The King's Fund

Ideas that change health care

# Innovative models of general practice

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# 1 Introduction

Primary care is the bedrock of a high-quality and cost-effective health system (Starfield *et al* 2005). Recent research has found that, in Europe, countries with a strong primary care system experience better population health and lower rates of unnecessary hospital admissions. It has also found that, while overall health expenditure is higher in countries with strong primary care structures, comprehensive primary care is associated with slower growth in health care spending (Kringos *et al* 2013). Within the NHS, general practice is the foundation of the primary care system. Simon Stevens, NHS England's Chief Executive, has said: 'There is arguably no more important job in modern Britain than that of the family doctor… A growing and ageing population, with complex multiple health conditions, means that personal and population-orientated primary care is central to any country's health system.' (**NHS England *et al* 2016**, p 4).

However, general practice faces significant challenges. Our report *Understanding pressures in general practice*, published in 2016, outlined the current crisis facing general practice in England (**Baird *et al* 2016**). We found general practitioners (GPs) dealing with a rising workload, which is becoming more complex and intense. At the same time, funding has not been growing at the same rate as demand. There is also a shortage of GPs, with fewer GPs choosing to undertake full-time clinical work in general practice, while large numbers are retiring and leaving the profession. This adds up to a profession under enormous strain and facing a recruitment and retention crisis. Pressures in the wider health and care system are also having an impact on general practice and as clinical thresholds for access to care rise in other parts of the system, general practice is required to manage more complex needs.

In recognition of the growing pressures in general practice, NHS England and partner organisations published the *General practice forward view* (GP Forward View) (**NHS England *et al* 2016**), which promised:

- additional funding
- help for struggling practices

- plans to reduce the workload
- expansion of the workforce
- investment in technology and estates
- a General Practice Development Programme to accelerate the transformation of services.

The government also committed to an extra 5,000 GPs by 2020 (Hunt 2015a).

However, in the two years since our report *Understanding pressures in general practice* (Baird *et al* 2016) and the GP Forward View (NHS England *et al* 2016), public satisfaction with general practice has declined further, with the British Social Attitudes survey reporting the lowest levels of satisfaction for 35 years (Robertson and Appleby 2018). Meanwhile, GP numbers actually decreased between 2016 and 2017 rather than increasing (NHS Digital 2018a). And with no evidence of any reduction in the workload, the question remains: So what is to be done about this crisis?

Our hypothesis is that new clinical delivery models are needed to meet the demands caused by an ageing population, changing disease burden and changing public expectations. These new models will alter the way in which general practice operates and interacts with individuals, families and local communities, to meet the needs of patients in acute phases of illness, patients with long-term conditions, and patients at the end of their lives. We believe that these models will be needed for general practice to provide effective, high-quality services in the future, although issues of funding and clinical workforce shortages would need to be addressed.

This report builds on The King's Fund's existing work, which has recommended a place-based approach to health and care, rooted in communities (Charles *et al* 2018; Alderwick *et al* 2015; Ham and Alderwick 2015; Addicott and Ham 2014).

# 2 Methodology

Following a comprehensive analysis of available literature and conversations with a wide range of stakeholders, we developed a set of core attributes which we believe define English general practice. We then drew up a long list of different delivery models of general practice from around the world. We found many of these through our literature search but identified others following contact with primary care leaders in the United Kingdom (UK) and internationally. We used the list to group the different models into common approaches and shortlisted those we felt could offer most insight for English general practice. Where models were too newly implemented to have been formally evaluated, we carried out telephone and face-to-face interviews to ask more questions about the model and identify any lessons learnt during the implementation phase.

Drawing learning from the examples set out in this report and our analysis of the literature, we identified ways of working that could support general practice in England to meet the challenges it faces and to deliver high-quality services across the core dimensions of general practice. We also developed a set of principles that should guide the development of new models of care for general practice as part of whole-system redesign.

# 3 The evolution of general practice within the NHS

General practice is entering a period of change that is perhaps more profound than at any time in the history of the NHS. As we explore the implications of these changes, it is helpful to start by understanding how general practice has evolved to where it finds itself now (*see* Box below for a detailed historical timeline).

General practice emerged as a separate discipline in the 19th century, initially with private doctors treating those who had the means to pay. Then in 1911, Lloyd George, Chancellor of the Exchequer at the time, introduced the landmark National Insurance Act, one of the foundations of the modern welfare state. This Act opened up comprehensive health care to all men at work, but not to their families. Eligible male workers were placed on the 'panel' of a named GP, a clear forerunner of NHS list-based general practice.

When the NHS was formed in 1948, health care became available to all citizens irrespective of their ability to pay. General practice became responsible for virtually all personal medical care, and it became the gateway for people to access hospitals, specialist care and sickness benefit. Since that time, the professional status of GPs has increased, with clearer professional standards, formal postgraduate training, and greater financial incentives to work as a GP.

General practice has also changed considerably in terms of the scope and nature of the services provided, its workforce, and how it is funded. What was a cottage industry in the 1950s has over the decades evolved into a complex web of different organisational models, with increasingly integrated clinical information systems, shared workforce arrangements, and standardised work processes.

Over the past few years there have been major structural changes in general practice, with the average practice list size now about 8,000 patients. We have seen the emergence of 'super-practices', some with list sizes of more than 100,000 patients, with organisational structures more in keeping with NHS trusts

than traditional GP partnerships. A number of NHS hospital trusts are taking over general practice contracts and either delivering care through a subsidiary (for example, Northumbria Healthcare NHS Foundation Trust working through Northumbria Primary Care) or integrating general practice care with their other services (such as the Royal Wolverhampton NHS Trust). Networks and federations of practices are also coming together, ranging from a handful of practices to more than a hundred, all looking for more effective ways of working and to address the increasing expectations being placed on them by the wider NHS.

This is all a far cry from the single-handed GP struggling to care for a list of patients at the birth of the NHS – a journey that Iliffe has described as the industrialisation of family medicine (Iliffe 2002), a journey that offers the prospect of a standardised service, performing in the same way wherever people live, but risks leading to health care that is impersonal and mechanised.

## The evolution of general practice: a historical timeline

### 1948: the NHS is formed

- With the formation of the NHS, GPs took on responsibility for covering the entire population and controlling access to specialist care – a major expansion of their role. Within one month, 90 per cent of the population had registered with a GP, leading to a major increase in GPs' list sizes and workload.
- GPs chose to remain outside the NHS as independent contractors rather than salaried NHS employees. Effectively having a franchise arrangement with the NHS, they were paid for the number of patients on their lists and for some specific activities such as vaccinations.

### 1950s: a challenging start

- The 1950 Collings report – the first major report on quality in general practice – found poor standards of care, bad working conditions and isolation from other professionals (Collings 1950). Many GPs worked under considerable pressure, with limited support.
- Most GPs worked in a single-handed practice or with one partner. The National Health Service Act 1946 had intended that, over time, GPs would be rehoused within health centres, but this proved unaffordable.

**1960s: contractual improvements**

- In 1966, a landmark new contract improved pay and conditions for GPs, along with providing additional resources for professional education, the improvement of premises and the employment of support staff.
- The following years saw improvements in terms of falling list sizes, increasing recruitment, improving facilities and a trend for group practices to become the norm.

**1970s and 1980s: increasing professionalisation and evolving roles**

- The Royal College of General Practitioners (formed in 1952) received its royal charter in 1972, putting it on the same footing as the other medical colleges.
- After years of concern about the adequacy of GP training, a three-year postgraduate training programme became mandatory from 1976.
- With the Alma-Ata declaration on primary health care in 1978, prevention and health promotion became seen as an increasing part of the GP's professional role (International Conference on Primary Health Care 1978).
- In 1983, the Royal College of General Practitioners launched a Quality Initiative in response to evidence of large variation in clinical practice. It introduced clinical audit and evidence-based standard-setting to general practice.

**1990s: increased accountability and market reform**

- The trend towards increased accountability was consolidated in the 1990 GP contract, which was imposed after it was rejected by GPs. This launched an era of greater external management of general practice; it increased the proportion of payments linked to practice list size and introduced elements of performance-related pay.
- GP fundholding allowed GPs to take on the responsibility for commissioning services on their patients' behalf, creating an incentive for GPs to become more involved with the wider health system.
- In the latter half of the 1990s, GP practices started working collaboratively to provide out-of-hours care through GP co-operatives.

**2000s: greater external control, competition and choice**

- The 2004 GP contract represented a new relationship between GPs and the NHS, with an increased emphasis on performance-related pay, with the introduction of the Quality and Outcomes Framework (QOF).
- The new contract removed the obligation on GPs to provide 24-hour care for their registered patients, leading to most GPs opting out of '24-hour responsibility'.
- Competition in general practice was encouraged through enabling patient choice of general practice, relaxing practice boundaries, and introducing wider private sector competition through Alternative Provider Medical Services (APMS) contracts.

**2010 to the present day: working at scale**

- In 2013, clinical commissioning groups (CCGs) were established, aiming to give GPs and other clinicians the power to influence commissioning decisions about their patients; more recently, assuming or sharing responsibility for commissioning primary care in their area.
- There is a requirement for all general practices to register with and be inspected by the Care Quality Commission.
- The GP Forward View (NHS England *et al* 2016) set the direction for the creation of extended group practices – federations, networks or single large organisations.
- Policy on seven-day access and extended hours, along with the funding associated with this (the GP Access Fund), has encouraged practices to collaborate at scale.
- There have been workforce changes – there has been a downward trend over the past decade in GP partners, along with a fourfold increase in salaried GPs who now make up nearly 30 per cent of the GP workforce. There are increasing roles for other professionals such as pharmacists, therapists and clinical support staff.
- Financial pressures, recruitment challenges, rising and changing workloads, and administrative demands have accelerated new patterns of working.

# 4 What is the essence of general practice?

While general practice has been evolving – from solo practitioners working from their homes to the present multidisciplinary enterprises increasingly based in large health centres – an underpinning philosophy of general practice and family medicine has emerged. Early thinking focused on the role of the individual GP and in many ways mirrored the early development of general practice – with the focus on single-handed or small group practices, and the GP as the central figure. The titles of seminal writings from these early days – *The doctor, his patient, and the illness* (Balint 1957), *The future general practitioner* (Royal College of General Practitioners 1972) and 'A new kind of doctor' (Tudor Hart 1981) – illustrate this focus on the individual clinician. However, the early definitions of general practice addressed the role of the GP while also recognising the need for the doctor to work with the support of a wider team (**Leeuwenhorst Group 1974**; *British Journal of General Practice* 1969).

