Department of Health

Keeping it Personal

Clinical case for change: Report by David Colin-Thomé, National Director for Primary Care

NHS

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Keeping it Personal

The traditional relationship between patients and GPs isn't going to change but the services patients are offered will be unrecognisable in ten years' time, according to David Colin-Thomé, National Director for Primary Care.

Introduction

Patients trust GPs. We're highly trained; offer high quality, cost-effective services and our communities respect us – so why aren't we doing even more? That's the question I ask myself as a practising GP. And the same question must be asked by nurses, pharmacists, physiotherapists and every other healthcare worker in primary care if we are to drive the evolution of new services.

Benefits of New Primary Care Services

1. Quicker, faster access to care.
2. More high quality services close to a patient's home.
3. Better buildings equipped with state-of-the-art equipment.
4. Better value for money.
5. Improved patient experience and outcomes.

GPs and nurses in general practice – the first line of care in England – see more than 300m people a year. That's about six visits to a local practice per person per year. Out of every 10 people using NHS services, only two of them are being treated by hospital consultants and their teams; the other eight are being treated by the country's 32,000 GPs.

Ninety-nine per cent of the population are registered with us and our practices treat the vast majority of sick or simply concerned people in this country. Our enduring appeal is due to the nature of the service we provide. It is personal, based on trust and confidentiality, and close to home. Economically, at about £20 per consultation we represent value for money and socially we have the ability to ensure a poor woman in Hackney gets a cervical smear as regularly as the affluent women in Hampstead would expect to.

Our training allows us to spot the first signs of cancer, give advice on weight loss and deal with depression and desperation. Many of us specialise in particular aspects of medicine and the nurses, midwives, therapists and pharmacists we work with have similar skills which the public value.

And all this frontline care is delivered for just under £8bn a year. This is a huge sum of money to you and me but only a fraction of the £90bn annual budget. That's why expanding the services GPs, nurses and midwives provide in our communities and homes, makes sense. And economically it makes sense. Take for instance the traditional six-week post-surgery check-up with the hospital consultant. Why are we still doing it for everyone when most patients pop in to see their GP if there is a problem after an operation? GPs have the skills necessary to decide whether a patient needs to return to a consultant. That doesn't mean GPs should see everyone dogmatically but it does mean consultants can be more discerning. A patient who has had a hernia repaired or varicose veins treated doesn't always need to return. The cancer sufferer does. But wouldn't it be better if the most ill patients returned quicker to the consultant because the GP has taken care of the patient with the varicose veins. Some hospitals already work in this way.

There are potentially huge savings for the NHS every year if it generally cut outpatient appointments in this way. Applied intelligently by GPs and consultants the reform would increase quality not diminish it. Consultant time would be freed up and GPs will spot and deal with minor complications more quickly. We need GPs and consultants working in partnership.

The Best of the Best

The Commonwealth Fund, a US think-tank, recently surveyed GPs in seven developed countries and found the UK "stands alone" in a number of areas.

1. **Greatest use of multi-disciplinary teams:**
   1st UK 81%
   2nd Netherlands 50%
   7th US 29%
2. **Greatest use of clinical audit to improve patient care:**
   1st UK 96%
   2nd Germany 69%
   7th Canada 45%
3. **Greatest use of patient clinical outcome data:**
   1st UK 78%
   2nd Germany 71%
   7th Canada 24%
4. **Greatest use of patient satisfaction surveys.**
   1st UK 89%
   2nd US 48%
   7th Canada 11%
5. **Greatest use of processes to follow up adverse events.**
   1st UK 79%
   2nd New Zealand 41%
   7th Netherlands 7%

Benefits of General Practice

- Higher patient satisfaction rates in the health services.
- Lower overall health service expenditure.
- Better population health indicators.
- Fewer drugs prescribed per head of population.
- The higher the number of family physicians the lower the hospitalisation rate.

