The national voice for LINks' members

Striking a Balance ... What matters most in general practice?

Response to 'Striking a balance' A Consultation by the BMA General Practitioners Committee

September 19th 2010

The National Association of LINks' Members
Public and Patient Involvement in Health and Social Care

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NATIONAL ASSOCIATION OF LINks' MEMBERS

Patient and Public Involvement in Health and Social Care

A NALM Report
September 2010

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THE AIMS OF NALM

1. Provide a national voice for LINKs' members

2. Promote public involvement that leads to real change and the ability to influence key decisions about how care services are planned and run.

3. Promote the capacity and effectiveness of LINKs' members to monitor and influence services at a local, regional and national level and to give people a genuine voice in their health and social care services.

4. Support the capacity of communities to be involved and engage in consultations about changes to services, influence key decisions about health and social services and hold these services to account.

5. Promote diversity and inclusion and support the involvement of people whose voices are not currently being heard.

6. Promote open and transparent communication between communities across the country and the health service.

7. Promote accountability in the NHS and social care to patients and the public.

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Striking a Balance ...
What matters most in general practice?

Response to 'Striking a Balance' ... A Consultation by the BMA General Practitioners Committee

Summary of the document

This consultation document suggests that general practice is the most cost-effective form of health care delivery in the developed world, and describes rapid changes in practice caused by increasing demands for services, rising expectations, evolving practice structures and changes to government policy. The central theme of the document is that competing expectations and the current economic climate are likely to result in difficult decisions over the coming years, in relation to priorities for general practice and services to patients. The Consultation closed on September 10th 2010.

http://www.strikingabalance.org.uk/media/gpcconsultationdocument.pdf

Key issues discussed in the document:

- Providing effective services within a limited budget
- Evolving GP practice teams
- How patients get appointments that meet their needs
- Out-of-hours (OOH) care and treatment
- Continuity and meeting the needs and expectations of patients

Current pressures on general practice:

- Growing demand for GP services
- People living longer and developing complex health care needs as they age
- More treatments available to treat illnesses
- National cost of healthcare is growing
- Transfer of care and treatment from hospital to general practice
- No major transfer of funds from the acute sector to general practice
- More time spent managing long-term illness
- Demands for longer or more frequent appointments
- Prospect of very little 'new' money available for health care or general practice

The BMA has sought responses focussed on how to ensure that general practice is fit to meet the needs of patients. They seek support for the case to develop and strengthen general practice in line with patient, public and GP priorities. The White Papers on the NHS was issued during the consultation period.

"The benefit of the current partnership model is that it provides a mix of continuity through the partners, refreshed by a flow of salaried GPs. If you don't have that flow, practices may become "stale" and out of touch with the latest thinking".

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The evolving practice team

NALM welcomes the Striking a Balance consultation, and observes that most of the major changes to general practice in the past have taken place without genuine public involvement.

Patients often think of their GPs as full-time workers spending their time continuously providing services to patients at their local practice. GPs often see their work as increasingly focussed on a variety of interests in the primary and secondary care sectors, teaching, being with their families and in other areas of work. There is a tension between the expectations and desires of patients for a model of primary care that meets their needs and expectations, and the actual development of primary care over the past 20 years.

The size of a general practice is often seen as a problem. The costs for GPs who wish to set up and develop practices on the traditional model of 'GP partners working as a team', are now considerable in terms of both resources and financial risks, and these are not necessarily underpinned by Primary Care Trust (PCT) guarantees.

It is common to hear people, opposed to the current model of general practice, describe GPs as running small businesses and claiming that they are not really part of the NHS. We would strongly argue that culturally and philosophically, GPs are fully part of the NHS, and although the business model which underpins primary care is a private one, most GPs see themselves as a fundamental part of the NHS, and are very likely to fully support the ethos that drives the NHS. We believe that this model is fundamentally different to a profit based model, led by national and international companies, which are seeking to displace the traditional GP service model.

Most people appear to want a GP who is dedicated and trustworthy, will listen to them as patients, treat them holistically; not as a cardiac/cancer/other patient. If specialist help is needed, people generally say they prefer to be transferred to a hospital. This might be a model of care that does not fit recent and planned developments in primary care, but if patients are not exercising their judgement well in preferring to access specialist care in the acute sector, it is for primary care practitioners to demonstrate the superiority of home based specialist care. It seems likely, that on a spectrum of expertise, GPs would not have expertise equivalent to that of a hospital consultant specialising in a narrow area of clinical practice. Equally, most patients probably do not require access to the most expert and specialised forms of diagnosis and treatment.