Howie and colleagues, in considering these and other writings on the nature of general practice, identified two 'core values' that underpin the work of GPs and their teams – 'patient-centredness' and 'holism' (Howie *et al* 2004). Others have emphasised the importance of general practice being the first point of contact with the NHS for most people. Heath has described it as 'the point at which the vast undifferentiated mass of human suffering meets the theoretical structures of scientific medicine' (**Heath 1995**).

A recent European definition of general practice has moved the focus from the individual GP to the practice as an organisation (**WONCA Europe 2011**), and emphasised the following characteristics:

- it is normally the first point of medical contact with the health care system
- it manages illness, which often presents in an undifferentiated way, and deals with health problems in their physical, psychological, social and existential dimensions (holistic care)

- it takes a person-centred approach and provides continuity of care
- it manages simultaneously the acute and chronic health problems of individual patients
- it co-ordinates care, working with other professionals in the primary care setting, and manages the interface with other specialties
- it promotes health and wellbeing by both appropriate and effective intervention
- it has a specific responsibility for the health of the community.

The Royal College of General Practitioners summarises this as providing 'continuing, comprehensive, co-ordinated and person-centred health care to patients in their communities' (Royal College of General Practitioners 2016).

## What do patients want from general practice?

Does this detailed, and quite complex, definition correspond to what the wider population want from general practice? There is in fact significant overlap between what patients say they want from general practice and the underpinning philosophy of care that has been developed by the academic bodies over the past 50 years.

A systematic review of 19 international research studies looked at which characteristics were ranked most commonly by patients as priorities for general practice care (Wensing *et al* 1998). The five most important were:

- humaneness
- competence/accuracy
- patients' involvement in decisions
- time for care
- accessibility.

Coulter (2005) reviewed the research evidence from the UK and internationally to answer the question: What do patients and the public want from primary care?

She highlighted five themes:

- interpersonal care – patients want primary care professionals who are good communicators and who have sound, up-to-date clinical knowledge and skills, and they want to be given sufficient time and attention and to be provided with advice on health promotion and self-care
- access – patients want easier and more flexible access to services
- choice and continuity – the heaviest users of primary care (older people and people with chronic conditions) place particular value on continuity of care from professionals they know
- shared decision-making – many, if not most, patients expect to be given information about their condition and treatment options and expect to be engaged in decision-making
- equity – the British public retain the view that services everywhere should be high quality and equally available to all.

## The core attributes of general practice

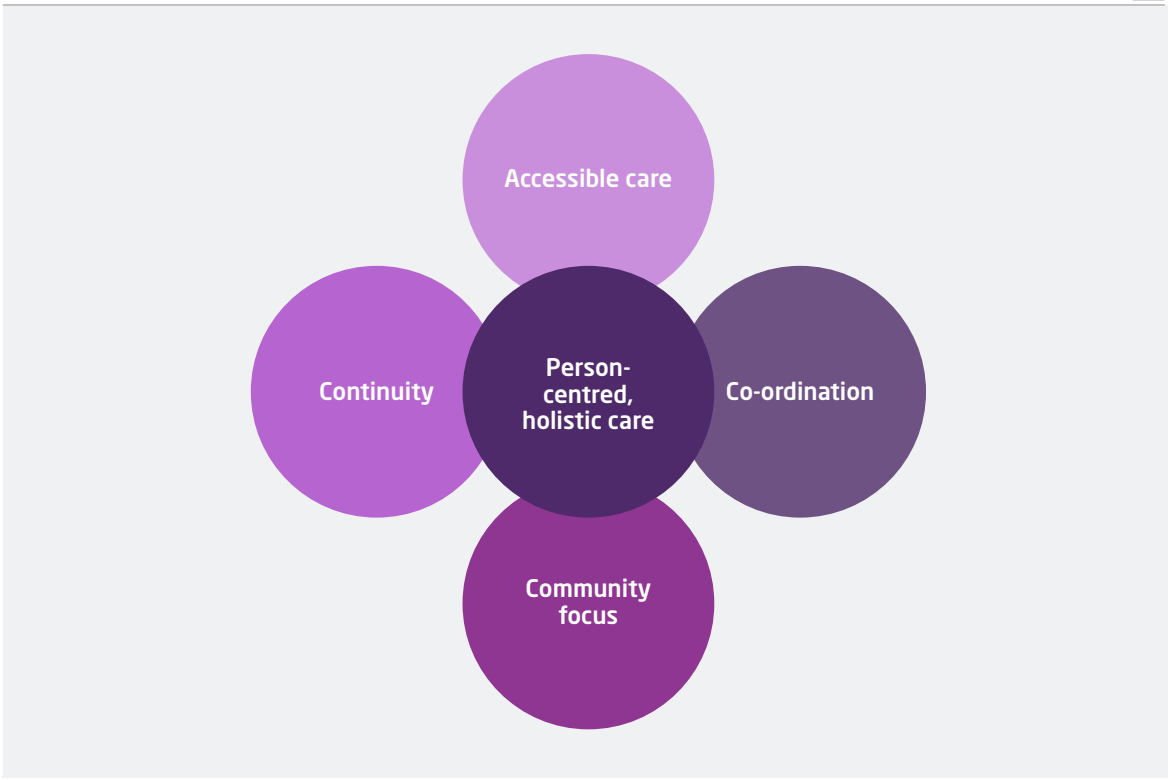
Based on our research, we have developed a five-part model, which we believe encompasses the different attributes that must be present for general practice to deliver effective and comprehensive care to its patient population (*see* Figure 1).

We now describe the evidence, nature and policy context for each of the five attributes in turn. It should be noted that the attributes do not apply solely to general practice and achieving them may depend on wider system contexts. Furthermore, although we describe them separately, it is clear that there is significant overlap across the attributes. And some may be more or less important for some patients and at particular times, and the balance between them may therefore change.

### Person-centred, holistic care

Providing person-centred care is probably the core tenet of general practice, with increasing evidence to suggest that this approach not only increases patient satisfaction but also helps people to take control of their own health and reduces

**Figure 1 The core attributes of general practice**




the use of formal health services (Fahey and NicLiam 2014). The Royal College of General Practitioners has identified three interlinked factors that are important for person-centred care (Farrar 2014):

- a holistic approach – this sees patients as 'whole people' 'who are complex, and live in complex communities in a complex world' (Freeman 2005); people should have their physical, psychological, social and spiritual needs, and the interactions between those needs, considered by their general practice team
- personalised and flexible care – this requires patients' priorities to be identified and respected and then met in a way that is most effective for them at that moment in time
- empowering patients as equal partners in their care – this is so that they can both manage their own ill health and maintain their health.

A narrative produced jointly by National Voices and Think Local Act Personal (2013, p 3) summarised views on person-centredness in the following statement: 'I can

plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.'

In a review of eight research studies looking at patient and GP views on what promoted patient engagement in a consultation – five studies from the UK and three from North America and Europe – several themes emerged that were shared by both parties (Parsons *et al* 2010):

- shared decision-making – this was facilitated by a good doctor–patient relationship, usually after several consultations with the same doctor and the development of mutual respect
- empathy – particularly where patients were presenting with mental health problems
- time available to facilitate engagement
- training and support – health professionals may need additional communication skills training to promote this approach and some patients may require support, perhaps from bringing a 'significant other' with them to the consultation
- informational support – access to information in an appropriate format.

Having enough time is clearly critical to both patients and clinicians in delivering person-centred care. Researchers from the University of Bristol found that, in practice, an average consultation included discussion of 2.5 different problems across a wide range of disease areas, in less than 12 minutes, with each additional problem being discussed in just 2 minutes. Doctors introduced further issues for discussion, in addition to those presented by patients, in 43 per cent of consultations (Salisbury *et al* 2013).

Time to listen and deal with the 'whole person' is particularly important. A study by Citizens Advice found that GPs in England reported spending almost a fifth of their time on social issues that are not principally about health (Citizens Advice 2014). Half the GPs surveyed felt that the time they spend on non-health issues helped them to understand their local communities. However, when patients raised non-health issues, only one-third (31 per cent) of GPs said they advised patients adequately themselves and most referred to external agencies.

A recent systematic review of the variation in primary care physician consultation time showed that, among economically developed countries, the UK had one of the lowest average consultation lengths at 9.2 minutes. This compared with an average of 15 minutes in Australia, 16 minutes in Canada, 20 minutes in Norway and 22.5 minutes in Sweden. The authors estimated that at the current rate of change, the consultation length in the UK would only reach 15 minutes in 2086 (Irving *et al* 2017).

Developing truly person-centred services is likely to mean doing so with the involvement of empowered and engaged patients who are effectively supported to engage.

The NHS has made a clear commitment to person-centred care. For this commitment to become a reality, general practice will need clinical teams with the appropriate skills and informational support. It also needs the resources and systems in place to enable patients to build long-term relationships with these teams and for consultations to be long enough to support this type of care.

### Accessible care

Access in general practice is about the ease with which patients can obtain appropriate and beneficial care. Access has several dimensions that change in nature and importance depending on the patient's needs. Boyle and colleagues (**Boyle *et al* 2010**) specified four dimensions: proximity (although they call it physical access), timeliness, choice and range of services:

- proximity involves being able to easily consult with a professional working in general practice either in person or remotely. This means considering and wherever possible addressing patients' accessibility needs for both types of consultation.
- Timeliness – being able to access general practice when needed – has been the main focus of national policy in recent years
- choice involves choice of GP practice, preference for a particular doctor and choice over what care is received
- the range of services available in GP practices includes services provided by the practice itself as well as partner organisations working in partnership with the practice.

The different dimensions of access are interrelated, and patients are willing to trade them off against one another depending on their preferences and the problem they have at the time. For example, when their presenting problem is poorly defined or undifferentiated, they may want to see a particular, familiar GP who is able to consider their illness in the context of their past medical history and personal situation. This means that the timeliness of the appointment may become of secondary importance, with many people willing to wait or amend their own schedules to fit in the appointment.

