



“The Wessex Charter for General Practice”

GENERAL PRACTICE. . . The Problems and Potential Solutions

“A Personal View”

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It is clear to all that the NHS is facing some of the greatest challenges since it began nearly 70 years ago. The NHS is not unique, as all countries in the western world, irrespective of the method of funding are facing the challenge of demand exceeding the resources available.

The Commonwealth Fundⁱ has identified the NHS as one of the most cost effective and value for money healthcare systems in the world and this is largely credited to UK general practice.

Over the last 5 years there has been an increasing problem with recruitment and retention of GPs, Practice Nurses and Practice Managers. The problem has become significantly worse within the last 6-9 months. This has been associated with a rising workload, falling resources and the negative publicity that general practice receives in the media. It is no wonder that there is a question about the very survival of individual practices as well as the speciality, namely general practice.

The purpose of this paper is to articulate the challenges that are faced by general practice and describe the range of solutions that need to be put in place as a matter of urgency. If general practice fails to survive, the NHS will collapse as an inevitable consequence. It is a personal view and is not intended to be a comprehensive package of solutions nor will every solution be applicable in every part of the country. There is little point in simply restating all the known challenges and major problems that general practice faces without offering some potential solution.

Doing nothing is not an option as this will lead to further decline and an inevitable end point.

1. The Current Challenges. . .

These have been well documented and include:

- *An ageing population;*
- *More patients with a long term conditions (15 million currently estimated to increase to 18 million by 2018);*
- *More patients with three or more long term conditions (1.9 million estimated to increase to 2.9 million by 2018);*
- *Demand rising faster than funding;*
- *Lack of investment in primary care;*
- *Too much focus on hospital based care;*
- *Recruitment and retention:*
 - *Younger doctors don't want to become GPs;*
 - *Many GP trainees are not looking for salaried post or partnerships, opting to work abroad or as locums;*
 - *Older GPs retiring before they expected to because of the excessive workload;*
- *Silo working (general practice, community services, hospitals and social care) – lack of integration;*
- *Unrealistic expectation of what general practice can deliverer with reduced % of the NHS budget;*
- *Hospitals looking to manage their budget by adjusting workload and by moving work to general practice without the appropriate shift in resources.*

This can be summed up by stating:

"The most significant problems that general practices face are workload and moral. The demand exceeds capacity and if urgent action is not taken general practice will not be able to deliver a safe service."

