Public Health England

Improving General Practice – call to action

PHE consultation response 07.11.2013

Initial consultation response from Public Health England supplemented with further comments received in October

Please note that Public Health England has also submitted a strategic response to the consultation.

Information, choice and control

More information about the general practice team, their training and interests and the emphasis the practice has on making sure people are well will help people to exercise more choice.

New metrics for health gain in the practice population would show the extent to which practices are working to keep their populations well. Measures of positive mental health such as The Warwick-Edinburgh Mental Well-being Scale (WEMWBS); of function (such as ADL); of life expectancy and disability free life expectancy of the practice population could be included (and incentivised in the GP contract). In addition health gains in children and those with additional needs such as those with long term conditions; people with drug and alcohol problems; people with mental health and learning disability could be included. Cancer profiles for GP practices are already available (www.ncin.org.uk).

In releasing comparative information we need to consider the individual practice in order to ensure meaningful engagement. For example, practices with high nursing home populations have very high morbidity that is not adequately adjusted for by taking the age and sex of the population into account (the health profile of an 80 year old in a nursing home is not equivalent to that of an 80 year old living in the community). Where there is a probabilistic element to the data not under the direct control of the general practice, this needs to be acknowledged.

As important as the information will be, informed dialogue should take place with every general practice to understand the data, to correct any inaccuracies; to share good practice of those who are doing better than they are and to support change. Healthcare public health consultants and public health information specialists can provide such outreach. Resources for this should be identified within the Local Authority Public Health core offer to Clinical Commissioning Groups (CCGs). Local Authority Public Health departments are supported by PHE centres who will be working with NHS England area teams.

Working with appropriate outside agencies and partners such as the local public health teams is proving to be very difficult for general practices due to data sharing and information governance policies. It would be helpful if systems were put in place to empower general practices to work in partnership with outside agencies in a joint endeavour to understand, monitor and improve the health of practice populations.

Answers to specific questions:

How do we go further in publishing – and getting practices to publish – an increasing range of comparative public information?

The principle of publication of practice level data has been accepted for some time. Many PCTs did publish such data. What is much more important is the support the system provides for users to make more use of the data. A good first step in this context would be to allocate to each HealthWatch a competent "Data Interpreter" to enable HealthWatch to provide briefings to the communities they represent.

How do we stimulate new forms of patient involvement and insight, including introducing the Friends and Family Test in general practice?

Many if not most general practices have user groups. However, what is not clear from the current system is the extent to which the work of those user groups lead to change. As a starting point, our recommendations would be to task HealthWatch to review on an annual basis the extent to which the recommendations of the user groups have been actioned by the relevant general practice and present a report to the local H&WB Board.

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Clinical leadership and innovation

Clinically led innovation

The use of programme budgeting and marginal analysis by CCGs and by federated or networked general practices could provide incentives to move interventions down the spectrum of care towards generalist care and prevention. By understanding the make-up of NHS spend across a whole programme provides insight into the potential for innovation. The STAR[1] tool supports decision making towards interventions of greater value for improving population health.

Stretching ambitions for primary care

The five domains of the NHS outcomes framework should be monitored at CCG level and wherever possible passed to individual practices (or where there are small numbers to federated or net-worked groups of practices) for stretch targets. Each practice should know its part in delivering against the outcomes framework.

Integration of mental health and wellbeing

- General practice has a key role to play in mental health, in terms of responding to the needs of people living and recovering from mental health difficulties (for example annual checks of people with serious mental illness), and in supporting the promotion and prevention agenda for this group of patients. People with schizophrenia die 5- 10 years younger than the general population from an increased risk of diabetes (280% increased risk); bowel cancer (90% higher); stroke (88% higher); heart disease (44% higher); breast cancer (44% higher)[2]In

[1] STAR –socio-technical allocation of resources. An excel spread sheet tool that supports multi-criteria decision making and generates graphical representations of the value provided by different competing interventions at a population level and in relation to health inequalities. Supported by the Health Foundation.

[2] Building health into the future. A report on health inequalities in Greenwich. The annual report of the Director of Public Health. 2008

addition to the general practice role in ensuring the physical health of patients with mental health difficulties, general practitioners help in ensuring patients understand their diagnosis and of adherence to their medication will significantly improve outcomes

