55 and over had a below average ‘DQ’ score. According to Ofcom, we hit our peak confidence and understanding of digital communications and technology when we are in our mid-teens. This drops gradually up to our late 50s and then falls rapidly from 60 and beyond. The implications of this for general practice attempting to move forward with disruptive technology are profound

Concluding remarks:

New technology is bringing the personalisation of care and the empowerment of the patient. The ability for the patient to be supported and coached can in theory be done virtually from anywhere, but there are distinct advantages for local, community-based general practices to provide this and be the hub from which local care service resource can be deployed in an effective, responsive and accountable manner, for and with patients.

Not all patients can adopt new technologies. Some people will have neither the skills nor the inclination, others may not have the mental or physical capacity to do so, and others still may not be able to afford it. General practice needs to maintain traditional care at the same time as moving forward using new technologies.

There is a role for work at national level, for example NHS Choices should build on its current Apps library a kite marking type functionality and a greater public and professional feedback system NHS England could consider supporting some vanguard-type work with federations of practices and App providers to explore how new technologies potentially change fundamental processes and the patient – professional relationship

Consideration needs to be given as to how to finance the use of Apps in general practice. Some are commercial, some are free, others are provided by voluntary groups. Should they be available on prescription? Should smartphones be available on prescription?

Consideration also needs to be given to incentivising general practice to adopt a new model of care.

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Appendix 8

How online patient record access can save practices time and money

Brian Fisher explores the benefits of online access – and argues that not only can this save practices time and money but there are patient benefits too

Anyone in England who wants it can now have access to their GP record. This offers significant opportunities for practices and patients.

The 2015 GP contract makes it compulsory for practices to enable patients to see only the equivalent of the Summary Care Record (SCR) which shares allergies, medication, name, address, date of birth and NHS Number. The SCR gives people little useful information and is really designed for clinicians, not patients.

From 2016 practices will be expected to share with patients the full record. However, practices can choose to offer more comprehensive access right now.

Sharing the full record offers most opportunities for saving resources. You can do this now.

This is because patients seeing their test results, their letters and the free text of their consultations enables them to make more decisions for themselves, moving demand away from the practice.

Saving time and money through patient record access

A study asked patients in two urban general practices who offered record access whether it had increased or decreased their use of the practice over the previous year. Using practice data, the change in appointments, telephone calls and staff cost was calculated. An average of 187 clinical appointments (of which 87 were doctors' and 45 nurses') and 290 telephone calls were saved¹.

The figures suggest that if 30% of patients used RA at least twice a year, a 10,000 patient practice would save 4,747 appointments and 8,020 telephone calls per year. This equates to a release of about 11% of appointments per year, with significant resource savings for patients and the environment.

Maximise the benefit

1. Prioritise patients with LTCs for record access.

They are the most likely to gain benefit. They have repeated investigations and referrals in the NHS and social care. Without record access, they have to contact the practice for every result, for the contents of letters, to check appointments and whether letters of referral have been sent. Record access means that they can do much of this without the practice, saving calls and appointments.

2. Tell patients about the key benefits

- Look at your test results and doctors' comments. Patients will soon be able to see doctors' comments on the results. Through their comments on the results, clinicians can reassure patients about minor abnormalities of no clinical importance. They can remind people of when they need to be reviewed. This is key way of improving safety and an efficient use of resources.
- Read the notes of our consultations. You will be reminded of advice and suggestions for next steps

¹ Fitton C, Fitton R, Hannan A. The impact of patient record access on appointments and telephone calls in two English general practices: a population based study *London Journal of Primary Care* 2014;6:8-15

- Share your record with family, particularly if you can't read English. Share it with other NHS staff, for instance those in hospital.
- Look at your letters. They can help you understand what the hospital and other agencies plan for your care.
- Look at the information buttons, if your record access system has them. They will give you more information about complicated terms and test results so that you can understand more about what you read.

3. Promote the e-suite of transactional services

Online appointment booking, ordering repeat prescriptions and secure messaging all offer big opportunities for taking pressure off your staff at the front desk. The practice should promote these.

4. Secure messaging is a new option.

It is universally available in England. It enables patients to message the practice, and for you to reply, in a simple manner, without using email. It may help you to reduce telephone calls. Research from the US suggested that combining secure messaging with record access can save 10% of clinic appointments. Similar studies in the UK have not been done.