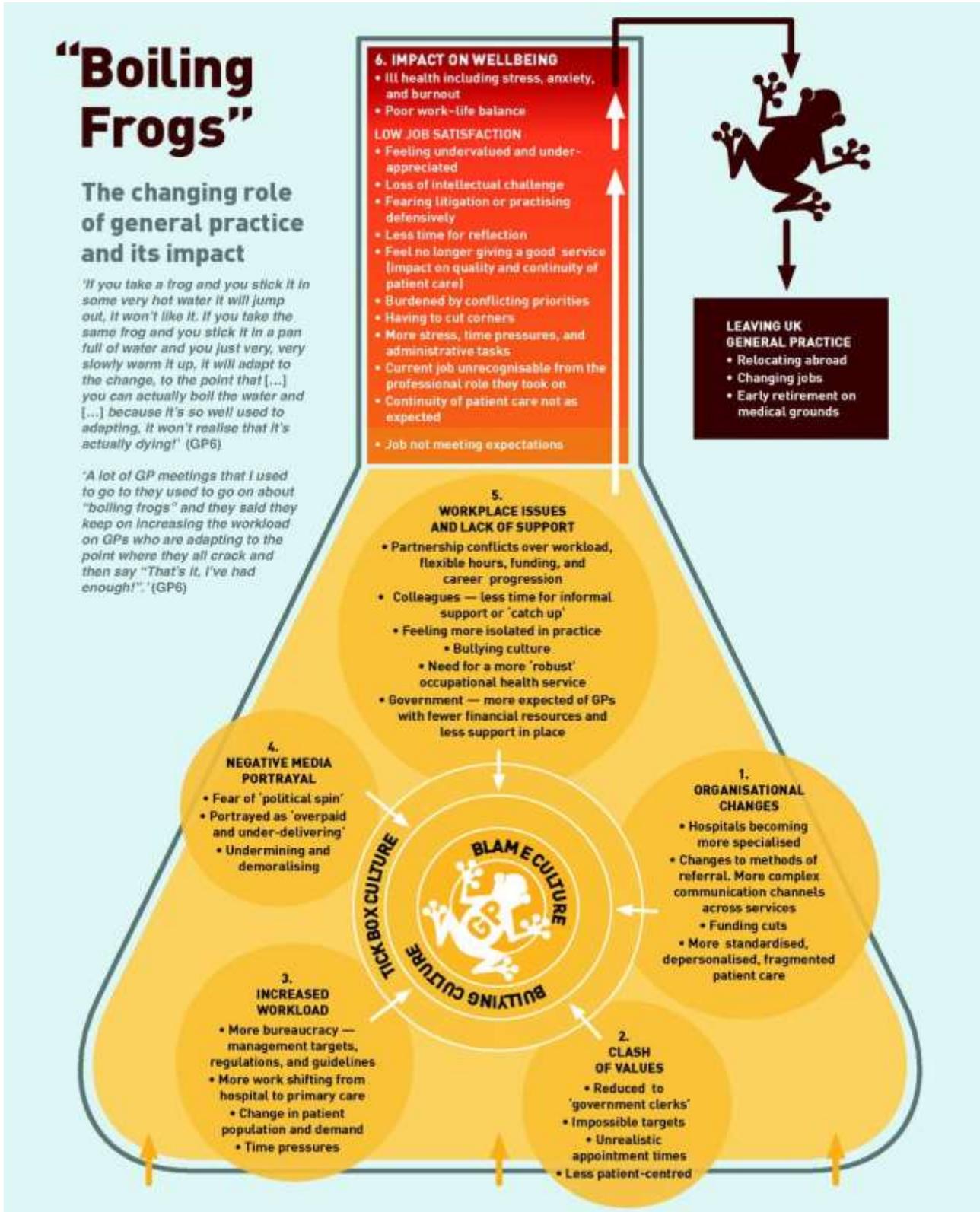
The Five Year Forward Viewⁱⁱ states:

*"The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years.*

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In a recent RCGP publicationⁱⁱⁱ there was an article called "Lost to the NHS – a mixed method study of why GPs leave practice early in England" - that referred to "Boiling Frogs" that encapsulated the current issues (see Figure 1).

Figure 1 – Boiling Frogs: The changing role of general practice and its impact. . .



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In a recent article in the Guardian Newspaper^{iv} entitled "What the NHS needs: Just EU average funding – and a pinch of dynamite" it reported the findings of a Kings Fund Commissioned report that states that despite the UK being one of the 10 richest countries in the world we come 13 out of 15 original EU countries in terms of our % of GDP spent on health. If we had level pegging with GDP over the last few years the NHS would have an additional £16bn per year and to meet the EU average we would have an additional £43bn per year.

If you look at the funding growth the NHS has received, in the first 60 years it has grown by an average of 4% per year. It would now seem that for the period from 2010 to 2020 the growth would be about 0.9% on average per year^v.

The risk is that we focus on all the significant problems that we face and do not consider what solutions are available to us.

Some of the solutions will need significant investment and for various organisations to work more closely together, some will require organisations to change their behaviour. One thing that is clear is that failure to address these problems will result in general practice imploding and the pressure on community services and hospitals will rise exponentially. In some areas this has already started to happen.

The GPC has recently published its "urgent prescription for general practice" which includes:

- Safe, manageable workload;
- More time with patients;
- Increased practice funding;
- More staff to support GPs;
- Less box ticking.

This paper has explored these areas and tries to propose some solutions. They may not all apply to every area but failure to address the problem will have serious consequences.