The traditional GPs contractual model has generally secured from general practice long term engagement between GPs and patients. However, the partnership model which has kept GPs working in teams - and working with patient populations for long periods, is now under threat from GPs' own aspirations for their career and personal development; the increasing instability of the business model and the attempts by big business to buy up general practice. The role of private healthcare companies is motivated partly by their desire to access the commissioning budget, i.e. taxpayer's money delivered through the NHS budget and partly to displace the socialised model of health care which most people in Britain are committed to.

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The proposals in the White Paper to transfer the commissioning budget to general practitioners will, in our view, damage primary care. They will ultimately have the effect of enabling healthcare companies and commercial consultants to access the healthcare budget and is a backdoor way of privatising the NHS. The proposal will ultimately turn many GPs into employees of private health care companies and reduce the influence of patient and the public in the NHS.

Development of multi-disciplinary teams in primary care

Generally, the multi-disciplinary general practice model has been a success, but patients are now being offered - or invited to choose - new and different models of general practice, which are often poorly described and feel more 'handed down' than consulted on.

Each member of the practice team has professional skills and specialist training, but the scope of that training and the means of choosing what is appropriate for a particular consultation, is difficult to decide upon because patients do not have sufficient information to make a choice. For example, practice nurses may have a wide range of specialist and general nursing skills. Patients do not know if these skills are the same as those held by community, district nurses or other nurses who work in community hospitals, acute hospitals or in other locations. It is usually impossible to decide if it is better to see a nurse or doctor. Equally, we know so little about the specialist training of GPs that patients cannot decide which doctor to go to, except by personal experience. There is also concern that as GPs decide and develop their own specialist interests, they establish themselves as a source of specialist care in the area they practice in and they won't be replaced if they move to another area; that is to say, the provision of specialist care in general practice does not appear to be subject to strategic planning.

In one London Practice the following information is available on the website:

The Partners ... We are an NHS partnership of four general practitioners working from our own premises in North London.

Dr Sharon Bennett FDS, RCS, MBBS, DRCOG, MRCGP
Dr Nicholas Brand MBBS, MRCGP
Dr Kathleen Tuck MBBS, MRCGP, DFFP, DipObs (RCOG)

Salaried GP ... Dr Linden Ruckert MBBS, MRCGP, DRCOG, DFRHC

The Practice Manager ... Mr David Gorman MBA, HDCR, MDCR

Practice nurses ... Glory, Carol

Phlebotomy ... Angela

The GPs and practice managers have a long list of qualifications ... and the nurses and phlebotomist have only their first names. Patients could reasonably conclude that the nurses and phlebotomist have no qualifications and low status.

Patients may wish to choose a GP with specialist knowledge in a particular field. They may wish to see a generalist rather than a specialist, and they may want information about a doctor's particular skills. This is very difficult to do.

There is generally a failure by general practice to plan with patients and the wider community what services are needed to meet local needs; how many specialist and how many generalist GPs are needed; what role each health professional has; what training and expertise they have; how to best access services and individual members of the team and how to co-ordinate with local authority social services teams to ensure effective and co-ordinated care.

NALM members particularly want to draw the attention of the BMA to the particular needs of patients in rural areas where practice size may need to be determined in part by issues of accessibility. Small practices, or outlets of larger ones, are needed in places that people can get to. For instance, in the case of very rural areas like Norfolk, Market Towns are ideal locations for practices, because that is where both public transport and informal transport systems (car schemes, voluntary minibuses) get people to. The same criteria of accessibility should apply to specialist services. There are also interesting innovations in some rural areas, e.g. in Yorkshire, there is currently a pilot "Neighbourhood Care Team" open 12 hours daily. Nursing staff include a prescribing nurse, paramedic, social worker and therapist. The team is backed by a doctor on-call at all times. There is one phone number for any member of the public to call in an emergency to discuss or report a need. If necessary, a nurse is dispatched to the person's home to deal with the problem and can arrange hospital admission, treat on the spot, prescribe, arrange for rapid assessment and any necessary home care including therapy. *T*ele-medicine is also being piloted to transfer results of tests taken by the patient or carer to clinicians - this can reduce or prevent a nurse or GP visit and reassure an anxious patient. To enhance care for cancer patients, they are given a number to phone at the Regional Cancer Centre if they are worried or sick, and can be immediately admitted if necessary.