- Recognise the importance of the family as a protective factor and general practices' unique role in their long term relationship with the family and their role in intervening early such as in mothers with postnatal depression
- Positive mental wellbeing has major impacts on physical health. People who are "languishing"[3] have more colds, time off work, high blood pressure, cardiovascular disease and fatal injuries. There is much that general practice can do to support mental wellbeing in their patients and their communities
- More specifically, it would be worthwhile to develop better ways of managing patients with Medically Unexplained Symptoms, i.e. those who have a psychological problem but who present with physical symptoms. They constitute approximately 20% of new GP appointments and rarely receive the psychological care that they need. Staff in primary care are not generally not equipped to assess them, and are not trained to manage them. Modelling suggests that Cognitive Behavioural Therapy for patients with somatoform disorder (a sub-group of those with medically unexplained symptoms) could save the NHS millions, so the use of Improving Access to Psychological Therapies (IAPT) programme and a clinical care pathway approach could lead to a major return on investment
- Addiction to prescribed medicines and to over- the-counter medicines is a key issue for PHE, an increasing focus for national and local government, attracts strong parliamentary lobbying and is mentioned in the Drugs Strategy. Anyone suffering from addiction to prescribed or over-the-counter medicines should seek help from their GP in the first instance. GPs, who are the front line professionals in charge of patient care, are responsible for prescribing and for managing any problems that develop for users. It would be helpful if GPs were encouraged to:

[3] Languishing: "an individual who is devoid of positive emotion toward life, is functioning poorly psychologically or socially, and has not experienced depression in the past one year. In short, languishers are neither mentally ill nor mentally healthy" CLM Keyes - 2010

- prescribe to avoid dependency
- audit their prescribing to help identify those on long term prescriptions
- identify dependent / pre-dependent use through regular check-up of individuals via a prescribing audit
- understand their locally agreed pathways for referrals into specialist care for the most complex, dependent patients.

Mobilising support of others for primary care innovation

- As part of the core offer of Local Authority Public Health departments to CCGs there should be healthcare public health consultants and specialists working to improve primary care effectiveness and reduce unwarranted variation. The core offer should also include accessible health promotion and engagement with community development work
- Academic Health Science Networks and Centres have an important role in encouraging innovation, for example by engaging practices in playing a part in evaluating new services and interventions, sharing best practice, supporting meaningful evaluations of services that practices or CCGs commission

Cancer screening

While cervical screening most commonly is initiated in general practice, breast and bowel cancer screening is delivered directly by acute trusts and coordinated by local screening programmes. The opinion of the patient's GP has been shown to be highly influential on participation rates and primary care is asked to ensure that any non-participation is a considered decision and to address issues of lack of understanding, misunderstanding or access. For older people (70+) primary care should ensure that their older patients are aware that breast and bowel cancer screening remains available on request direct to the screening programme and there is no upper age limit.

Answers to specific questions:

CCGs and practices are expressing increasing levels of ambition for developing new models of integrated primary care but feel they lack space to innovate.

- **How can we best stimulate and create space for clinically-led innovation?**

It is not possible to change one part of the health system without having a major impact on the rest. As a consequence, our communities as a whole do not reap the full benefits of innovation be it in organisational structures and processes or clinical interventions. Our view is that we need to be more radical in our approach to supporting innovations. What does this mean? It means suspending some of the current financial payment systems and reducing some of the transactional bureaucracy, replacing these with accounting systems that value innovation very directly and enable financial flows to support the innovation. Conceptually, programme budgeting although 40 years old, does provide us with an accounting system which take account of pathways and therefore enable innovations to be more directly mainstreamed.

Suspend payment by results system for a finite period of time and make agreements with the local health system and the local communities to live within the agreed budget for that population.

Many of the current leaders of general practice are very familiar with medical models of disease and less so with social models of health and ill health. We need to identify and support general practice leaders who have a better understanding of these issues so that general practice can take an active role in meeting the needs of local communities.

- How can we challenge and support local health communities, including CCGs and health and wellbeing boards, to develop more stretching ambitions for primary care?

  The critical challenge is to enable the local communities served by particular practices to have a say about what the ambitions should be and the rate at which those ambitions should be achieved. Moreover, the final agreement (and the balance between national and local targets) for each practice should be made by the Health and Wellbeing Board.

- How do we best support integration pioneers in testing new ways of commissioning and contracting for integrated primary care and community services for people with physical and mental health conditions?

  There is considerable literature and experience on integrated care and there are examples of commissioning of integrated care. Our understanding of the critical challenge is budget holder hostility to the practicalities and the difficulty system leaders have dealing with that challenge. Without addressing these social/psychological barriers to integration progress will be slow.

Freeing up time and resources

The prevention of long term conditions is vital to the rise in pressure on general practice. The challenge is how to resource the extended period of time for prevention to deliver whilst the pressure from those who are acutely ill remains. Taking a programme view of commissioning for value in healthcare shows how unbalanced the current spend is on specialist care, including interventions of lower value than prevention interventions in general practice. There is considerable potential to shift resources within and between programme budgets. There are key points earlier in the care pathway where large gains can be achieved – for example, finding and treating atrial fibrillation, securing proactive monitoring of patients at risk from hypertension, increasing physical activity in those with pre-diabetes, early musculo-skeletal conditions such as osteoporosis. Another approach to resourcing increased prevention activity is to think more broadly about the nature of the general practice team – involving health visitors and district nurses and health promotion specialists. Other resources in the community include pharmacies, peer patients, expert patients, community and voluntary groups.