The following list is not comprehensive but tries to identify many of the problems that general practices face and proposes some potential solutions.

2. Funding. . .

Despite numerous attempts to address the appropriate funding to deliver a service that is one of the most cost effective in the world, any change seems to produce as many if not more losers than gainers.

Spending on GP services increased by 10.2% between 2006/7 and 2010/1 – compared to a 41.9% increase in spending on hospital services – the major problem general practice faced was that expenses in the period 2007 – 2010 increased at a faster rate than income. The proportion of NHS funding supporting general practice has fallen from 10.4% in 2005/6 to 7.47% in 2012/3^{vi}.

The current average funding for a registered patient in England in 2014/5 was £136 per average patient and £141 in 2015/6, but this figure is misleading because it includes the cost of premises and dispensing fees. It should also be remembered that within this there is a wide range of funding per patient that practices receive.

Practices receive £73.56 per patient in 2015/6 to deliver essential services (this is weighted using a complex formula). The latest data on the HSCIC website looking at payments to general practice relates to the year 2014/5 and details the total funding general practice receives, of which 13% (£17.68/patient) is related to QoF, 8% (£10.88/patient) to enhanced services and 8% (£10.88/patient) to premises^{vii}.

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Therefore, on average a practice receives £125 per patient for unlimited access to general practice for a year. There can be a difference of up to £40 per patient comparing the lowest to the highest funded practice in a CCG. The variation is even greater if you compare the lowest to highest funded practice in England.

Solution:

- 1. The core funding per practice needs to be increased significantly.***
- 2. The variation between the lowest and highest funded practices needs to be reduced significantly.***
- 3. Any review of funding needs not only to take into account deprivation but must also take account of the ageing population, especially those over 85 and the growth in long-term conditions.***
- 4. Workload is affected with the provision of other services such as community staff, social care and the voluntary sector. It needs to be recognised that general practice workload is complex and there are many things that impact this.***

3. Reduced Regulation. . .

➤ ***Care Quality Commission***

Much has been written about the shortcomings of CQC. This is in terms of the work involved to prepare for a visit, the cost of funding the inspection, the weighting given to aspects of a practice organisation that is disproportionate to the inherent risks that exist in general practice.

Solutions:

- 1. After the first round of visits, routine inspections should occur every 5 years for those who are judged as good or outstanding.***
- 2. The cost of the regulator should be fully resourced by NHS England.***
- 3. The proportionality of the inspection and details should be negotiated between CQC, the Government and the GPC.***
- 4. Practices should have a fair and impartial appeals mechanism.***

➤ ***End of the Quality and Outcome Framework***

This has now reached the end of its useful life as a system of payment for delivering a set of quality markers.

The funding is not seen by practices as additional reward for doing this work but is part of the essential funding that is required to resource a practice.

QoF has improved care to patients in certain disease categories but has also had some perverse consequences. For example, many practices focus on delivering care to patients where there is little proven benefit due to frailty, associated conditions or life expectancy means that care needs to be tailored to the individual.

Solutions:

- 1. Stop QoF in its current format.**
- 2. Re-invest the funding into the core practice contract.**
- 3. Retain a far smaller number of Key Performance Indicators (KPIs) that are disease specific and targeted at the clinically appropriate population.**
- 4. Continue using a reporting mechanism that measures quality but without the financial penalty of not achieving the upper threshold levels.**
- 5. Natural Communities of Care (NCoC) to be encouraged to compare achievement with all providers.**

➤ **Enhanced Services**

Local contracts for services outside core GMS services have multiplied so it is not uncommon for practices to hold multiple contracts. Some of these are for small volume of services and the administration and bureaucracy associated with the contract means that monitoring is disproportionate to the service commissioned.

There is also a wide-ranging inconsistency with the amount a CCG invests in local contracts with practices. This might be acceptable if practices were only expected to provide services that are commissioned but as we all know this is inconsistent. In some areas practices are funded for the delivery of a complex leg ulcer service but in a neighbouring CCG this service is delivered unfunded.