For most people, general practice is their first point of contact with the health service when they need health care. However, recent conversations that we have had with patient representatives have revealed the confusion caused by the increasing number of 'entry points' into health care, whether face to face, by telephone or online.

There is a strong association between quality of GP clinical care as measured by performance in the Quality and Outcomes Framework (QOF) and the level of patients' satisfaction with access measures in the GP Patient Survey. These include how easily patients can get through to their GP surgery by telephone, how easily they can book appointments, how quickly they are able to see a doctor and whether they can see a GP of their choice (Raleigh and Frosini 2012). However, Quality and Outcomes Framework performance may be more an indication of good practice organisation than the delivery of high-quality, holistic care.

The GP Patient Survey asks: Overall, how would you describe your experience of making an appointment? In June 2012, 79.3 per cent rated their overall experience as good, whereas in July 2017 this was down to 72.7 per cent. The difference between the best- and worst-performing clinical commissioning groups on this question was almost 30 per cent. Patients are also finding it harder to get through to their GP surgery on the telephone – a drop from 77.9 per cent finding it easy in 2012 to 68 per cent in 2017. This drop might be less concerning if significantly more people were using online services but this was not the case (NHS England 2017b).

Much recent policy activity in English general practice has focused on extending access beyond traditional working hours. Such schemes have been justified by referring to public preferences for convenient appointment times, and employers'

changing attitudes to their employees taking time off work (Hunt 2015b), and the need to use GPs' expertise to help patients manage in the community without resorting to other urgent or emergency care services (Hunt 2015a).

The Prime Minister's Challenge Fund was announced in October 2013 to help improve access to general practice in England and increase innovation. Twenty wave-one pilots started in April 2014 and continued through to October 2015. Over this period, £60 million was invested in the pilots to provide extended access to slightly more than 5 million patients. A formal evaluation found that a 14 per cent reduction in A&E attendances for minor problems (42,000 attendances) was achieved across the pilot schemes, compared with a 4 per cent drop nationally. However, there was no change in either the number of emergency hospital admissions or the use of GP out-of-hours services across the pilot schemes (NHS England 2016). A further £100 million has been committed to support 37 schemes in wave two. Slightly more than £250 million is being invested across England in 2018–19 to support extending access to general practice for the whole population of England (NHS England 2016). However, the National Audit Office is concerned that although the Department of Health and Social Care recognises the importance of improving access, it has limited understanding of the pressures in general practice. It also believes that the Department of Health and Social Care and NHS England have not fully considered the consequences and cost-effectiveness of their commitment to extend access (National Audit Office 2017).

Furthermore, a policy focus that emphasises access may be detrimental to creating the conditions needed for person-centred, holistic care. In the current model, increasing access while lengthening appointment times will be impossible without a very significant increase in capacity. The National Audit Office recognises this issue and warns that efforts to increase the GP workforce, which will be crucial to improving access, are at particular risk from falling retention rates and increases in part-time working (National Audit Office 2017).

### Continuity of care

Traditionally in general practice, continuity of care is viewed as the relationship between a single practitioner and an individual patient, extending beyond specific episodes of illness. This sense of affiliation ('my doctor' or 'my patient') has been referred to as longitudinal, personal or relational continuity. In contrast, in specialist

services such as mental health care or cancer care, the relationship is more typically established between a team and the individual patient.

Continuity of care has two core elements that distinguish it from other aspects of health care; these are care over time and the focus on individual patients (Haggerty *et al* 2003). Care over time is the longitudinal component of continuity, where the timeframe of relationships may be short, such as during a hospital admission, or open-ended as in general practice. Continuity is also a description of how individual patients experience their care.

Haggerty and colleagues have described three types of continuity (Haggerty *et al* 2003):

- relational continuity – an ongoing therapeutic relationship between a patient and one or more health care professionals that bridges episodes of care (the traditional understanding of continuity)
- management continuity – a consistent and coherent approach to the management of a patient's health problem(s) that is responsive to the patient's changing needs (this has also been referred to as integrated care or seamless care)
- informational continuity – the use of information on past events and personal circumstances to make current care appropriate for the individual patient (this information may be captured in a clinical record or may be tacit, such as a patient's preferences, values and social situation, and/or held in the memory of a clinician).

There is now a significant research base, much of which has been summarised by Freeman and Hughes (2010), regarding the advantages and benefits of relational continuity, which include:

- increased patient and staff satisfaction
- reduced conflicts of responsibility for clinicians – particularly reducing the 'collusion of anonymity', where a succession of clinicians deal only with what is most immediately pressing

- increased security, trust and respect within the doctor–patient relationship, which increases the willingness of patients to accept medical and health promotion advice – this supports the 'wait-and-see' management of non-specific symptoms that are often self-limiting, and may reduce the undesirable medicalisation of symptoms
- improved problem recognition and quality of management of long-term conditions, with the evidence particularly strong for diabetes care
- reduced costs – for prescriptions, tests, A&E attendance and hospital admissions.

Recently, three key studies have shown that relational continuity in general practice is associated with reduced A&E attendances, reduced emergency admissions and reduced outpatient department attendances (Barker *et al* 2017; Katz *et al* 2015; Hansen *et al* 2013). Perhaps most importantly, there are now at least four studies showing an association with improved survival in older people (**Maarsingh *et al* 2016**; Leleu and Minvielle 2013; Worrall and Knight 2011; Wolinsky *et al* 2010).

Despite this growing evidence base for its benefits, relational continuity in English general practice is deteriorating. The GP Patient Survey shows that where patients have a specific GP they prefer to see or speak to, the number being able to do this either all of the time or a lot of the time fell from 65.3 per cent in 2012 to 55.6 per cent in 2017. Along with getting through to the practice on the telephone, this was the largest deterioration for any element in the survey over this five-year period (**NHS England 2017b**).

Current national policies, particularly those promoting general practice at scale and extending access in general practice, may well have the unintended consequence of decreasing relational continuity of care and in turn creating more pressures within the wider system. The GP Forward View and the associated Time for Care development programme, both launched by NHS England in 2016, are focused on improving access and recruitment, increasing productivity and supporting practices to work at scale, with no mention of initiatives to promote continuity of care. Given the evidence base for the benefits of relational continuity described above, particularly for reducing pressures elsewhere in the health system and for improving clinical outcomes in older people, this omission is surprising.

In relation to the other two types of continuity described by Haggerty and colleagues (Haggerty *et al* 2003), management continuity is important when a patient is receiving care from two or more clinicians or provider organisations. It is about crossing boundaries and bridging gaps in health and care systems that are increasingly complex. Appropriate information transfer – informational continuity – is a key factor in management continuity and it may more appropriately be considered as a component of management continuity rather than as a separate entity. This is considered further in the following subsection on the co-ordination of care.

### Co-ordination of care

The *NHS five year forward view* (Forward View) describes a future where health and care provision will be fully integrated, with seamless movement between services:

> *…a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results.*
>
> (NHS England *et al* 2014, pp 7–8)

Patients report (National Voices 2012) that they want:

- to tell their story once
- the professionals involved in their care to talk to each other
- to know who is co-ordinating their care
- an identified single point of contact.

The Canterbury health system in New Zealand, which is on a journey towards delivering this sort of integrated care, has as a core principle 'the right care, at the right time, in the right place and by the right person' and a key measure of

success is a reduction in the time that patients spend waiting (Timmins and Ham 2013). This is not an original concept, but the patient-centred measure of reducing the time spent waiting, be it waiting for an appointment date for an assessment, investigation or treatment, or waiting to be seen on the day in a community clinic or hospital setting, has been a key factor in motivating a wide range of professionals to work towards this goal.

The need for specialists to work more closely with general practice has been well documented, with a wide range of examples that go beyond simply relocating specialist clinics in general practice. These include mechanisms to provide GPs with easy access to advice, providing outpatient services jointly with general practice, and working in multidisciplinary teams (Robertson *et al* 2014).

What is the role of general practice in helping to create this future? As practices grow larger there is an increasing need to co-ordinate care properly between clinical staff within the practice organisation itself. In addition, many other services have an interface with general practice and there is strong evidence that a failure to co-ordinate care across these interfaces is inefficient and at times dangerous (Øvretveit 2011). As described in the previous subsection, management continuity is important when a patient is receiving care from two or more clinicians or provider organisations and informational continuity is a key factor in this. The GP practice has a key role in co-ordinating this care, and helping patients navigate their path through the system.

Activities involved in co-ordinating care within general practice include having a named clinician(s) who:

- routinely provides the patient's care (providing relational continuity and building a strong relationship over time – *see* the previous subsection)
- acts as a guide/navigator and advocate
- works with the patient to develop a personalised care plan
- supports the patient to maximise their potential to self-manage and stay well
- ensures that the patient's clinical record is comprehensive and up to date
- reviews and seeks input from the practice team and wider primary care team as/when needed.

Examples of the types of information flow that should occur between general practice and other services are:

- communication from general practice to accompany the referral of patients to other services, and the subsequent provision of information back to the practice
- notification when patients use the GP out-of-hours service, attend A&E or are admitted to hospital
- the information needed to continue to manage patients' care following discharge from another care setting (eg, tests carried out and medication prescribed).

A survey of primary care doctors by The Commonwealth Fund in 2015 found that while the UK compared favourably with other countries in terms of communication between health providers (particularly between primary and secondary care), 79 per cent of GPs in the UK reported that their patients had experienced problems in the previous month because their care was not well co-ordinated (**Osborn *et al* 2015**).

The ability to share clinical records electronically can streamline much of this information transfer and address patients' frustration at having to repeat their stories on numerous occasions. It can also ensure that important clinical information – such as allergies, medication use and significant medical history – is accessible across organisational boundaries. However, given the sensitivity of some health information, there is an ongoing debate about balancing the issues of confidentiality with patient safety (Papanikitas 2013).

A review of evidence on the impact of clinical care co-ordination shows that it can improve quality and save money – depending on which approach is used, how well it is applied and the context (Øvretveit 2011). However, it is challenging (and time-consuming) to develop and sustain relationships in a multi-layered health and care system (**Baird *et al* 2016**). As will be described later, those primary care organisations that have made real progress in this area have required significant investment in time and other resources, along with a constancy of focus.