Effective utilisation of community pharmacists within the multi-disciplinary team is also essential to enhance the effectiveness of primary care, by improving the fit between patient need and access to primary care practitioners. Pharmacists provide specialist advice on medicine interactions which should be made more available to GPs and patients – they have a special role with patients who have severe and chronic illnesses who may suffer unexpected side effectives of medication. Community pharmacists can also have an important role in preventative health care and management of minor ailments.

LINks believe that collaboration between the public and general practice - locally, regionally and nationally - is essential to develop and defend the current model of practice, and we believe that GP practices need to be more accountable to the public. LINks sometimes find that it is more difficult to influence general practice than other parts of the NHS. NALM is determined that the LINks, their successors Healthwatch, Patients' Participation Groups and the wider public, should have more influence in the commissioning of services both at practice level and GP consortia level.

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Recommendations to the BMA

- Services in each area should be planned between GPs, LINks/HealthWatch, Patients Participation Groups, the practice population, and the PCT.
- The ratio of specialised to generalist GPs should be agreed, not on the basis of GPs career choice, or arbitrary policy decisions, but on the basis of local need.
- Strategic planning to meet local need, population growth and common significant health problems, must be part of a community planning agreement or compact.
- Within this local compact, a picture of all practices in the geographical area should emerge, showing what skills and expertise are available, how practices can share resources to better meet need - and where there are shortages of particular staff with particular skills - that need be addressed. This approach values the generalist GP, nurse, counsellor and therapist and plans for access to appropriate specialist services.
- Details of the professional qualifications, expertise and specialist skills of each member of primary care teams, should be placed on their website and in practice publications, so that patients can decide which professional is most appropriate to meet their particular needs for each consultation.
- Practice nurses should not be used as 'triage nurses' if this role diminishes their professional role as nurses, rather than elevating their professional skills and expertise.
- Effective utilisation of community pharmacists within the multi-disciplinary team is essential to enhance the effectiveness of primary care, by improving the fit between patient need and access to primary care practitioners and providing expert advice on medicines and medicine management.

Question to the BMA

Is there any evidence that systems of primary care, outside the UK, deliver services which have better health outcomes? If so how do costs compare with the UK system?

Getting an appointment and improving access to appropriate care

Many practices have very poor websites and it is common to find considerable difficulties in contacting practices by email. Email would be an excellent way for patients to communicate with the practice, ask questions, ask if symptoms should concern them and find who would be the most appropriate health professional to see. Email conversations between patients and health professional in primary care are entirely appropriate. Discussions by phone are also appropriate. As an example, the London Ambulance Service operates a Clinical Telephone Advice line, which enables clinically trained staff to discuss symptoms and to plan the best course of action.

The reason why current appointments system sometimes fail, is that practices are not

sufficiently well organised to communicate over the phone and by email. Consequently, patients make an appointment to see a doctor because they can see no other way of getting the advice they need.

If the structure of general practice was clearer, and patients could navigate the system based on their needs, the pressure on GPs would decrease. Patients need to know which GPs are specialists and which are generalists, and about the skills and training of every member of the primary care team. If they could make appointments based on their assessment of their needs to fit in with the availability of an appropriate member of the primary health care team, the demand for specialist care for minor problems would decrease, whilst the provision of appropriate specialist care for patients who are more seriously ill would increase. Patients do not want to access inappropriate resources - they simply do not have the information available to make decisions about who would best meet their needs.

Some appointment systems force patients to accept an appointment within 48 hours because they cannot make appointments for a period further into the future. There is no reason why appointment systems cannot be designed to accommodate the patient's assessment of urgency of their problem.

Is it often said that pharmacists have a role in reducing the pressure on general practice. We believe there is a fundamental conceptual error in the 'reducing pressure on general practice' approach. The real question should be: "how do we ensure that patients are able to choose the most appropriate health practitioner in a primary care team – which includes the pharmacist?"