Other examples of services that are funded in some areas of the country but not in others include:

- Phlebotomy
- Monitoring disease modifying drugs
- Minor injuries
- Post op follow up including wound care
- Enhanced diabetic care

This list is a sample only.

Solutions:

- 1. There should be a national list of services that are outside GMS and if provided by a practice they should be funded.**
- 2. For some of the small volume or less complex enhanced services they should become part of a "primary care offer" – this will detail the services to be provided, with appropriate funding and reporting will be kept to an absolute minimum.**

4. Workload. . .

➤ **Workload, Recruitment, Safety**

The major problem that general practice faces is an excessive workload and the consequence of this becomes the difficulty in recruiting and retaining and risks the service becoming unsafe.

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The number of consultations in general practice has risen from 300,000,000 per year in 2008 to 340,000,000 in 2014^{viii} and in 2015 these have reached 370,000,000. Between 2008 and 2015 the consultation rate has increased by nearly 20% yet the increase in funding received by general practice during this period was less than 1% per year.

It should also be noted that the increase in workload is not just the number of consultations but is the growing amount of paperwork, people presenting with more complex problems (especially in an ageing population) and as other organisations experience a rising workload they push more and more work the way of general practice, some appropriately but much is not.

Many services are organised on a system that controls capacity. When the service is nearing capacity the waiting times are lengthened or referrals are declined as that service's caseload is deemed to be full. For general practice you are not able to say, "sorry I can't see you my caseload is full".

Solutions:

- 1. Increase the workforce in general practice – using a different skill mix and these roles should be fully funded.**
- 2. A comprehensive plan needs to be drawn up to stop hospitals shifting work without the shift of resources to deliver that work.**
- 3. There should be an immediate end to the following:**
 - a. Practices ordering hospital transport;**
 - b. GPs being asked to send another letter because the patient has DNA'd an appointment.**
- 4. Other issues that must be addressed:**
 - a. All OPDs must be supplied with "fit notes" and have the ability to prescribe – failure to issue an appropriate fit note or prescription should have consequences.**
 - b. The copying of results to GPs should stop as this generates significant workload but there should be a system in place where if required the GP can view hospital results and download them into their system.**
 - c. OPD letter must be sent electronically, within a week of the patient being seen, and reviewed by the practice**
 - d. Discharge summaries must be comprehensive, completed and sent electronically on the day of discharge.**
 - e. Failed discharges are not just those where the patient is re-admitted; the Friday afternoon discharges, at about 5pm, where an elderly frail person is discharged without any support and who frequently live alone should be stopped.**
- 5. For 3-4 years post qualification, create a number of GP Fellowships; these would fund a day a week of extended training and service work related to areas that would benefit general practices. For example, Diabetes, MSK, Respiratory, ambulatory care, frailty, care of the elderly. The posts would be based in the community and would add capacity to the system by the service element of the work undertaken. The posts would be associated with posts that involve 2-3 days a week of working as a GP, this could be as a partner or a salaried GP. See next item.**

- 6. If younger GPs take up the role as a GP Fellow the option should be to join this to a role as a partner, a salaried GP in a practice or a new role where a GP provider company employs them and then they are subcontracted by mutual agreement to one or more practices, allowing stability or if agree working in a more peripatetic way. Advantages for these posts are they will add capacity, allow younger GPs a chance to work with a number of practices and gain valuable skills, it would also create some stability in the workforce.**
- 7. General practice urgently needs to increase its capacity and the Government has promised 5,000 more GPs. The problem is that with the current challenges we are losing more GPs than we are able to recruit. The workforce is not increasing but shrinking.**

The answer is to make general practice a better place to work – we need to use a far greater skill mix to expand the workforce and this needs to be fully funded. Some of this could be at practice level but some will be groups of practices working together in natural communities of care. See later – Pharmacists, Emergency Care Practitioners, Specialist Nurses, Mental Health workers, MSK Extended Scope Practitioners.