### Community focus

There is now widespread recognition that the communities in which we are born, live, work and socialise have a significant influence on our health and wellbeing – a much greater influence than health care. The Forward View acknowledges that the UK has 'not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments' (NHS England *et al* 2014, p 9). It argues that the NHS needs to get serious about prevention, empowering patients and engaging communities.

General practice has traditionally been rooted in local communities. Before the implementation of patient choice legislation for general practice in 2015, which allowed patients to register with a general practice outside their local area, GPs had a registered patient list drawn exclusively in geographical terms. Even now, the vast majority of a practice's patients will live close by and GPs are well placed to understand the needs and context of the local community in which their patients live.

In the United States, the Institute of Medicine published *Community oriented primary care: new directions for health services delivery* in 1983, which added community focus and epidemiological approaches to the Institute's existing list of the core attributes of primary care (Institute of Medicine 1983). Around the same time, in the UK, Tudor Hart was almost a lone voice calling for GPs to take on responsibility for the health of the neighbourhoods in which they worked (Tudor Hart 1981). He proposed that the GP team, in addition to reacting to problems brought by individual patients, should be involved in an active search for unmet need, in screening for preventable disease, and in planning the continuing care of chronic disease. Even though most practices would now see this as part of their core responsibilities, there is significant variation across the UK in how well these tasks are being delivered (Goodwin *et al* 2011).

'Community orientation' is now one of the 12 core competencies for GPs in training, who are required to understand the potentials and limitations of the community in which they work, its characteristics, and how these might have an impact on health needs (*see* Royal College of General Practitioners undated). There are many assets within communities that can be mobilised to promote the wellbeing of individuals and families living there, and also to support service delivery in general practice through volunteering (Gilburt *et al* 2018). One approach to mobilise these

has been the development of social prescribing – a means of linking patients with sources of support within the community – which is listed as one of the 10 high-impact actions in the GP Forward View (NHS England *et al* 2016).

We suggest that GPs and their teams have an important role in building trust with local communities, through both participating in local community initiatives and on occasions providing leadership. As highlighted by Freeman and Hughes (2010), continuity of care is central to building trust in a therapeutic relationship, which in turn supports shared decision-making about health. In a similar way, GPs and their teams over time can build relationships with local communities to support effective change across the wider community. Batalden and colleagues suggest that, at its most basic level, this requires civil discourse with respectful interaction and effective communication. But it also demands deeper trust, more cultivation of shared goals and more mutuality in responsibility and accountability for performance (Batalden *et al* 2016). Clearly, general practices are not the only organisations in local communities that can support this sort of local engagement and action, but they have the potential to be powerful agents of change.

These attributes are not new, but are a way of restating those elements that general practice will need to address if it is to deliver patient-centred, holistic care. Given current pressures, delivering these elements using current models will be challenging without a significant increase in capacity. In this report we identify innovations that might support general practice to deliver care that captures all of the elements, while recognising that additional capacity will still be required if general practice is going to be able to meet future demands.

# 5 Ways of working

How might general practice of the future deliver a service that provides the dimensions of care that we have identified? We have looked across the UK and internationally for innovative models of general practice that have taken a different approach to providing care, assessing those ways of working that might be applicable to general practice in England and the extent to which they deliver on those dimensions. These models are not mutually exclusive, and many meet several or all of the dimensions, but we have chosen to group examples to highlight a particular aspect of care delivery. While some of the interventions have been fully evaluated, many are new and as such we have depended on the available literature and brief interviews with those involved.

## Team-based working

Our previous work found that GPs often felt very isolated in their working life, managing a continuous stream of in-person and telephone appointments, with little room for reflection or collaboration. They reported that they were not always doing the tasks most appropriate for them and that an increase in flexible working and responding to access needs meant that relational continuity with their patients was difficult (Baird *et al* 2016). Ethnographic research in the United States found a similar pattern:

> *The practices we observed were divided, hierarchical and under stress. Physicians struggled to meet their demanding rosters of patient visits; they were hours behind schedule from the moment their work began every day. The rest of the practice staff was largely restricted to supporting the constellation of activities around the physician–patient encounter. Patients, meanwhile, could be left in limbo while they waited for a moment of the physician's time.*
> (Chesluk and Holmboe 2017, p 878)

Shortages of GPs combined with increased demand have added to this pressure. Practices both in the UK and internationally are attempting to address these issues by adopting a team-based model of patient care. These teams take many different forms, but most are moving from the more traditional approach to one

where a small team comes together to take responsibility for a group of patients and collaboratively shares the care of those patients. Sometimes called 'micro-teams' or 'teams within teams', they bring together a range of skills. These teams often include a GP, a nurse practitioner or case manager, a medical or health care assistant and an administrator. This approach:

- allows patients to build an ongoing relationship with a small number of professionals
- improves access by removing the 'bottleneck' of the GP
- offers an environment in which all professionals can undertake work that is matched to their abilities.

Evidence suggests that team-based care offers advantages in delivering the core attributes of general practice that we have identified, including improved access, more efficient co-ordination and improved continuity (Wagner 2000). Fundamental to this approach is the belief that when practices draw on the expertise of a variety of team members, patients are more likely to get the care they need (**Schottenfeld *et al* 2016**).

Research shows that a number of elements are required for successful teamworking in primary care (Ghorob and Bodenheimer 2015; Hochman 2015), including:

- being located in the same place
- a stable organisational structure
- a culture shift from doctor-driven to team-based care
- defined roles and workflow
- good communication through 'huddles' (very short daily meetings where teams discuss their work for the day), team meetings and informal 'handoffs' of patients.

Building relationships and trust within the team is particularly important and reflects wider literature on effective teamworking (**Wisdom and Wei 2017**).

In addition to a micro-team, primary care teams might also bring together a wider range of professionals, including behavioural health specialists, social workers, health coaches, midwives and pharmacists. The most effective teams include the patient as an active member of their care team (Bitton *et al* 2018).

From the perspective of some clinicians and patients, team-based care may feel like a departure from patient-centred care because it can split care delivery across several team members; effective communication within the team and between team members and the patient is therefore critical (Schottenfeld *et al* 2016).

### Nuka, Southcentral Foundation, Anchorage, Alaska, United States

**Description**

During the 1990s, guided by input from 'customer-owners' (the term used for the Alaska Native people who are the users, and also the owners, of the health system), the Southcentral Foundation made significant investment in a generalist model of care called Nuka. It created small teams, typically with one GP, one nurse case manager, one member of case management support staff and one certified medical assistant. The nurse case manager handles routine health issues and triage; the case management support person schedules appointments and communicates regularly with patients; and the medical assistant greets patients and carries out routine monitoring tasks. The GP handles only the most complex duties, particularly diagnosis. Each core team is responsible for around 1,400 patients and each group of six teams is supported by an integrated care team, which includes a dietician, a pharmacist, behavioural health consultants and midwives. This wider support team therefore provides support to around 8,400 patients. There is also a manager who oversees each clinic, a front desk for each clinic, and a call centre. The teams sit together, going to the patients in clinic rooms rather than the patients being brought to them. This allows them to make informal handoffs to other professionals, often acting opportunistically, and make personal introductions to other professionals, which builds trust and confidence.

The teams keep 70 to 80 per cent of available time for appointments free on any given day so that they can respond to demand. They use wider communication channels including the telephone, text and email but customer-owners can always have a face-to-face discussion with the doctor if they prefer. They can provide holistic care for their populations, by combining a range of generalist skills covering

both physical and mental health in the teams and bringing specialist skills into the teams where needed, rather than referring patients out to other teams. The model supports co-ordinated care for the entire population, in comparison with models where only higher-risk groups are referred out to care co-ordinators and multidisciplinary teams. The Southcentral Foundation does still refer patients to specialists, such as its paediatric and women's clinics, and to the hospital system, but the aim is to do so as little as possible.

**Lessons learnt**

The Nuka model was based on engagement with the community, realising that most customer-owners managed their own health for the vast majority of the time, and that the primary care system needed to build trusting, long-term relationships with its community, so that over time it could have a real impact on how people in the community lived their lives. The Southcentral Foundation chose a model that would deliver this focus on relationships, with small primary care teams who could develop meaningful relationships with patients and families. This means that the teams are better placed to support their populations because they understand their motivations, their clinical history, their personal backgrounds and their families. The core team allows doctors to spend more of their time on people with newly diagnosed conditions rather than advising those with complex needs who are on known pathways and protocols. People are sent to the right person to care for them, removing the doctor as a bottleneck.

The transition to the new model was complex, and significant investment in staff engagement, organisational development and training was critical. Key was choosing to invest in a model of generalist, holistic care rather than technical specialist expertise, including physical infrastructure to allow the workforce to be located in the same place. Investment in data analytics allows primary care teams to view a dashboard of information about their performance and how they compare with other teams.

**More information**

www.southcentralfoundation.com/nuka-system-of-care/

## Healthy Prestatyn Iach, Prestatyn, Wales

### Description

Based on the Nuka model of care developed by the Southcentral Foundation, Healthy Prestatyn Iach was created by Betsi Cadwaladr University Health Board in April 2016 when several practices in the area closed or were at risk of closure because of difficulties in recruiting GPs. The practice has five multidisciplinary KeyTeams, each one caring for an allocated group of patients. Each KeyTeam serves around 5,000 patients and comprises two full-time equivalent GPs, nurse practitioners, occupational therapists, pharmacists and a dedicated co-ordinator. Supporting the teams are a range of other professionals, such as physiotherapists. A practice nursing service, including a nurse and health care assistant team, provides a range of traditional nursing services from each site, including monitoring, vaccinations and immunisations and contraception. The practice operates a same-day service from one site during the week for urgent primary care problems, such as infections and minor illnesses, with no appointment necessary. One of the five KeyTeams focuses on patients in care homes, patients who are housebound with complex medical needs and patients with advancing frailty. The practice has been working closely with a social enterprise and town council to develop community support for patients.

### Lessons learnt

While based on the Nuka model, there are interesting differences in the KeyTeam structure. The use of occupational therapists in particular has been seen as a significant benefit and has created a change in approach, and a shared team room allows for informal discussion and support. While the team approach creates continuity for patients with a single team, this was a significant change for patients who were used to a relationship with a single GP. This required ongoing engagement and communication to address. Recruitment challenges and rising demand continue to cause issues for the practice and mean that the average patient list of 5,000 per team is much larger than would be the case in the Nuka model.