The Challenge

Faced with an ageing population, pressure to apply every new technical and medical advance and people's rising expectations of public services, we have to find new ways of coping with the tide of healthcare needs pounding our hospital and practice doors.

In primary care that doesn't mean creating faceless GP factories or breaking the link between GPs and patients. We want extended services and personalised care.

If our aim is to take pressure off acute services and provide even higher quality primary care, the link between patient and GP must remain and grow stronger.

GPs in the future won't see everyone for everything, but as the individual's own doctor, they will manage and control far more of a patient's social and healthcare needs.

At the moment, if a patient needs specialist help they are immediately referred to consultants based in general hospitals. If they need social help they are referred to social services. They move outside a GP's ambit of control only to return with the next problem, which is likely to be related to the previous problem.

Primary Care in Numbers

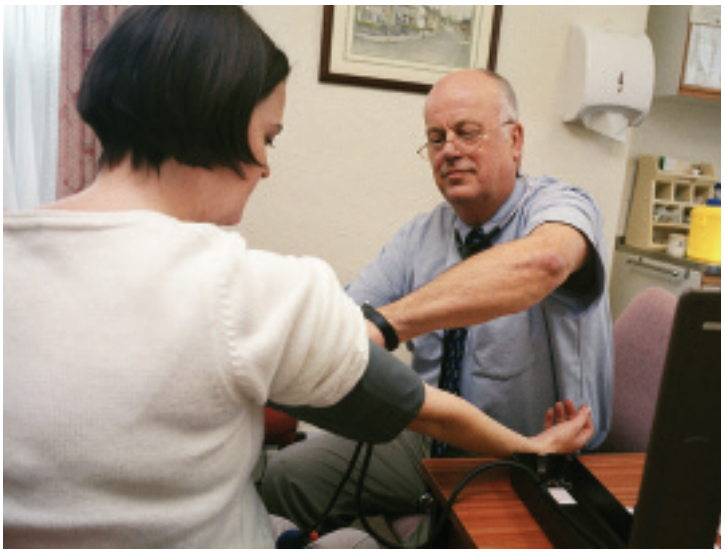
- **Employs:** 32,000 GPs, 112,000 practice staff, 22,000 practice nurses, 4,000 care professionals as well as 20,000 pharmacists and 18,000 dentists.
- **Visits:** 800,000 people everyday visit a practice – nine out of 10 NHS patients treated entirely within primary care.
- **Prescriptions:** 605 million dispensed 2005/06 at cost of £6.6bn. Ninety-four per cent of population visit a pharmacy once a year.
- **Buildings:** Since 1997 more than 500 primary care centres have been built and 2848 practices refurbished. There are also 75 new Walk-In Centres around the country treating 3 million people.

That doesn't have to happen. Technology means diagnostic investigations and a significant array of surgery can be done in a few hours and much can be done without referral to a specialist. Less intrusive surgical and diagnostic techniques mean patients no longer need to stay in beds for days recovering. Co-operation between social services and the NHS now means a nurse in many areas can co-ordinate all a person's needs from bath handles to day care.

When the NHS was conceived it was logical to bring the patient to the specialist; now, advances in technology and medicine present us with the opportunity to bring the specialist to the patient. Bringing care closer to home. Making it personal rather than impersonal.

Opportunities – Day Surgery

As Dr Tim Richardson has shown in Epsom, up to 80 per cent of patients previously referred to hospital for routine care can be dealt with by GPs, nurses and consultants near or in their homes. Dr Richardson's practice now owns and runs the Old Cottage Hospital, Epsom through their day surgery company Epsom Day Surgery Ltd (EDS), offering a range of day case surgery, diagnostic procedures and clinics normally associated with district general hospitals. They have been providing this service for their patients for 12 years and are now expanding the services to help manage similar care for a network of 16 practices and 121,000 patients.