➤ **Muscular Skeletal Extended Scope Practitioners**

Often, as physiotherapists gain experience they are forced to focus on one joint. This specialisation has some advantages but also has drawbacks. Many experienced physiotherapists leave the NHS to work privately where they can offer a wider scope of care.

MSK work accounts for about 20% of general practice workload and recent studies have shown the benefit^x of an extended scope practitioner. They are able to take a history, examine the patient, make a diagnosis, order blood tests and x-rays and manage the patients by advice, exercise, medication or joint injection.

Evidence shows they can add capacity to a practice if direct booking was allowed and in addition their presence can reduce the referrals to Orthopaedics and Physiotherapy.

Solutions:

- 1. Consider appointing an Extended Scope Practitioner in a practice or working with a group of practices.**
- 2. Link this with a natural community of care and link the community physiotherapy service with a small group of practices and extended scope practitioners.**
- 3. As this has system wide benefits these posts should be fully funded.**

➤ **Mental Health Services**

The National Service Framework for Mental Health^x was published in September 1999 and led to the mental health services focusing far more on those patients with serious mental health problems. But this failed to address the growing numbers of patients with mild to moderate mental health problems and particularly the growing numbers of patients with personality disorders.

It is estimated that about a third of GP consultations are related to mental health^{xi}.

Improving Access to Psychological Therapies (IAPT) started in 2008^{xii} and has helped with the growing numbers of patients who need help.

Mild and moderate depression as well as personality disorders could be managed by a mental health worker or a Community Psychiatric Service that was based in a practice and working as part of a practice team. This would add capacity and skill to the practice team.

Solutions:

- 1. Consider recruiting CPNs and Mental Health workers to be based in practices and working as part of the practice team.**
- 2. These workers should have strong links to the local mental health team.**

5. Medication. . .

➤ **Coeliac Disease**

In Scotland GPs no longer prescribe gluten free food for patients with coeliac disease^{xiii}. This service is delivered through Pharmacists.

Many gluten free foods are now widely available in supermarkets and are no more expensive than other food products.

Solutions:

- 1. England should follow the example of Scotland and introduce the same system.**

➤ **Stoma and Products**

GPs prescribe stoma products, despite the fact they have little or no knowledge of what they are prescribing and are certainly not making the decision as to what product will be used.

Solutions:

- 1. Patients should be given a personal budget for stoma products and therefore deal directly with their chosen company.**

or

- 2. Another organisation should be commissioned to manage these products.**

➤ **Nutrition**

Practices are frequently asked to prescribe nutritional supplements either for patients who are being PEG fed – a dietician from the hospital generally manages these patients, with GPs having little or no knowledge of these products.

For many elderly patients in Care Homes GPs are requested to prescribe food supplements, again GPs have little or no skill or knowledge in this area.

Solutions:

- 1. GPs should stop prescribing these products.**
- 2. Commission an alternative service who have the knowledge and skill to manage these patients.**

6. Pharmacists

There is good evidence that Pharmacists working in practices have a positive impact both in terms of quality and cost^{xiv}.

There will be benefit to the practice in terms of added capacity – and an associated reduction in GP workload but there will be greater benefit to the system in terms of reducing drug costs, reducing admissions and A/E attendance due to improved quality.

The Pharmacist can help with:

- Repeat prescribing;
- Ensuring concordance following hospital discharge;
- Can reduce poly-pharmacy in the elderly;
- Have been shown to reduce cost and increase the quality of prescribing in care homes;
- Could reduce spend on food supplements;
- Can manage long-term conditions – esp. where the management is largely reliant on medication.

There would be benefits in terms of these roles being able to be shared with community pharmacies or when this is not the case create closer liaison with community pharmacists.

As these roles develop there is a risk that skill professionals become isolated within a practice. Consideration should be given to working within natural communities of care.