### More information

http://healthyprestatyniach.co.uk/

## Tower Hamlets micro-teams, London, England

### Description

Tower Hamlets is a London borough in east London, which covers much of the traditional East End. It is characterised by wide inequalities and pockets of high social disadvantage, with people living with more illness, consulting more frequently, and dying younger, compared with more affluent areas. The number of patient contacts per GP is very high, resulting in both patients and doctors feeling more stressed after consultations. Meanwhile, a large number of GPs (65 per cent) in Tower Hamlets work on a salaried or sessional part-time basis. Restoring relational continuity of care has been high on the agenda of the local CCG and the GP community after local audits and feedback from patients showed that this was a significant problem. The Tower Hamlets approach has been to pilot the introduction of micro-teams. These are seen as a way of retaining the best aspects of 'small is beautiful' models of general practice under the rational and efficient umbrella of a practice 'macro-team'.

Four practices volunteered in 2015 to develop the concept of micro-teams (Risi *et al* 2015). These practices had higher levels of performance on the Quality and Outcomes Framework, and also higher self-reported levels of personal achievement, than the majority of local practices. One other practice participated, which already had an established personal list system, but wished to further develop the micro-team concept. All practices had list sizes of more than 10,000 patients. Practices used the micro-teams to either cover the entire population or focus on patients with multiple long-term conditions and/or at risk of an unplanned hospital admission. The core concept was of two to three buddying doctors working in a small team, and some practices also included a receptionist and a member of their administrative staff in the micro-team.

Over the past two years there has been mixed progress within the four practices, with only one practice managing to implement the micro-team model with a significant degree of success, largely due to the simultaneous roll-out in this practice of quality improvement training for all staff. Early findings from the work have shown that the micro-team approach can improve safety, reduce GP workload by avoiding duplication of effort and improve co-ordination.

### Lessons learnt

Over a number of years, Tower Hamlets has tested the concept of providing many back-office functions on a large scale through the Tower Hamlets GP Care

Group. The aim of the micro-team initiative was to enable practices to reorganise themselves so that 'front-office' functions, defined as all direct contacts with patients, could be delivered to maximise relational continuity by what was essentially a part-time clinical workforce. The following key lessons can be drawn from the experience so far.

- Involve patients from the start of the changes and give them the flexibility to choose their micro-team.
- Engage the whole practice team, from GP partners to reception staff. The latter are particularly important in ensuring that patients understand the new processes. Buy-in from all GPs involved is vital. Implementation is difficult where there is significant staff turnover.
- Create opportunities for longer consultations so that the potential for relationship-based care can be maximised.
- In practices with several micro-teams, attention needs to be given to the infrastructure that supports the teams and also how to handle work that might fall between the teams.
- Investment is needed to support staff training.
- External input to support change management is important.

## Digital innovations

Digital technology affords people new possibilities for interacting in general practice. Patients and professionals alike have taken this technology, experimented with it, adapted it and put it to use for general practice. In this section, we discuss how technology has been used to change the consultation between the patient and the professional.

Digital technology changes rapidly. First, it changes quickly in terms of the things we can do with it, as new products, services and updates are released frequently, and infrastructures continue to develop. Second, the uses to which we put technology also change quickly; users adapt technology, and develop skills and different practices as they integrate it into their personal and working lives. The evidence base therefore requires some careful consideration as studies can become rapidly outdated by both technological developments and social change.

The evidence covering remote consultations in general practice is a prime example of this tricky evidence base. The technology and context relating to remote consultations have transformed in recent years. Ten years ago, smartphone use was exceptional rather than the norm it is today and videocalling was an established but cumbersome technology. Partly because of this, there is little evidence and a continual debate about the best way to deploy these technologies as part of a GP delivery model. However, according to a recent summary of the evidence, remote consultations can involve some overhead costs but they reduce consultation length, improve accessibility and patients appreciate being given the option (**Castle-Clarke and Imison 2016**).

Despite the absence of robust evidence, it seems that there is real potential for digital innovations to play a role in GP delivery models. They can help to support access to health care by creating flexibility in the increasingly busy lives of patients and their GPs. For patients with long-term conditions or those who find it difficult to access their GP practice in person, simple-to-use platforms providing video or telephone consultations could play an important part in their ongoing relationship with their GP. So too could giving the patient the technology to monitor and share information about their health remotely between consultations.

However, some marginalised groups are likely to find it more challenging to access digital models of care because they experience barriers to using online services, such as:

- people with few digital skills
- people unable to afford the relevant technical equipment
- people without access to an appropriate environment in which to use the technologies
- people for whom English is not their first language.

While these barriers and the factors behind them often pose a challenge for interacting with established models too, it is incumbent on those working on digital models of care to ensure that inclusion is prioritised. The digital inclusion charity Doteveryone urges technology developers and their partners working in health care to 'design for the needs of the furthest first', pointing out that if digital services 'can work for an older person with multiple co-morbidities or for a homeless teenager, it is more likely to have the capacity to work for everyone' (**Doteveryone undated**).

In recent years, policy and investment from the central health bodies have been directed towards expanding the range of technologies being put to widespread use in general practice. The Forward View called for the new organisational models to make 'fuller use of digital technologies' in general practice (NHS England *et al* 2014, p 19). Meanwhile, the GP Forward View calls for the use of digital technology to change patient–professional interactions through remote consultations and other initiatives, but also to support ways of working at scale across multiple sites or using data to better co-ordinate care (NHS England *et al* 2016). It pledged a £45 million fund to allow GPs to purchase e-consultation systems for their practice (*see* the example below). It also pledged a forthcoming framework for assessing (and hopefully improving) digital maturity in general practice, along the lines of the Digital Maturity Assessment exercise carried out across provider trusts in 2015 (National Information Board 2015).

### GP at Hand, London, UK

#### Description

GP at Hand is a partnership between an existing GP practice and Babylon Health. The model of care is centred around the use of a smartphone app to book and carry out GP consultations and is the first time that all patients can routinely interact in this way with an NHS practice. Patients switch their practice registration to the GP at Hand practice. The GP patient choice commitment means that they can register with the practice even if they do not live in the local area (NHS Choices 2017). The service also provides care at certain physical locations in central London for appointments requiring investigations and physical examinations, arranged during a smartphone consultation or with the practice telephone support team.

#### Lessons learnt

GP at Hand is a new service and is currently being evaluated (Crouch 2018). It commits to extremely short waiting times (20–30 minutes at peak times) for a smartphone appointment with a GP, and smartphone access allows patients to interact with their GP at a place convenient for them. Patients with more complex needs who may need more face-to-face care are advised to consult with clinicians at GP at Hand before registering. Patients are not routinely able to select a specific or regular GP through the app. This means that the type of continuity provided by the service is informational continuity through the clinical record system and other

internal systems that the practice uses, rather than relational continuity between a GP and the patient. To make special arrangements to see a specific GP, patients can contact a clinical support team by telephone.

How this model affects the continuity and co-ordination of care, and how referral pathways into the rest of the health system are performing, will be studied in a forthcoming evaluation. A service provided by a remote workforce may be less likely to provide community-focused care but this has not been evaluated.

The practice had grown from 4,970 patients in November 2017 when GP at Hand launched, to 24,652 in March 2018, with 85 per cent of new registrations made by people between 20 and 39 years old (NHS Digital 2018b, 2017). This suggests that it is attractive to younger patients who may prioritise convenience of access over other attributes of general practice.

### More information

www.gpathand.nhs.uk/

## E-consultations

### Description

E-consultations (also called online consultations) is a term used to refer to online platforms that use forms or a series of branching questions to gather information about the patient's condition for the practice to act on. The platforms can also offer advice about appointment booking in the practice, self-help health advice and signposting to other NHS services. The exact approach varies across different products and in how they are implemented by practices. The information gathered from the patient can be reviewed and used by the GP to decide about whether they should refer the patient to another member of the practice. It can also be used to complement history-taking at the start of a consultation.

### Lessons learnt

More than 300 practices in England are already offering online consultations but an evaluation of pilots in 36 practices using one of the platforms – eConsult – found very low use of e-consultations, with the most common reason for an e-consultation

being an administrative request, for example for a fit note, repeat prescriptions or test results (Edwards *et al* 2017). Findings from other pilot sites suggest that dealing with these administrative tasks does free up time for GPs by managing patients who do not need to be seen face to face (NHS England 2017a). The early evidence suggests that e-consultation systems need careful implementation and refinement before they bring benefits to patients in terms of access, as well as other aspects of quality in general practice.

### More information

www.england.nhs.uk/gp/gpfv/redesign/gpdp/online-consultations-systems-fund/

## Telephone triage

### Description

'Telephone-first approaches' have become increasingly common in English general practice. Where this model is introduced, a patient wanting to see a GP calls the practice and is called back on the same day (often within the hour) by a GP, who consults with the patient to decide whether the problem can be resolved over the telephone or whether a face-to-face appointment with a doctor or other health professional is required.

There are two main commercial companies that provide management support to practices adopting this system in England: GP Access and Doctor First.

### Lessons learnt

A major evaluation of telephone-first approaches was published in 2017 (Newbould *et al* 2017). It found large decreases in face-to-face consultations and increases in telephone consultations and it suggested that up to half of patient problems could be appropriately dealt with on the telephone. Using results from the national GP Patient Survey, the evaluation found that GP practices using a telephone-first approach reported a large improvement in patients' perceptions of time waiting to be seen. However, the approach was associated with an overall increase in GP workload, as there was an overall increase in the average time that GPs spent consulting.

There was significant variation in the experiences of practices that adopted the telephone-first approach, with some finding that it transformed their ability to meet demand for appointments, but others finding that it increased demand. The researchers observed that the approach worked better in practices that were organised and data-driven and were already able to meet demand, and that it was less likely to prove successful in practices that were already struggling to meet demand. There was also variation in the way patients experienced the approach: patients with language barriers and patients who could not easily take telephone calls at work were less welcoming of the approach.