Evidence of patient benefits

Studies across the world agree that record access:

- Improves relationships between patients and practices
- Supports self-care and shared decision-making
- Improves compliance with medication
- Increases patient confidence and understanding
- Is safer because data can be shared through the patient

Minimise the risks

It makes sense to think about the following scenarios and to consult Patient Online for solutions <http://www.england.nhs.uk/ourwork/pe/patient-online/> or the RCGP here http://www.rcgp.org.uk/Clinical-and-research/Practice-management-resources/~/_media/Files/Informatics/Health_Informatics_Enabling_Patient_Access.ashx

- Allowing children access
- Recording third party information
- Coercion in the family or elsewhere

Remember, you can arrange for detailed access to start only after a date set by the practice.

So old letters and consultation free text will not be seen by the patient before that date.

Appendix 9

Simplifying data collection for payment and monitoring

Henry Clay reviews the impact of GPES and CQRS on general practice and makes recommendations for NHS England and CCGs

GPES (the General Practice Extraction System) and CQRS (Calculating Quality Reporting Service) make up the system through which data are collected from practices for payment and monitoring purposes. GPES was designed to automatically extract data from GP systems and feed it into CQRS to calculate payment. The aim was that it would be more versatile than its predecessor, QMAS, and reduce the bureaucratic burden on general practice.

The new system went live at the beginning of 2013/14 but instead of making life easier for practices, it's been made it more difficult. It has been a disappointment to everyone involved with the BMA's GPC calling the implementation a "botched job" and the Health and Social Care Information Centre issuing a sincere apology in summer 2013. In July 2015, the National Audit Office issued a scathing report into the system's ballooning costs and failure to meet requirements. It concluded: "It is unlikely that GPES in its current form can provide the NHS-wide service planned¹."

In 2014/15, the Primary Care Foundation surveyed over 250 practice managers who were at this stage still feeling the ramifications of introducing this new system. From a practice perspective, it felt almost as though it had been designed to be as opaque and as complex as possible. Far from making their life easier, it became more difficult as not only had practice managers to learn to use a new system but also to implement manual workarounds when data could not be extracted from GP IT systems. We asked them about their problems and what would help. This is what they told us:

"CQRS or manual payments - not a mixture of both. This is such a mess - it has been going on for far too long and shows no sign of actually coming to an end. A real nightmare!"

"A single process and toolkit for reporting on activity. Currently some services are reported via emailed spreadsheet, some via manual entry on CQRS and some by automated extraction (this latter requires a lot of initial setting up for practices, e.g. creating data entry templates etc.). Some services are reported monthly, some quarterly and some at the end of the year."

"Make everything automated rather than having to submit monthly/quarterly returns. The CQRS system is going some way to do this, but it's still in its infancy and still has problems. For example, the extended hours enhanced service must take up thousands of hours. We have to complete a form quarterly with someone counting the number of patients attending and those that do not attend and for what purpose?"

"CQRS to be up and running properly collecting the data. However, this needs to be with some notice with ALL the information that is needed so that templates can be properly set up and established with the correct Read codes. There seems to be an expectation of returning lots of information that is not that clear in the original service specification. CQRS is also quite confusing as to which are still manual data completion requirements and which automatic. I trust this will be resolved by the start of next financial year."

¹ <http://www.nao.org.uk/report/general-practice-extraction-service-investigation/>

“Additional data required through CQRS - for dementia in particular - is excessive. Surgeries do not have the resource to develop the level of data reporting clearly expected in the new enhanced services. Governments have become thirsty for data & information - and the DoH is no exception. The Dementia ES has no less than 16 data elements about various aspects of care for patients with dementia for suspected dementia.”

“CQRS is not helpful, user friendly or practical - from conversations with NHSE colleagues they seem to have a similar experience. The volume of management information to be completed monthly is excessive and often difficult to find accurately contributing most to the hours of bureaucratic time spent.”

“CQRS doing the job it was set up to do, we are still having to manually submit information into CQRS which in itself is a clunky non-user friendly system.”

Looking ahead

HSCIC and NHS England have plans to develop the existing system further and have put in place a remediation plan that will replace those parts of GPES that do not work to provide a suitable data extraction service in the future. A user group has already identified and prioritised a number of potential improvements. In addition HSCIC is working closely with a number of practice managers to identify the demands from GPES and CQRS to streamline and simplify things for practices.