Solutions:

- 1. Recruit pharmacists to work as part of the practice team as they are doing in Northern Ireland^{xv}.**
- 2. These posts should be fully funded.**
- 3. The posts should work with other pharmacists within their natural communities of care.**
- 4. Funding for the posts could come from the reduced prescribing costs that it is believed these posts would create.**

7. Long-Term Conditions (LTCs)

There are currently 15 million people with one or more LTCs and this is expected to increase to 18m by 2018^{xvi}. There were 1.9m people with 3 or more LTCs in 2008 and this is expected to increase to 2.9m by 2018^{xvii}. This will have massive implications on the delivery of healthcare especially as a significant number of those with 3 or more LTCs are elderly and frail and will have social as well as health needs.

People with long term conditions use a significant proportion of health care services (50% of all GP appointments and 70% of days spent in hospital beds), and their care absorbs 70% of hospital and primary care budgets in England^{xiv}.

This rise in prevalence is mirrored by the significant increase in the number of consultations undertaken in general practice every year.

Hypertension, Cardiovascular Disease, Diabetes, Asthma, COPD and Frailty account for a vast majority of the LTCs in terms of activity and workload.

There is good evidence that as a nation we need to do more to prevent some of the LTCs through health promotion. Once a person has a LTC the care is focused on improving the quality of life and reducing the risks of complications of an individual patient. Delivery of care is all too often fragmented between different organisations and we focus resources on managing the complications in secondary care (especially true of

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Diabetes and CVD) rather than identifying those who would gain most from proactive management and support.

➤ **Frailty**

Frailty is a common geriatric syndrome that embodies an elevated risk of catastrophic decline in health and function among older adults. As our population gets older there are more and more patients with complex health and social care needs. They live in the community but are at very high risk of hospital admission and once admitted have a prolonged length of stay.

Solutions:

- 1. In areas of greatest need, create an acute visiting service that would be using the skills of an MDT that could include GPs, Geriatricians, Community Nurses, Therapists, Paramedics and Social Workers. This team would have access to the GP clinical records. Funding would be additional to PMS or GMS. This service could link to NHS 111.**

➤ **Diabetes**

The number of people with diabetes in the UK has increased from 1.9 million in 1996 to 2.9 million in 2012 and in 2015 the numbers had reached 3.5 million^{xviii} (prevalence is more than 6%).

It is estimated that diabetes costs £10bn per year^{xix} largely due to the management of complications such as amputation, blindness, kidney failure and cardiovascular disease^{xx}.

Most of the additional resource to manage diabetes has been invested in hospital-based care especially managing the complications of diabetes. The stark evidence suggests that more work needs to be focused on prevention, identifying those who would gain most by active management and those where control will make little difference to the life expectancy or quality of life of an individual.

Tower Hamlets PCT looked at diabetic care, focused on gaining good control of blood pressure, blood glucose and cholesterol. This was shown that with modest investment in the community significant reductions in complications can be achieved but these may take some time to be realised^{xxi}.

Solutions:

- 1. Replace QoF with a small number of indicators – BP, HBA1C and Cholesterol.**
- 2. Risk stratify the population:**
 - a. Those with complications – under specialist care**
 - b. Those whose general state of health means that tight control will not benefit the person in terms of quality or length of life.**
 - c. Important groups where better management would improve outcomes.**
- 3. Investment in community and general practice management of diabetic patients. This service should be using the common health record to prevent duplication.**
- 4. Practice/locality based diabetic service created which is embedded in general practice – would consist of Specialist clinicians (consultants, doctors in training and specialist nurses), GPs and practice nurses. Working as a single team is essential.**
- 5. Create common tools such as Apps or Web based resources that have local ownership and are promoted to all diabetic patients – encouraging self-care.**

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- 6. We need to create more capacity in the system to meet the rising prevalence – this could be achieved by creating GP training posts where the trainee spends a day a week working as part of the integrated diabetes team.**
- 7. Some specialist training could occur in the integrated community team – currently in some areas hospital based diabetic consultants are blocking this.**
- 8. Reduced costs of complications will be delivered by greater investment in care before complications.**
- 9. Over a period of time practice nurses have delivered more and more diabetic monitoring. These nurses have become experienced and skilled – when they retire it can be difficult to recruit and train new nurses. Consider the role of a specialist diabetic nurse being community based and embedded in practices working with HCAs and practice nurses in a radically different way from how they do now.**

This is an example of how the delivery of LTCs needs to be seen as a system rather than a number of unconnected silos. A similar exercise should be considered for other common LTCs.