Digital technology in general practice is not just about allowing patients to access care in different ways; it can also allow GPs to access support that allows them to provide an enhanced level of care. It is now common practice for the internet to be used in the consultation to source up-to-date guidance through online textbooks or guidelines from sources such as the National Institute for Health and Care Excellence (NICE).

### Bay Health and Care Partners Advice and Guidance, Morecambe Bay, England

#### Description

Advice and Guidance (A&G) is a bespoke web-based system that allows GPs to request advice from secondary care specialists in two-way secure electronic conversations. GPs access the system via EMIS Web (the electronic patient record system used by all GP practices across Morecambe Bay). From a patient's record in EMIS, the GP clicks on a link to A&G which passes the current patient's details through automatically, meaning the GP doesn't need to re-enter these details. This opens the new conversation page and all the GP needs to do is select a specialty from a drop-down box, enter their question and click 'submit'. The GP can choose to be contacted by phone and provide details of when they will be free and what number to contact them on. The system allows for a conversation to go back and forth until the GP is happy their questions have been answered. Currently 26 specialties can be contacted through A&G, including radiology – where GPs can arrange direct access to more specialised investigations such as MRI, CT, and radioisotope bone scans, after remote discussion with a radiologist. Practice nurses

can now use the system to connect with a growing number of nurse specialists. The standard response time is five days, but most replies arrive in one to two days (the average response time is currently 1.8 days), and GPs receive an email notification that a response is waiting for them to view.

In 2016–17 there were 7,651 A&G queries raised by GPs; of these 1,807 were radiology queries. GPs stated that if the A&G service had not been available they would have referred a patient for an outpatient assessment on 4,377 occasions, but after receiving specialist advice that referral was avoided on 2,942 occasions (67 per cent reduction), with GPs managing the care themselves, performing further investigations or accessing support from elsewhere. A later referral will sometimes occur, but this will be after further investigations or treatment options have been tried. The system was established to promote communication between GPs and specialists, while anticipating it would also reduce the need for outpatient attendances. Feedback from users has shown it to be a powerful educational tool, as well as empowering GPs to better manage patients in a community setting.

**Lessons learnt**

This is an example of local innovation, with a system designed by clinicians for clinicians – the lead proponent was a local GP. Engaging specialists and GPs in the design was crucial, as was a robust pilot period during which glitches were sorted before wider roll-out. The pilot period also allowed a local tariff to be developed to fund the time involved for specialists to respond to queries. Ensuring that automated real-time feedback was built into the system from the start has allowed the collection of robust performance data.

**More information**

www.bettercaretogether.co.uk/News.aspx?ID=46

## Community-centred approaches

We found many examples of GPs engaging with wider community services to improve patients' lives, often based on taking an 'asset-based' approach (as opposed to a 'deficit' approach). Assets might incorporate:

- personal assets – eg, patients' knowledge, skills, talents and aspirations

- social assets – eg, relationships and connections that patients have with their friends, family and peers
- community assets – eg, voluntary sector organisations, associations, clubs and community groups
- neighbourhood assets – eg, physical spaces and buildings that contribute to health and wellbeing, such as parks, libraries and leisure centres (Greater Manchester Public Health Network 2016).

Social prescribing is a popular community-centred approach. Definitions of social prescribing can vary, but essentially it gives GPs an additional, non-medical referral option to help address patients' mental health problems and low levels of wellbeing in particular (Bickerdike *et al* 2017), and it typically involves both the voluntary sector and volunteering. Social prescribing programmes tend to be small-scale and evaluations are limited by poor design, which makes it challenging to assess the evidence on outcomes or value for money (Bickerdike *et al* 2017; University of York 2015). Nevertheless, there is currently a growing political appetite for increasing the availability of and access to community-centred approaches as a way to improve health outcomes.

### General Practitioners at the Deep End, Scotland

#### Description

The Deep End group is a network of 100 practices that serves the most socio-economically deprived populations in Scotland, mainly in Glasgow. It was developed by the Royal College of General Practitioners in Scotland in 2009. GPs in the deprived areas were often working with patients with complex multi-morbidity and other non-medical challenges, such as a lack of employment opportunities and social isolation. They found that they were spending a lot of time trying to help patients with problems particularly related to housing and poverty. This was difficult to do in the space of a 10-minute consultation and without good knowledge of or access to community-based services that could help.

GPs in the network identified a need for a practice-attached 'link worker' to help address some of these challenges. In 2014, a link worker approach was introduced in seven Deep End practices wherein a 'community links practitioner' (funded by the Scottish government through to March 2019) is attached to the practice and works

with patients to help them access resources and support for non-medical issues. The link worker can accompany patients to appointments with other organisations if needed. The relationship with the link worker is not time-limited, which enables them to follow patients up and potentially offer further assistance. This builds capacity within the practices, strengthens links with local community organisations and improves communication between the different services.

Another Deep End initiative is an advice worker embedded within general practice as an additional form of assistance that can be offered to patients who could benefit from advice about finances or debt management, housing and social security. The project was intentionally designed so that this type of advice and support is provided 'in-house' and seen as part of the daily running of general practice. GPs and other practice staff refer patients through an online referral system as an additional form of support, not as a replacement for a GP appointment. Once the referral is made, the advice worker can make a face-to-face appointment with the patient and offer advice on a range of housing, social security and financial management matters. With permission, advice workers can access the patient's medical records to get a better idea about their health. Advice workers can also refer patients on to additional forms of support in the community, such as organisations for carers or homeless people.

**Lessons learnt**

In an evaluation of the link worker programme, participants identified some benefits, including the link worker's ability to act as the patient's case manager, and the worker's position within GP practices, which operated as a bridge between organisations. The evaluation found that the success of the approach was also contingent on the community organisations having access to enough funding to provide services and make and maintain their links with primary care (**Skivington *et al* 2018**).

Two practices within the Deep End network piloted the advice worker project from December 2015 (and the initiative is ongoing). An evaluation found that advice workers helped the 165 patients referred between December 2015 and September 2017 to access approximately £850,000 worth of social security support. It found that a key feature of the success of the scheme, as opposed to schemes where advice workers were not embedded within the practice, was the development of trust between the advice workers and clinicians in the practices, with each respecting the other's knowledge and expertise. The individual patient's relationships with practice staff, including GPs and non-clinical support staff, were the defining

factor in their engagement with the service. GPs suggested that having an advice worker embedded in the team contributed to stronger patient–doctor relationships, helped to reduce their non-clinical workload and freed up time (Sinclair 2017).

**More information**

www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

## Small Isles Medical Practice, Isle of Eigg, Scotland

**Description**

When the resident GP on the Isle of Eigg passed away, it was necessary to find new ways of providing general practice to the remote islands of Canna, Eigg, Muck and Rum in Scotland, the nearest of which lies an hour by boat from the mainland. Inspired by the Nuka model of care in Alaska, which provides care to very remote populations, a key principle was community involvement and engagement, working with the local community to determine what the options were. Central to the model are four health and social care support workers, based within local communities and trained to deliver care such as wound dressing, blood taking, dispensing and toenail cutting. The support workers know the people they are treating, and they are likely to remain within the community for a long time, thereby providing continuity of care.

The support workers are part of a wider multidisciplinary team, which includes GPs who visit the islands on a regular basis. Patients can make an appointment to see a GP from the team on the islands on designated days and out-of-hours service provision is available through the rural practitioner team on the Isle of Skye. Other agencies have been involved in the programme on the Small Isles. The Red Cross delivered some basic first-aid training to residents, and the Scottish Ambulance Service has worked with communities to develop a First Responder scheme. The former doctor's house on Eigg was converted into a health and wellbeing centre, with a consulting room, waiting room, dispensary, office and stores. Staff accommodation has been included to enable a GP or other professional to stay overnight if necessary (NHS Highland 2017, 2016, 2015, 2014).

### Lessons learnt

Building strong relationships and trust between health care leaders and the community was critical to the success of this innovation. The main priority for the islanders was a sustainable community, which they strongly believed required sustainable health care and there was initially much resistance to the loss of a resident GP, with fears that it would mean people would leave the island. The project leader from NHS Highland spent considerable time building relationships with the community and started working with those who were interested in change. The project leader and a community leader visited the Nuka system in Alaska to learn about the model, and the community leader was then able to share her understanding with the local community. One of the doctors from the practice on Skye who would be providing a visiting service also spent time visiting the island building relationships.

The team that visited Alaska brought back training materials for the health care support workers and adapted them for their needs. The training has been accredited by the Remote and Rural Healthcare Educational Alliance, providing a qualification that gives the workers transferable skills. There are plans to provide the first responders with a higher level of training so they can administer drugs, supported by a health care professional via telephone, and to provide mental health and paediatric first-aid training. Adapting the model to meet the specific needs of the islanders was critical, as was providing locum medical cover to the islanders while the model was developed and implemented.

As a sole practitioner, the resident GP had been responsible for all health and care needs on the island. Now the service provides islanders with more choice, with a visiting team of doctors, including a female doctor, and access to professionals including midwifery, community psychiatry and district nursing, so the islanders have access to a wider range of team-based care. There are new babies being born on the island and a thriving school and fears around the potential effect of not having a resident doctor have not been realised.

### More information

www.nhshighland.scot.nhs.uk/

## Robin Lane Health and Wellbeing Centre, Pudsey, England

### Description

The Robin Lane Health and Wellbeing Centre is a medical centre in the market town of Pudsey. The GP practice within the centre has a list of more than 13,000 patients and is open six days a week, offering a diverse range of health and social services, including 'standard' general practice. The centre incorporates the Love Pudsey charity, which provides the base for a patient-based volunteer programme, with more than 30 volunteer health champions, who support and run more than 60 health and wellbeing activities. The overall aim of the centre is to care proactively for its population by preventing or delaying the onset of illness and to address the social factors that have an effect on health. The centre's approach is to work with 'patients as partners' to develop both the medical services and the non-medical activities and groups that promote healthy lifestyles and emotional wellbeing. The practice has a Practice Participation and Involvement (PPI) group, which is registered as a foundation charitable trust of Robin Lane. The PPI group plays an active role in the delivery and future planning of services at the practice, which includes supporting the patient volunteer programme. The centre takes a broad view of the different things that contribute to wellbeing, adopting the following five universal elements of it: physical, social, community, purpose and financial (Rath and Harter 2010). In addition to routine appointments, the practice runs a 'walk-in' service (for routine and urgent health issues) six days a week; counselling services; patients can access Weight Watchers, a dancing group (specifically for patients with Parkinson's disease or other conditions that can limit mobility) and befriending through activities such as a youth café, a ukulele group and a walking group.