The changes already delivered or in progress are:

- Updating the data entry screen so that information is recorded against the payment date
- Enhancements when entering data manually to clarify the on-screen descriptions, to reduce the amount of information needed to trigger payment and to allow figures to be checked and corrected before they are declared
- Adding notifications to practices so that they are less likely to miss deadlines when manual entry is required
- Improving and updating the training material as well as improving the visibility of the on-line training resource
- Simplifying access to the training materials so that this can be accessed from within GPES/CQRS
- Introducing changes to support co-commissioning so as to allow CCGs to manage and pay practices for services provided
- Improving the communication with practices so as to make them aware of the developing capability of GPES/CQRS and to gather ideas for further enhancements.
- Whilst in 2013 only QOF information was extracted from systems in 2014/15 7 services were added and in 2015/16 this will be increased to 15 (plus another 9 extracts for services outside CQRS).

This is much more than a dim light at the end of the tunnel. Real progress has been made. Whilst all of this is welcome, we have a number of recommendations:

Recommendations for commissioners including NHS England

- NHS England should ensure that GPES with CQRS (or successor systems) become the default process for collecting summary and patient level information for reporting and payment. It should be available nationally not just for NHS England and HSCIC but also for Public Health England, CCGs, local authorities and Healthwatch and the other users identified in the original business case. The system needs further development to realise this ambition - but reducing the pressure on general practice is vital if the government and NHS England's aims are to be achieved.
- All commissioners should ensure payments are simple to reconcile with the information from the practice clearly identifying the period and rationale for the payment. Capita have ambitions to do this for payments made as part of practice support services, but the same is also applicable to payments from CCGs and local authorities
- All commissioners should check the practicalities of collecting the relevant data from practices

as part of developing any payment mechanism and use one of a limited number of standard payment methods. For example commissioners could consider:

- Paying according to registered population - Paying according to registered population within an age range or for those with a particular condition
- Paying for specific tasks that have to be recorded on the system (for example vaccinations), usually as Read codes
- Paying according to an activity that can easily be captured and coded on the system (for example the review and updating of a management plan for a patient) - but make sure that the templates are set up to provide this information from the start.

Commissioners should be particularly wary of introducing new methods or variants that cannot be not supported by simple configurations or minor changes to the systems

Case study

How complexity can easily be introduced into reporting.

In developing the agreement for the enhanced service for avoiding unplanned admissions it was recognised that practices might have worked hard managing cases and providing care to patients who subsequently died. Whilst the logic of taking account of this and ensuring that the practice is rewarded accordingly is clear, the fact that the historic record is no longer part of the live system means that GPES is unable to collate this information. This has resulted in greatly increased complexity and manual data entry by practices imposing yet more work on the practice. It seems likely that a far simpler process (say of assuming that those who died will have been on a care plan) could have provided a reasonable approximation and much reduced the burden of reporting. We are unsure how far this was considered during the negotiation of the enhanced service - but we received the strong impression from practices that they would have fought hard for a simpler arrangement that could have been easily handled through GPES in the interests of reducing the bureaucratic burden.

A caution

We are firmly convinced that the development of GPES and CQRS (as well as the planned development of the practice support processes being undertaken by Capita) is already and will continue to reduce the burden on practices. But it is appropriate too to remember the realities of life in a busy general practice where news of planned improvements may sound a lot like jam tomorrow.

The timescale for changes can be extended, particularly if there are new complexities that have to be overcome. Each additional requirement requires the various software suppliers to develop, test and roll-out the necessary changes for the information to be collated within their system, GPES has to be programmed to accept and transfer the information and CQRS needs to be developed to carry out the appropriate calculations and appropriate outputs developed. Finally where the information triggers payment, the process (recently awarded to Capita) needs to be configured appropriately. It is inevitable that sometimes a claims process will require data to be entered manually for a period whilst an automated service is developed.

Second there is work still to do. Whilst the process for providing information to GPES for both Vision and SystmOne is now operational, EMIS is a little way behind and Capita have only just been given the contract for practice support services. With the recent under-investment in developing these systems they have some catching up to do - and it will take a little time.