8. Community Nursing. . .

In 1986 the Department of Health published the Cumberledge Report - a review of Neighbourhood Nursing^{xxii}. This report identified that District Nurses, Health Visitors, School Nurses and Practice Nurses worked in isolation and therefore recommended that all, except Practice Nurses, should work together and be put under nurse management.

This has inevitably led to the separation of nurses and for District Nursing to be geographically based rather than practice based. Although there may be some advantages in this move there have been many disadvantages not least in terms of teamwork, communication and fragmentation of care.

Solutions:

- 1. Create natural communities of care.**
- 2. Establish an extended primary care team.**

This is a stream of work that is currently being undertaken as part of the Hampshire Vanguard^{xxiii}. It is attempting to provide out of hospital care delivered at scale but this is embedded in the practice building on the registered list, supporting practices working together, leading the local community services and giving the freedom to redesign the delivery of services to improve quality, reduce duplications, remove layers of bureaucracy and empower frontline clinicians.

Extended Primary Care Team



The Extended Primary Care Team (EPCT) **pools the knowledge and care resources** of primary care, community and mental health services, social care, pharmacists and voluntary, community and social enterprise sector partners, to manage the population health of their community.

They will operate in a single team under the leadership of local GP's.

An Extended Primary Care Team may operate at the level of a large practice, or a group of smaller practices.

9. Urgent Care. . .

There are many definitions of urgent, emergency and routine care. For the purpose of this document:

Emergency Care – means a person has a potential life-threatening problem that needs to be addressed as soon as possible – within minutes or a few hours.

Urgent Care – means that a person is ill or believes that they are ill and needs to have their clinical problem addressed within 24 hours depending on need.

In 2011 the RCGP published a document called – “Guidance for commissioning an integrated approach to emergency and urgent care – a whole systems approach”^{xxxiv} which describes how their needs to be a common approach to urgent care across general practice, community and hospital based care.

For many, general practice operates as the first point of contact for a person who is ill or believes they are ill. But can an individual practice in 2016 be expected to meet the demands and complex presentations of the needs of a population – or is it time that this should be re-considered?

For example, in an area with a high level of elderly population . . .

Solutions:

- 1. Create an acute visiting service that covers a population of 30,000 or greater.**
- 2. The team would consist of GPs (employed separately from a practice), Care of the Elderly Consultants and Trainees, GP Trainees, Community Nurses and therapists, a mental health worker and a social worker. It is important that this team works with practices and use the same clinical records.**

One of the many great strengths of general practice is continuity of care assisted by life-long medical records and the holistic approach to care. For some patients they need to see a clinician for an urgent problem but continuity of care is less important than access.

Solutions:

- 1. Create an urgent care centre – which complements general practice rather than is set up in competition, staffed with a range of clinicians. This model has been established in some areas of the country and has been shown to reduce A/E attendance (a high priority for the Government).**
- 2. Create a common health record – this enables safe and effective care with the sharing of information between the practice and the urgent care service.**

10. Workforce. . .

Younger doctors are not choosing to opt to train as GPs in sufficient numbers; GP trainees on completion are rejecting partnerships and even a salaried role and many are opting to move abroad. Older GPs are choosing to retire earlier than they had planned largely due to workload and the current state of general practice. The largest growth area is as locums – but this is not sustainable.

Talking to younger and older GPs, many would still want to work as a GP but perhaps in a broader community role. So perhaps we should consider other options to enhance the workforce.

Solutions:

1. GP Fellows:

As described before, create some funded roles for 2-3 years where a young GP could work 2-3 days a week as a salaried GP or partner and a day a week (funded) to undertake service work for example urgent care, care of elderly, diabetes.