Together with other local GPs the practice has also formed the first Specialist Personal Medical Services (SPMS) company called The Epsom Downs Integrated Care Services (EDICS). It has a contract with the local Primary Care Trust to provide and manage all GP outpatient referrals and has direct access to diagnostic tests and minor procedures undertaken by GPs with special clinical interests. These services are provided within a fixed budget but for far less money than the PCT or the practices previously paid.

GPs with specialist skills in this area work alongside senior consultants from neighbouring hospitals to carry out the work in the cottage hospital and other primary care facilities. Patients benefit from an integrated one-stop service that can refer them to consultants who are literally down the corridor, carry out x-rays and other preliminary diagnostic investigations and perform operations like cataracts, hernia and endoscopies on site.

The process has fewer steps, which means waiting times are shorter and the quality is higher because patients are guaranteed to see experienced consultants who are paid a fee per case by Epsom Day Surgery. This approach, coupled with the reduction in appointments, means productivity is high and the costs are around 10 per cent cheaper than NHS tariffs for surgery and up to 25% cheaper for the outpatient services.

Dr Richardson's philosophy is: "Do 100% of the work for 90% of the cost rather than 90% of the work for 100% of the cost. It's also the only way we will get back to financial balance, improve quality and access and deliver on waiting time targets without blocking our patient's ability to get expert care when they need it."

Not every GP will want to be this entrepreneurial but, as Dr Richardson has found, many practices are willing to support and join this type of exercise because they recognise the benefits it can bring their patients

The Changing Face of Primary Care

1950s – General practice providing local care but limited services.

1970s –GPs working with a team of nurses and other staff to provide personal care and beginning to offer some care for patients with chronic conditions e.g. asthma.

2006 – Personal care delivered close to a patient's home by a large team of professionals and providing comprehensive care to patients with long term conditions. A range of services previously delivered in hospital and increasingly, direct access to social services and other organisations.

Opportunities – Tackling Inequality

Dr Angela Lennox has shown the same approach can work in areas where social issues need to be tackled before healthcare can be delivered effectively.

Prince Philip House on the St Matthew's estate, Leicester provides for its community by putting GP, mental health, police, drug, alcohol, teaching and benefit advice all under one roof with many other services, including a community charity.

When Dr Lennox arrived on the St Matthew's estate it was violent, suffered from high unemployment and housed many families in chronic debt. Staff at Dr Lennox's practice were verbally abused and physically attacked and treating people was a constant struggle.

Dr Lennox explained: "I thought if people are shouting at us and attacking us maybe we aren't providing the services they need. And what's the medical effect of advising someone to stop smoking when it's the only thing holding them together?"

The answer, which was right for the St Matthew's estate, was a building that offered safety, services and opportunities.

Dr Lennox added: "Of course they wanted health services but they also wanted a coffee, dentistry, opticians, contact with the police and help getting jobs."

And Dr Lennox's own prescribing has changed as a result. She is more likely to prescribe an educational course down the corridor to someone with mild depression than anti-depressants.

The approach works both ways. A tacit health support network has grown up on the estate which is literally saving lives. The tenants' association will now ring her up about elderly people who they think may need a visit.

Not all GPs, nurses and pharmacists are as motivated or entrepreneurial as Dr Lennox or Dr Richardson but even smaller initiatives can improve the care we give our patients alongside the effectiveness and efficiency of our practices.

In my Runcorn practice, the physiotherapist no longer sends me a letter telling me what treatment has been given a patient.

They simply log on to the practice computer and type directly into the patient's notes.

My practice systematically uses computer records to identify patients with long-term conditions prone to being admitted to hospital. We now offer them intensive advice and care which curtails emergency admissions and shortens stays in hospital because treatment is started before admission.

Best Practice in Primary Care

1. Supporting patients to improve their health, independence and well being.
2. Better access to GPs.
3. Better access to community services.
4. Support for people with longer term needs.
5. Care close to home.