The development of self-help groups for patients with chronic illness and long term conditions would be a very effective way of both supporting patients and entering into discussions with them about the re-design of systems to access care. These groups should also be linked to the development of 'expert patients', who can advise and help primary care teams acquire a good understanding of chronic conditions, and provide them with relevant information and advice about the most effective ways for patients and primary care practitioners to collaborate.

Recommendations to the BMA

- Primary care websites should be improved to enable communication on clinical issues between patients and primary care staff.

- Primary care practices should develop effective telephone and email systems to enable patients to discuss issues with clinical staff and agree the best course of action.

- Patients needs to know the skills and training of every member of the primary care team, including pharmacists, so that they can make appointments based on their assessment of their needs to fit in with the skills and expertise of an appropriate member of the primary health care team.

- GPs, nurses and other health professionals all have areas of expertise which may

be focused on a single practice or several. The strategic planning of how to use these resources should be discussed with LINk/HealthWatch and local patients groups.

- Appointment systems should be rationalised to ensure that patients can plan when they need care, and from whom. The Eurostar system for booking trains to Europe could be adapted to general practice.

- Self-help groups should be established to support patients with chronic illness/long term conditions, and to enable them to participate in the re-design of primary care systems. This approach should be linked to the development of 'expert patients' at practice level.

Patient information and education
If patients don't understand how the system works and about the expertise of staff in the primary care team they are never going to use services effectively.

Care and treatment outside normal working hours

The ever more complex relationship between general practice, NHS Direct, Pathways, ambulance services' urgent care, GP out-of-hour's services and polyclinics/GP led health primary care clinics is a major problem. In addition, there are GP services in A&E and a range of open access clinics. All of these services are welcome, but make for an ever more confusing primary care sector and very difficult choices for patients. It is difficult for patients to exercise their judgement in relation to the selection of an appropriate service in such a mixed field of care. Better communication is needed to inform people of the options available and why it is not always appropriate to attend A&E.

Improvements to care should involve local GPs, LINks and other patients' group working collaboratively in the planning and arranging of care.

NALM and National HealthWatch should be involved in the national monitoring of quality standards, nationally agreed service standards and the system to confirm that overseas doctors are fit to practice professionally and when they are on duty.

Out-of-hours services need to be based on travelling times. It takes several times longer to get to an out-of-hours base by Norfolk country lanes than by one of our few dual carriageways. Travelling to centres is often entirely reasonable in some part of cities and towns. However, in rural or offshore areas - and where people are too ill to travel or are disabled - it is an unreasonable expectation. The use of taxis - with drivers trained in first aid - would be effective in many situations to enable patients to get to centres. In some areas and situations, the costs of transport to these centres should be paid by the NHS.

Recommendation to the BMA

- Urgent, 'Out-of-Hours' and 'Open Access Care' should be planned on an area basis, to ensure the co-ordinated provision of appropriate care. The core aspiration must not be diversion from GP practices.

- The involvement of LINKs/HealthWatch locally and NALM/HealthWatch nationally, is essential in the planning of care and care standards.

- The use of taxis with drivers trained in first-aid, would be a valuable service for people who need to get to an centre, but are not able to, or do not have the resources to do so. It may be appropriate for costs to be picked up by the NHS.

Continuity in general practice and coordinating care in the modern NHS

> *"Because patients in the UK register with a GP practice, GPs are able to take overall responsibility for each patient's care, looking at the patient's health as a whole and coordinating any care received elsewhere in the NHS by referring to the most appropriate service, following-up on hospital visits and collecting test results".*

This statement makes good sense, but does not represent the real world as experienced by many patients.

Continuity of care is highly valued and of fundamental importance, especially by people with chronic and long term illnesses. If patients find a member of the primary care team with whom they can communicate well, a continuing dialogue can be of great value. Patients may also get to know that particular members of the team have particular strengths, they may prefer for some conditions, a person of the same gender or who speaks the same language. People with long term conditions should be able to opt for practices where continuity is available.

Access to GPs with 'care of the elderly' experience is likely to become increasingly important with an ageing population. We imagine that home visits by GPs will become an increasing feature of a service in which continuity of care and observation of the patient at home becomes accepted clinically as best practice.