2. Care of the Elderly:

With an ageing population and the inability to recruit GPs or Geriatricians – should we think more imaginatively about the care of the elderly?

A role in care of the elderly that was community based and working as part of an MDT may appeal to older GPs who want to retire from mainstream general practice but may still want to continue with clinical care, this happens in many hospices.

3. Ambulatory Care:

This has largely been a hospital-based service but could be developed as a service that is community based as well as hospital. This might attract some younger GPs who want to have a portfolio career and are looking for variety.

4. Urgent Care:

Many GPs find the workload and the inability to manage a day in terms of the length of the day. Many urgent care centres work on the basis of a shift system – which helps with workload and sustainability of the workforce.

5. Long Term Conditions:

We need to have a radical re-think about how the management of LTCs is resourced. Some such as diabetes does not have sufficient resource of capacity to deliver safe and effective care. Consider funding GP Fellows, Trainees, experienced GPs at the level of the natural communities of care to add capacity, offer variety to workforce, improve integration and deliver the Five Year Forward View.

11. Patient Empowerment...

General practice has recognised that there are numerous patients who would consult with a GP when they may not be the most appropriate person for the person to see. This is because the default for most health and many social care problems has been to “see your GP”. This is true for many acute problems as well as long term conditions.

Patients have been disempowered over the last 30 years as the NHS has progressively “medicalised” many health related issues.

Patients with long-term conditions spend less than 1% of their time in contact with healthcare professionals^{xxv}. The rest of the time they, their carers or their families manage on their own. These are not my words but are detailed in page 13 of the Five Year Forward View. This aspiration needs to be realised as soon as is possible.

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Solutions:

There needs to be a far greater emphasis on handing control and responsibilities to patients and communities.

There also needs to be greater use of smart technology to support both self-management and monitoring.

Acute Illness:

- 1. Promote the use of online advice, this may be a web-based information or via an App. This should be interactive and be able to provide practical and convenient advice as well as sign posting to appropriate services. One example of this is Web-GP^{xxvi} but there are others. This should be made available to all practices and linked to practice websites. It should be part of the GP System of Choice offer funded by the NHS.***
- 2. Promote alternative to general practice for acute minor illnesses including community pharmacies***

Long-Term Conditions:

- 3. Many long-term conditions benefit from the patient understanding their condition, the importance of on going monitoring (where appropriate) and the management.***

This can therefore be divided into:

- Information***
- Education***
- Monitoring***
- Managing***

The medical model that is currently used is that most of the above is delivered in the practice and occasionally via the hospital.

Care planning for specific long-term conditions such as hypertension, diabetes, asthma, COPD or cardiovascular disease is very predicable. Technology could be used to support patients to take greater responsibility for their condition.

Apps are beginning to be available that will support patients with all of the above. The outcomes should be better quality of care, improved outcomes for the patients, freeing up GPs to spend more time doing what only they can do and possibly could result in less visits to the GP.

This would also allow a greater sharing of patient specific information as this would be under the direct control of the individual.

12. Conclusion. . .

This document is not intended to be comprehensive or complete but is an attempt to detail some potential solutions to the current crisis that general practice faces. In fact this is a crisis the country faces not just the GPs.

Successive Governments have focused on hospital-based care and most of the key priorities remain hospital focused. The consequence of this is that when the hospitals struggle to meet these targets they attract additional resources and this results in the amount available for community services, mental health and general practice reducing. The Five Year Forward View detailed the transformation that was needed to

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have a sustainable NHS which included a far greater focus on out of hospital care and greater investment in general practice and community based services, we now need to see these words turned into action.

A significant investment of resources is needed to ensure sustainable general practice and to deliver a safe and effective healthcare system.

If as a nation the population wants to have a good quality service that delivers excellent outcomes with good access then an honest debate is needed with the general public to align expectations with the resources that are able to deliver them.

If general practice received 10% of the NHS budget rather than the current 7.7% this would be a good starting point but with the demographic changes it needs to increase to more than this figure.



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