Answers to specific questions:

We are working to identify how to simplify the demands we place on practices and how we can stimulate improvements in efficiency.

How might we develop QOF so that that we preserve its essential features but create more flexibility for practices and reduce the feel of a tick-box culture?

The principle of rewarding high quality care is right. The definitions of high quality care and linking that to a financial reward system could lead to unintended consequences. We would support the use of NICE or some other independent body to develop metrics for measuring high quality care for QOF. This needs to cover the causes of poor health in local communities and the evidence of cost effective interventions.

How might we develop QOF so that that we preserve its essential features but create more flexibility for practices and reduce the feel of a tick-box culture?

This can be achieved by moving to monitoring practice population outcome gain and supporting practices to undertake a developmental approach to improving the health of their patients. The developmental approach would mean practices gaining more and more flexibility as they show they have the processes, training and culture to manage and improve population health outcomes and reduce health inequalities. Incentivising GPs with additional payments to do specific tasks can lead to the tick boxing they wish to avoid. However, there may be some legitimate room for effective monitoring of NICE guidelines as an interim step between current process targets and outcome targets. For example, there are a number of Quality Outcome Framework (QOF) conditions (hypertension, depression) where NICE guidance states an alcohol screen and a discussion with the patient about alcohol and its impact on their condition should be carried out. But we have no evidence that these simple processes are delivered.

How should general practice IT systems develop to support more efficient and integrated working?

In order to develop more efficient and integrated workings the capability of general practice to manage and analyse data needs to improve. This could be via a lead IT practice for smaller teams or a lead within larger practices. The role of the practice manager in leading development of IT systems should be recognised. Effective data

linkage (across a programme budget area) could provide effective risk stratification systems and information about outcomes.
Templates or processes that would direct / alert GPs or the practice team to investigate alcohol and drug use, especially linked to appropriate long term conditions could be developed. This could lead to better overall care of the patient and better management of their lifestyle and condition

How can we help ensure that practices are making most effective use of all practice staff, including practice nurses and practice managers?

Practice nurses are in a great position to investigate lifestyle issues, such as alcohol and drug use, mental health problems, the role of lifestyle factors in health and wellbeing in patients with long term conditions and those on QOF registers, to help them understand the links between their health conditions and how their lifestyle choices impact on their health. There needs to be regular and accessible training of practice nurses who are giving health promotion messages (and others in the general practice team) on the evidence base about risk factors and the most effective approaches to achieving sustainable behaviour change.
Practice managers who understand the potential of pro-active management of patients on their general practice registers save lives and promote wellbeing. By systematically and conscientiously assertively contacting people for prevention services and wellbeing planning and by focussing the work of all members of the practice on engaging with people to maintain their health they contribute to population level outcomes. Their role in following up patients who have not attended screening programme appointments is essential to improving uptake and coverage. This crucial role of practice managers needs to be recognised and supported with awards and training and continuing professional development.
'Making Every Contact Count' efforts seem to be currently aimed at secondary / acute care providers, but the principles should apply equally to primary care. Primary care is well placed to investigate lifestyle issues, such as alcohol use and to offer brief advice on healthy lifestyle, cancer prevention and screening programmes and self-management of existing conditions.

Public Health England

Defining practice accountabilities for high quality

PHE supports the key responsibility of general practice to provide proactive care management and would want to extend this to proactive health and wellbeing management. PHE welcomes the opportunity to work with NHS England on refreshing the core features of general practice.

Answers to specific questions:

We are testing options for defining more clearly the key responsibilities and accountabilities of GPs, for instance in relation to proactive care management and monitoring and assuring wider quality of care.

Should we seek to develop a joint concordat with key partners that re-affirms and refreshes the core features of general practice?

This is important to refresh and enthuse general practitioners. It should be about the values and principles that underpin general practice. It could consider how we might reinvent the culture that Julian Tudor Hart espoused during his career as a GP in South Wales. Part of this could be about renaming general practice as Community Orientated General Practice to distinguish the future from the current or some other name change. More importantly, it should also focus on ensuring general practitioners and practices support health promoting life styles as well as working with the local DPH to influence the wider determinants of health.

How can we put general practice at the heart of more integrated out-of-hospital services and give GPs and practices greater responsibility for coordinating care for patients?

The complexity of needs that people have coupled with the range of services required, does make it very difficult for practices to undertake the co-ordination role in any meaningful way without them being part of a primary care team. In this context the notion of "the primary care team including care services" serving a defined population becomes critically important and the importance of a range of skilled colleagues to be seen as equal members of the primary care team is vital. The practice as a location in addition to the register does provide tremendous potential to deliver individual and community centred care.