And, although we don't offer day surgery on site, neither do we wash our hands of the patient once they've been taken to hospital. The practice matron visits wards and ensures everything a patient needs is ready for their swift discharge. The practice and the hospital really do work in partnership. We successfully reduced length of stay by 31% through partnership and co-operation. That means patients go home quicker, happier and recover faster. A similar approach enabled the practice to get 97% of urgent social services assessments done on the same day when previously "urgent" visits had taken three weeks. Similar results have come out of case management trials in Stockport, Cornwall, Epping Forest and Luton.

Three GPs, three very different practices. The common factor is an understanding that primary care clinicians must expand their traditional role as a focal point for the management and treatment of the public. New services must treat patients through co-operation with other services, disciplines and professions, not in isolation.

The abiding message of the public consultations for the *Our health, our care, our say* white paper was the need to link services together. If that makes sense to the public it should make sense to us. By working closely with patients, community nurses, pharmacists, therapists, social services, voluntary organisations, mental health trusts, hospital trusts, social enterprises and the private sector we can provide better services and better outcomes for our patients.

Best Practice

These new working relationships will include helping the patient to manage their own conditions. Patients want to do more self-care just as they are keen to manage their own social care budgets. It is important we help to join these things together while recognising many people will only have the confidence to do it if they are supported by advice from a trusted clinician.

This approach is particularly important for people with chronic conditions like heart disease, asthma and diabetes. The evidence shows that managing a disease is better than reacting to it.

The best care management programmes involve multidisciplinary teams, self-management, the education of patients and carers. Community matrons will be essential for monitoring patients with complex conditions but we know this model only works if they have quick access to services and specialists. This is particularly true with older people.

In future, comprehensive geriatric assessment, access to telephone advice, pharmacist-led medication reviews and nurse-led case management will all be part of a primary care package which will also include social services. These additional services will be offered in combinations that suit the patient and their carers.

This approach will reduce emergency admissions, readmission after treatment and allow for the early discharge of patients.

Cornwall Case Management Study

Twelve Community nurses in three primary care trusts were given 50 patients each to manage. All were taking at least four prescribed drugs and had two previous emergency admissions.

The number of inpatient admissions dropped by more than 40%, GP appointments fell by more than 70% and emergency admissions by 40%.

The net saving per patient was £45,000. The project saved £914,000 in hospital admissions alone.

Studies have shown increasing self-care can reduce hospital admissions by 50%, outpatient visits by 17% and it is estimated for every £100 spent on self-care, £150 is saved.

Early studies on the Expert Patient Programme show there has been a seven per cent reduction in GP appointments and a 16% reduction in emergency admissions.

And this approach extends into social care where direct payments and the piloting of individual budgets are already stimulating the development of modern services delivered the way people want.

Pharmacists, thanks to their new contract, will also be utilised even more extensively. Community pharmacists already dispense 1.5m prescriptions a day, making them an invaluable point of contact for patients and their carers.

At the other end of the spectrum, our colleagues in Accident and Emergency departments are keen for us to prompt the public to use NHS walk-in centres and GPs and also GP out-of-hours services for non-serious emergencies.

Professor Ian Philp, the national director for Older People, describes in his report how a community hospital run by GPs specialising in geriatric medicine can offer elderly patients alternatives to treatment in district general hospitals through cost-effective intermediate care.

Primary care is diverse and the best practice I see evolving over the next decade will match that diversity.

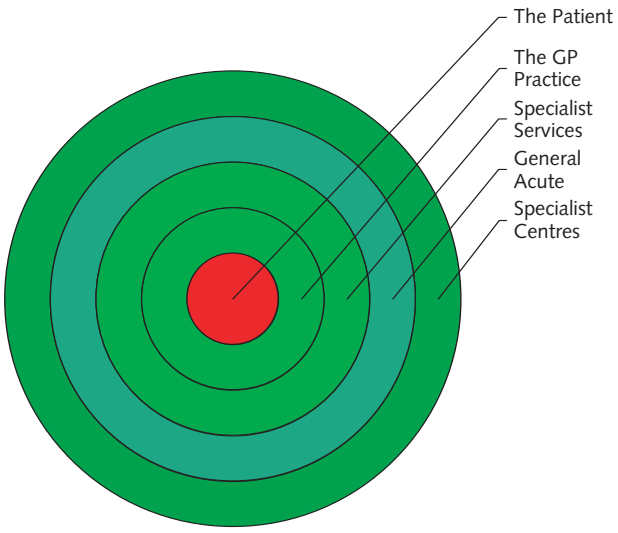
The Model

Patients will be put at the centre of a "ring of care" as GP practices offer many more services.