But, we find that the concept of quality in primary care, as presented in the consultation document, vague. Quality is a term with multiple definitions and perhaps little agreement between patients and doctors on a common definition. The statement: "*the evidence of the effect of continuity on quality of care is more mixed"* is confusing. Patient groups looking for information to assess the quality of general practice, e.g. QOFs, often find that GPs are uncomfortable with patients using QOFs for this purpose. Patients often see quality as; good communication; staff who ensure effective liaison between the practice and secondary care; easy access to services; not queuing in the rain whilst waiting for the surgery to open; opportunities to discuss issues without feeling like a nuisance; consultations which feel like shared decision making, and not being patronised.

Primary care practitioners may regard the patient journey, flow of patients through the system, tackling health inequalities and willingness to follow medical advice as key indicators of quality. Work toward agreeing a shared definition at practice level between staff and patients would be invaluable.

Patients often report that co-ordination of care within practices is not well managed and it can be difficult to arrange multi-disciplinary meetings within a practice for patients with complex and long term problems. Multi-disciplinary teams based on larger practices should aim to meet the needs of local communities, and it is essential that these teams are accessible beyond the boundaries of a single practice and that the personnel, their expertise, specialisms and accessibility are well known and understood in the community.

However, conflict in practices is a major issue and different practices in the same building often cannot agree on basic co-operation. Competition between practices is expensive, wasteful and undermines the effective planning of primary care. We agree that primary care staff should collaborate rather than compete with each other and that short term contracts for primary care centres undermine the long term development of localised primary care.

Development of primary care in some areas should be focussed on the growth of populations, rising needs in relation to ageing populations and proactive work to reduce health inequalities and meet the needs of new communities and those living in areas of relative deprivation. The current system inhibits needs-led primary care development.

Practice boundaries are often unpopular because they limit the right of patients to choose a primary care service that meets their needs. With primary care practices offering out-of-hours services far less frequently, the need for practice boundaries may be far less critical, enabling patients to access primary care service near their work or home. The provision of minor care outside the boundaries of a primary care services, is not a great problem and open access to sexual health services has been popular and successful in encouraging patients to attend for care. Enabling anonymity, especially for young people, may be an essential means of building trusting relationships with the NHS before the patients is ready to engage fully with a primary care team. However, the abolition of GP boundaries might be seen as a green light for some practices to expand their business, inevitably at the cost of other practices, leading to greater conflict between practices, rather than greater co-operation.

To resolve these contradictions we need local agreements between primary care, local authorities as providers of social care, patients groups and LINks to find solutions that meet local need. To support this approach we would like to see an extension of the Quality and Outcome Framework (QOF) system to include indicators for the effectiveness of patient/public participation in general practice.

Recommendation:

- Continuity of care is essential, but patients need to know what they can expect from this kind of relationship between patients and primary care teams, e.g. an agreement describing how patient's 'needs' will be met. The introduction of a 'continuity impact' test could be an important way of evaluating the potential impact of new approaches to primary care on the more traditional methods.

- Primary care services must be provided in a way that is sensitive to a person's culture and communication needs. Being able to choose a practitioner of the same gender is essential.

- Patients, LINks/HealthWatch and primary care teams should develop local quality strategies and agree which quality standards and indicators of quality are want in each primary care practice.

- Discussions should take place between the BMA and NALM on the development on a set of primary care quality indicators and an agreement reached on the role of QOFs in the local determination of quality.

- The Quality and Outcome Framework (QOF) should include indicators for the effectiveness of patient/public participation in general practice.

- Multi-disciplinary primary care teams should be based on larger practices, but should be fully accessible to the wider community on the basis of local need. Information describing the services provided by these teams should be published locally.

- Competition between practices should be strongly discouraged, whereas collaboration between primary care teams is essential and should be strongly encouraged.

- Primary care development should be needs-led and based on population growth, demography and views expressed by community groups including patient participation groups (PPGs) and LINks/HealthWatch.

- Practice boundaries should not be used to limit the aspirations of patients to access the primary care services they need, but the loosening of practice boundaries should be managed to prevent competition between practices.

- Examples of good practice in each area should be publicised and patients involved in evaluation, and encouraging other practices to experiment with good practice.

- Patient and public involvement and influence in GP commissioning is essential. We recommend that half of all commissioning teams should be made up of PPG and LINk/HealthWatch members.

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