### Lessons learnt

The practice was inspected by the Care Quality Commission in 2016 and rated as 'outstanding' (Care Quality Commission 2016b). The commission noted how the centre was proactive in engaging with its patient population and local stakeholders in the design and delivery of its services and that community-centred resources were used for older people. The practice made the decision not to appoint a GP to fill a vacancy but instead appointed a wellbeing co-ordinator and a community matron to work with older people. The practice list has increased by 40 per cent over ten years but it has managed to cope with this growth without extra doctors by implementing the approaches described and through rethinking the way the practice is organised.

It also changed the way it approaches health care provision, with the promotion of wellbeing and proactive care becoming the driving ethos as opposed to creating services to react to demand. In order to achieve this the practice has built strong partnerships with its patient population and the wider local community.

**More information**

www.robinlanehealthandwellbeingcentre.com/

## Community wellbeing practices in Halton, Cheshire, UK

**Description**

Halton is a borough in the north-west of England and is made up of two neighbouring towns – Runcorn and Widnes. Wellbeing Enterprises Community Interest Company has been running there since 2006. In 2012, Halton CCG and Halton Borough Council commissioned Wellbeing Enterprises to design and deliver a community-centred model, beginning with a pilot project to test out the effectiveness of community-centred health approaches in primary care based on three general practices, which was then expanded to all 17 general practices. This model is called Community Wellbeing Practices (CWP) (Swift 2017). Once they are referred by a GP or self-refer to CWP, patients are offered a one-to-one session with community wellbeing officers who undertake a structured 'Wellbeing Review'. Patients are supported to develop an individualised action plan to address personal challenges, tap into their personal strengths and access wider sources of support to improve their health and wellbeing. Patients then have access to a range of activities, including social prescribing, asset-based community projects and community wellbeing and resilience programmes (South 2015). Community wellbeing officers work with patients over approximately four weeks and review progress regularly by telephone and in person.

Community wellbeing officers are an integral part of the team, accessing patient records and attending practice meetings. They spend a substantial amount of their working week in the practice to support health promotion and meet with patients in waiting rooms (Swift 2017). Patients and the public play a key role in the implementation of the CWP model. A number of patients who have used the social prescribing option go on to become joint facilitators of sessions alongside

tutors. CWP has also established volunteer schemes in a number of general practices through which patients have joined patient participation groups or delivered health promotion projects (Swift 2017).

**Lessons learnt**

Before launching CWP, staff from Wellbeing Enterprises spent time securing the 'buy-in' of the local general practice community. General practices could opt in; seven did so straight away and the other ten followed after six months. Wellbeing Enterprises offered brief interventions training to general practice staff to help them respond more effectively to patients' social needs. More than 5,000 patients have been supported by the CWP model and outcome data shows statistically significant improvements in a range of areas that have been measured using validated tools, such as depression symptoms, anxiety levels, self-reported wellbeing and health status. Feedback from GPs has been mainly positive, and staff agree that the CWP model has improved access to community-based services for patients (Swift 2017).

**More information**

www.wellbeingenterprises.org.uk/category/halton/

## Segmentation

Some models of care have developed to find ways to meet the needs of particular groups, particularly high-needs, high-cost patients. In doing this they are able to create teams that can meet needs in a more bespoke way and provide an enhanced service to that population. A 2009 report on care management for patients with complex needs, for example, concluded that 'the transfer of high-risk patients from traditional primary care to separate "high-risk clinics" or "high-risk teams" has shown great promise' (Bodenheimer and Berry-Millett 2009, p 14). The report recognised that while primary care is the logical place to undertake case management for complex conditions, the pressures caused by increased demand and a shrinking workforce in primary care mean that primary care visit lengths are not sufficient to manage complex patients. By focusing more resources on those groups with higher needs, for example patients with multiple and complex conditions, services are able to offer longer appointments to address those needs. Segmented models are often more able to locate specialist services in one place,

particularly psychiatry, diabetology and cardiology, and therefore specialist advice and support.

### Ron Robinson Senior Care Center, San Mateo, California, United States

#### Description

Opened in 2004, the Ron Robinson Senior Care Center in California operates as part of the San Mateo county public health system and is located in the county hospital on a site that houses other health and care services for older people. It includes both primary care and geriatric assessment for adults aged 60 and older, with a focus on those whose chronic or complex health issues would benefit from the time and resources that clinic staff can offer. Physicians and nurse practitioners provide primary care and the wider multidisciplinary team, which includes nurses, a psychiatrist, a psychologist, a licensed clinical social worker and a rehabilitation therapist, provide counselling and ongoing care management.

The centre particularly serves low-income older people from the county's diverse population, with more than half of its patients identifying as Latino (60 per cent) and languages spoken including Arabic, Cantonese, Farsi, Hindi, Mandarin, Russian, Tagalog and Vietnamese.

#### Lessons learnt

While the majority of patients are Medicaid beneficiaries (that is, they have a low income), some private patients are also choosing the centre because of its bespoke focus. In 2015, the centre served more than 3,000 patients with more than 13,000 visits. Key to the success of the centre is close links between clinic staff and representatives from social care, community health and local community organisations, with bi-weekly meetings that build relationships and trust between professionals. Continuity of care for vulnerable patients, who see a team they know and can build relationships with, has also been a key factor in improving health outcomes (Perry 2016).

#### More information

www.smchealth.org/location/senior-care-center

## ChenMed, Florida, United States

### Description

ChenMed is a primary care-led group practice based in Florida, which serves low-to-moderate-income older patients, most of whom have multiple long-term conditions. Its care model includes a one-stop-shop approach for delivering multispecialty services in the community, and smaller physician list sizes of 350–450 patients, which allow for intensive health coaching and preventive care. The clinics offer services on site, including dental care, x-rays, ultrasounds and acupuncture, as well as support from five to fifteen specialists, and patients receive the majority of their primary and specialist outpatient care at the centre. As access is an issue for their patient population, they provide free door-to-door transport for patients.

### Lessons learnt

The model allows for close working between specialists and primary care doctors, with the latter easily able to obtain advice. The clinics are designed to promote collaboration and conversation between professionals, with a large nurses' station in the middle of the practice where specialists do their paperwork, which is sufficiently far away from patient consultation rooms for spontaneous discussions between professionals. In many cases, the specialist can have a brief face-to-face consultation with the patient's primary care provider immediately after they have seen the patient. On average, patients received 86 per cent of all their ambulatory health care in the clinics. Primary care doctors see an average of 18 patients a day and patients usually see their regular primary care provider (88 per cent of patients' primary care visits were with their designated primary care physician in 2011). Preventive care is emphasised throughout the system. Research has found that the model lowers rates of hospital use, improves patients' adherence to medication and leads to higher rates of patient satisfaction (Tanio and Chen 2013).

### More information

www.chenmed.com/

## Health 1000, London, UK

### Description

Health 1000 is a bespoke GP practice for older people with complex health and social care needs. It was established in outer east London in 2015 as a two-year pilot, funded by the Prime Minister's Challenge Fund. It provides a one-stop primary care and social care practice for the 1,000 most complex older people in the area. 'Complex' is defined as having five or more long-term conditions and patients are recruited by invitation from their current practice. The staff are a multidisciplinary team of health care professionals, including GPs, specialist doctors, nurses, physiotherapists, occupational therapists, pharmacists and social workers. Patients and carers design their care programme with the team and a personal support worker helps to ensure that health and social care is personalised. The service works with Age UK to develop wellbeing services. The service also provides specialist support to four nursing homes.

### Lessons learnt

Evaluation results to date suggest that the service improved perceived quality of care for patients, but that it had not yet demonstrated any difference in the subsequent use of hospital services. Staff felt Health 1000 had improved the quality of care patients were able to access, including better medicines management and a reduction in unnecessary outpatient referrals. Staff also stressed the benefit of improved continuity on resource use, for example reducing duplication. Challenges included issues with technology related to prescribing, the distances that staff needed to travel to reach patients over a wider area and the complexity staff faced in managing different systems across three boroughs. Recruitment of patients to the new service had also proved difficult (Sherlaw-Johnson *et al* 2018a). Evaluation of the nursing home support service found that the ability of nursing home staff to access clinical support improved significantly and face-to-face contact with GPs increased, which improved the quality of patients' experience of care. The evaluation also found a reduction in emergency admissions to hospital in the last months of the patient's life (Sherlaw-Johnson *et al* 2018b).

### More information

www.haveringccg.nhs.uk/Local-services/health-1000.htm

## Bevan Healthcare Community Interest Company, Bradford, UK

### Description

Bevan Healthcare is a social enterprise housed within Bevan House primary care centre in Bradford, Yorkshire. The primary care centre provides NHS general practice services for patients in Bradford and Leeds, particularly designed to meet the needs of those who are homeless or in unstable accommodation, as well as refugees and asylum seekers. Alongside general practice appointments, patients can access a wide range of support, including social prescribing, general counselling and cognitive behavioural therapy, counselling and therapy for women following rape, sexual health and family planning advice, welfare and benefits advice and a drop-in for homeless people.

Bevan Healthcare also serves the community through outreach work. This involves the 'street medicine team' offering health care to homeless people either on the street or in emergency accommodation; as well as the Bradford Bevan Pathway Team, comprising health and social care professionals who assist patients who are homeless or vulnerably housed by ensuring that appropriate discharge plans are in place following hospital admission. Bevan Healthcare partners with Horton Housing, which runs Bradford Respite and Intermediate Care Support Services (BRICSS). BRICSS provides supported, temporary accommodation following hospital admission. While staying at the unit, patients are encouraged and supported to gain the skills and confidence to live independently.