GPs will continue to have a list of patients with whom they have a trusted personal relationship but how and by whom those patients are treated will change.

They will be encouraged to buy and design new services giving them an incentive to provide treatment normally delivered in hospitals. This process will be accelerated by Practice Based Commissioning (PBC) which 93% of GP practices have now signed up to.

Under new PBC guidelines GPs will be able to take on a larger budget, covering more services. There will be less bureaucracy around business cases and tendering making it easier for practices to develop new services and work with other practices as consortia.



PBC will enable GPs to expand the breadth and scope of primary care, to help patients stay as healthy and independent for as long as they can, and to ensure they receive the right healthcare in the right place from the right person.

And as more acute services are provided in the community, it will become more attractive for consultants and their teams to work outside hospitals and bring their services to the patient.

The new payment system for NHS treatment also means the more patients a practice can treat the more money it gets to improve care – a further incentive to offer and pay for new services.

When a patient needs to see a specialist hospital consultant, the GP will act as the patient's advocate and help them choose the best NHS Trust, Foundation Trust or independent hospital for their needs.

This diversity of providers and growth in primary care services will be bound together by the GP/patient relationship and the national computer record system which will allow us to update patient records in real time. No more lost letters, incorrectly filed reports or illegible notes.

Quality

At the heart of the new services will be a guarantee of quality.

The new Quality and Outcomes Framework (QOF) goes someway to representing a guarantee to patients that their primary care is both high quality and improving.

The result of the second year of QOF indicated that most NHS practices are offering patients a high level of clinical and non-clinical care.

The financial rewards associated with QOF, which is part of the new GP contract, gives practices incentives for the quality of services they provide. It shows for the first time that GPs are providing a good service in areas ranging from diagnosis and ongoing management of conditions to record keeping and the overall patient satisfaction with their practice.

This quality check is being supplemented with a national patient experience survey. The survey will focus initially on how accessible patients find primary care services and whether they are being offered a choice of services.

Patients' responses will trigger bonuses for practices in areas like: ability to consult a GP within two working days, ability to make advance bookings, ease of telephone access, and ability to book with a favoured GP and whether a choice of secondary care providers was offered.

And GPs are taking their quest to deliver better services further. I am exploring with GP leaders as to how we can even further improve the quality of care, maybe through a voluntary accreditation system. This approach, that many practices undertake in the UK, will emphasise continuous improvement in standards of patient care. We do not wish to have a star ratings system but to find a mechanism that will further reassure patients that their practice is operating within the highest clinical and managerial standards.

This drive for quality is not a bureaucratic exercise in box ticking. Driving up the standards of all practices is narrowing inequalities in the NHS.

Early indications are that standards in practices serving the most disadvantaged people in the UK are catching up with those practices serving the most affluent areas of the country.

Conclusion

The evolution of primary care I have outlined is about adding and improving, not cutting and rationing services. It is designed to take the pressure off acute services and recognises 21st Century hospitals should be centres of excellence *but only for care that has to be delivered there* ie. emergency and core specialist services. It allows us to give patients what they want – personal care closer to home. And it enables GPs to have greater involvement in treatment, not less, by offering more services under their own control.

International comparisons show English primary care scores well on equity, quality and efficiency and we have three important characteristics that set us apart – co-ordination, continuity and comprehensiveness. My aim has always been to maintain and enhance this unique combination of attributes.

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