The starting point for this is the inclusion of the health and social (as opposed to just social care) needs of practice populations within JSNAs. This should provide the basis on which the Health and Wellbeing Boards deliver their statutory duty to promote integration of care (both commissioning and delivery).

How should we define high quality general practice and their responsibilities/ accountabilities, through the GP contract?

The GP has some unique skills which includes; the ability to differentiate between ill health requiring specialist care from that which does not, the ability to manage risk and the respect they command amongst local communities and the ability to manage ambiguity and uncertainty. Therefore, there are some specific and core skills that every general practitioner has to have to be competent. However, delivering 21st Century general practice is not just about the individual general practitioner. We need to start thinking about the range of primary care services (including lifestyle related issues) that a defined population requires. It is in that context that we need to define high quality general practice and not simply on the basis of a general practitioner. We would suggest that the current GP contract incentivises a new definition of quality – one that emphasises health and wellbeing gain and working in a wider context of the community.

GP Contract: Incentives for Outcomes

How could the GP contract develop in ways that better support wider NHS objectives for improving outcomes, reducing inequalities, empowering patients and securing most productive use of overall NHS resources?

How far should we create stronger incentives for both inter-practice collaboration and collaboration with other primary care providers, acute, community and social care services?

This is fundamentally important. The notion of a system which brings together primary care, social care, community services and acute care is vital to enable coherent change takes place. Such a system should also be able to influence much more strongly public sector providers of housing, leisure and transport more effectively through the Health and Wellbeing Board.

There is very clear evidence about the impact of the wider determinants of health and the primary care system should play its part in working with the DPH to advocate improvements in the relevant determinants of health.

How far should we seek to reward practices for wider outcomes, such as enhancing quality of care for long term conditions and reducing avoidable emergency admissions, or reducing incidence of strokes and heart attacks, or improving patient experience of integrated care?

Focussing on individual practices is unlikely to be very helpful over a short time period because numbers to track outcomes will be small. This could be addressed by analysing individual practices (over a certain size) over a number of years or rewarding groups of practices. The challenge will be in agreeing a reward system that reflects the evidence of cost effectiveness and is perceived to be fair.

Workforce Development

We will need to work collaboratively with Health Education England, the Centre for Workforce Intelligence and other parties to help shape development of the primary care workforce.

What are the strategic priorities for improvements in education and training to reflect the evolving role of general practice, the changing profile of the general practice workforce and the challenges facing the health service in the next ten years?

There needs to be both, a greater understanding of social models of health and ill health and the range of actions that a GP individually or practices as a group can take to have a greater impact on local communities. It is appropriate to rediscover the principles and the practice of GPs such as Julian Tudor Hart. GPs and their teams need to understand the wider context within which they operate and the extent to which their actions can build up to powerful population level change if they are proactive about working with all their registered population to achieve health and wellbeing gain.

The literature review from the Kings Fund that you reference would be a good starting point on which to base evidence based practice and policy for training purposes.

Specific issues and questions

How do we ensure that people with more complex health and care needs have a named clinician with responsibility for coordinating their care? Should people with more complex needs have a named GP with responsibility for overseeing their care?

Having a named person would be useful if their role is to assist shared working arrangements and care coordination. This continuity of care should be at the core of general practice but has been lost in some of the larger practices.

One group of patients who have complex health and psychological needs are offenders on release from prison. Continuity of care is essential for their long term conditions (that are more prevalent than in the general population). Drug and alcohol addiction programmes need continuity as do specific treatment regimes for TB and Blood Borne Viruses.

A vision for general practice in England

General practice at its very best brings together prevention; diagnosis and treatment for individuals, families and communities. The strengths of general practice with its near total population coverage, the skills of the general practice team to work across physical, psychological and social needs, and the high regard that the population still have for the opinion of their GP and practice nurse should put general practice at the heart of preventing the 10,000 preventable lives lost each year in England and promoting wellbeing in their populations. We would like to see the vision for general practice be aligned to the NHS outcomes framework's five domains [4]. Whilst all five domains are relevant to general practice we will focus our comments on the first two – preventing premature mortality and improving the quality of life of people with long

[4] Five domains of NHS outcomes framework: i) preventing people dying prematurely; ii) enhancing quality of life for people with long term conditions; iii) helping people to recover from ill health or following injury; iv) ensuring people have a positive experience of care; v) treating and caring for people in a safe environment and protecting them from harm

term conditions. General practice also has a role in directly supporting relevant outcomes across all of the Public Health Outcomes Framework.

To shift self-management upstream before people develop a long term condition would mean that maintaining and promoting health needs to be central to the funding and incentives, training and culture of general practice.