### Lessons learnt

The Care Quality Commission inspected Bevan Healthcare in 2016 and rated it as 'outstanding' in all five quality domains (Care Quality Commission 2016a). NHS England has named Bevan Healthcare as a good practice example for how it involves patients who are disadvantaged and seldom heard. Bevan Healthcare has set up an Experts by Experience Group of volunteers who have experience of homelessness or who are refugees or asylum seekers. There is a health champions programme in which patients volunteer to engage others in the community to support those with long-term conditions to self-manage. Volunteers also help out as 'waiting-room buddies' and as bus drivers for the street medicine team (*see* NHS England undated). As a social enterprise, any financial surplus is spent on improving services for patients.

### More information

www.bevanhealthcare.co.uk/index.php/en/

## New roles in general practice

The Forward View acknowledges that 'healthcare depends on people' and that even the most innovative care models will fail without the right numbers and skill-mix within the workforce to deliver them (NHS England *et al* 2014). It has been suggested that up to 20 per cent of the work undertaken by GPs could be done by nurse practitioners, while health care assistants could cover about 12.5 per cent of the work done by nurses (Wanless 2002).

Challenging the boundaries of traditional roles and supporting medical and non-medical staff to extend their scope of practice provide a real opportunity to manage the demands on general practice teams. Expanding the skill-mix within teams by introducing new roles into the team – such as clinical pharmacists, physician associates and paramedic practitioners – enables the delegation of duties. This can improve access to care, enhance patient safety and streamline patient pathways, ensuring that holistic care is delivered more efficiently, with patients being seen by the most appropriate person, who has extensive knowledge of their condition, at the right time. Access to specialist advice and support is also key to helping both patients and GPs (Robertson *et al* 2014). There is evidence, as highlighted by the examples below, that introducing new roles could successfully bridge the workforce gaps that exist within general practice, supplementing, rather than substituting, existing team members.

In this section we highlight some primary care teams who found novel ways of dealing with the challenges they faced by expanding their skill-mix and maximising the use of their workforce to improve patient access and care and to ease the burden of work on staff.

### Collaborative care, United States

#### Description

Collaborative care is an approach adopted by a number of providers in the United States. It is a specific type of integrated care developed at the University of Washington that is designed to manage common mental health conditions in primary care, based on the principles of effective chronic illness care. Trained primary care clinicians and behavioural health professionals provide evidence-based medication

or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected against a co-designed care plan, which sets out personal goals and clinical outcomes.

The care team has a primary care physician, a full-time behavioural health care manager and a psychiatric consultant working with the patient. The behavioural health care manager typically oversees 100 to 150 patients. They support the primary care physician by co-ordinating treatment, providing proactive follow-up of treatment response, alerting the primary care physician when the patient is not improving, supporting medication management, and facilitating communication with the psychiatric consultant about treatment changes. They also offer brief counselling (using evidence-based techniques such as motivational interviewing, behavioural activation and problem-solving treatment) and help to facilitate changes in treatment if the patient is not improving as expected. The psychiatric consultant does not usually see the patient, except in rare circumstances, and does not prescribe medications, but is available to the behavioural health care manager and the primary care physician for ad-hoc consultation as needed.

**Lessons learnt**

Collaborative care has been tested with patients in a number of countries and health care systems. Studies have found that it is associated with significant improvement in depression and anxiety outcomes compared with usual care (Archer *et al* 2012). A study in Minnesota identified the factors felt to be key in the successful implementation of collaborative care for depression across the state. Factors correlated with higher levels of knowledge, skills and confidence among patients in managing their own care were:

- strong leadership support
- well-defined and implemented care manager roles
- a strong primary care physician champion
- an onsite and accessible care manager.

Low remission rates at six months were correlated with an engaged psychiatrist, not seeing operating costs as a barrier to participation, and face-to-face communication and informal handoff between the care manager and primary care physician for new patients (Whitebird *et al* 2014). This informal, rather than formal, referral-based approach to accessing specialist care is seen as a key element of a collaborative care

model, taking advantage of co-location but going beyond physical co-location to a fully collaborative, shared approach to care (*see* Care Partners undated).

**More information**

https://aims.uw.edu/

## Mount View Practice, Fleetwood, England

**Description**

A report by the Primary Workforce Commission mentions paramedics as a means of bolstering the primary care workforce, stating that the use of paramedics warrants 'further piloting and evaluation' (Primary Care Workforce Commission 2015, p 23). Mount View Practice has a patient list of 11,700 in an area of high deprivation, high prevalence rates for long-term conditions and a life expectancy below that of the national average. Driven by the loss of four part-time partners – equivalent to losing two experienced GPs – and difficulty recruiting new GPs, the practice was forced to find new ways of delivering care and turned to paramedic practitioners (Spencer 2016).

To ease pressures on staff and increase access for patients, the practice developed an 'acute access team' consisting of a paramedic practitioner, a nurse practitioner, a clinical pharmacist and an on-call GP who co-ordinates care and provides support when required. The practitioners and pharmacists do the majority of the face-to-face patient contact.

The paramedic practitioner usually carries out a surgery in the morning, dealing with minor ailments, before going on home visits to see patients who are housebound or have long-term conditions. These visits constitute the majority of home visits from the practice, while the GP carries out home visits for new patients, those who have no diagnosis and, occasionally, those coming to the end of their lives.

During a home visit, the paramedic practitioner has full access to the patient's notes and can contact the on-call GP at the practice for advice by telephone or via video link, which allows the GP to see and interact directly with the patient and carer(s) to aid safe management. Interestingly, the practice has had written consent from its

local coroner stating that it would accept a death certificate from a GP following a video consultation, in the same way it would if the GP had visited in person.

**Lessons learnt**

Mount View Practice has found that releasing the GP from undertaking acute home visits, seeing patients with minor or self-limiting ailments and monitoring long-term conditions has freed up time for the GP to see more complex patients. This has improved patient access to health care by creating more appointments, allowing sick patients to be seen more quickly, and it has had a substantial effect on reducing GP stress levels (Spencer 2016).

Although there is limited quantitative evidence about the impact of this scheme, Mount View Practice reports good feedback from patients and carers and the Care Quality Commission rated as it 'good' in all domains during the last inspection in 2017 (Care Quality Commission 2017). The practice has reported that its main challenge is that paramedic practitioners are unable to undertake prescribing accreditation, although the College of Paramedics has received support from the Commission on Human Medicines to push for paramedics to be allowed to follow a common non-medical prescribing course. It also reported that some patients have requested to see a doctor but are usually reassured that the paramedic practitioner is suitably trained, not working in isolation and has access to all their information to make informed decisions.

**More information**

www.mountviewpractice.nhs.uk/

## Academy Medical Centre, Forfar, Scotland

**Description**

The Academy Medical Centre is a practice of 10,000 patients and has been moving to a team-based model of care, based on the Nuka model in Alaska, using core micro-teams to manage the list of patients.

Since July 2017, it has also employed two behavioural health consultants (one full-time equivalent) – health psychologists by training, who work with patients on issues

such as lifestyle change and managing long-term conditions and offer brief focused mental wellbeing interventions. They are based within the practice, supervised by the local psychology team. They spend time talking to core team members and these informal conversations mean they can be ready to provide responsive support and same-day appointments for some patients. The behavioural health consultants have some pre-booked appointments but also keep time free so that a GP or nurse can bring a patient along to meet them opportunistically. If a GP knows that a patient is attending on a certain day, the behavioural health consultant can keep some time free at the same time to facilitate a handover. There are no formal referrals, just a note added on the shared information system for the health psychologist to pick up that day.

### Lessons learnt

Regular team 'huddles' allow for more in-depth conversations about what is going on for the patient. This allows a more effective understanding of the patient's likely needs, rather than second-guessing a referral form, and the behavioural health consultants can then provide direct feedback to the GP. Clinicians feel that the service has been most effective for those patients who might be resistant to using other services; for example, they might need to access weight-loss support, but do not attend external groups even after a referral. The patients are introduced informally to a behavioural health consultant by another health professional whom they already trust and are seen in a familiar location. The behavioural health consultants are then able to more easily build trust to work, for example, on a patient's motivation and any psychological barriers they have.

### More information

www.academymedicalcentre.co.uk/

## Iora Health, Boston, Massachusetts, United States

### Description

Iora Health's model uses a significant number of non-medical staff to serve its diverse list of 40,000 patients across 29 practices and 11 states. It focuses on providing patients with the required emotional and practical support to engage with their health and adopt health-promoting behaviours. It strives to achieve this by incorporating health coaches into their teams.

Iora Health's clinics are typically staffed by two to three GPs, a clinical team manager (usually a nurse), a social worker and six to nine health coaches who are split into teams and assigned patients, for whom they act as advocates. The health coaches are often recruited from customer service backgrounds and are hired for their relationship-building. The team works with the patient to set health goals and the health coach actively supports the patient to achieve those goals.

On clinic days, the health coach greets the patient on their arrival and sits with them to discuss how they are progressing, find out any concerns they have or issues they are dealing with, and review the patient's agenda for the visit. They follow the patient into the consultation with the doctor, where they serve as the patient's advocate. After the consultation, the patient and their coach review the treatment plan together, enabling the patient to clarify any points they may have misunderstood. The health coach uses this time to provide the patient with the education and coaching required to achieve the goals that they have set together.

### Lessons learnt

This model enables continuity of care and allows appropriate care to be provided for the patient within the context of their lives. Knowledge of the patient's social situation also allows the health coach to identify and seek solutions for factors that are having a negative impact on the patient's health. Daily morning 'huddles' enable staff to discuss patients they are concerned about, therefore enabling proactive, holistic care provision before a situation escalates. Iora Health claims that its model has resulted in a 30–35 per cent reduction in emergency department attendances, as well as a 28–41 per cent reduction in inpatient admissions, and it has high patient satisfaction rates.

### More information

www.iorahealth.com/

## Whole-system redesign

We end this chapter on ways of working by briefly considering general practice redesign in the context of the redesign of the whole health system. There are a number of systems across the world that have recognised the importance of placing general practice or family medicine at the centre of their redesign initiatives. The King's Fund has previously argued that general practice should take the lead in developing care out of hospital by taking responsibility not only for its own services but also for many other services used by patients in the community. We proposed a move away from the model of small, independently minded practices towards new forms of organisation that enable practices to work together and with other providers to put in place the integrated services that are required (**Addicott and Ham 2014**).

A model of primary care has been emerging internationally, known variously as the patient-centred medical home, the primary care home and the health care home. Systems adopting a patient-centred medical home model generally work at scale to deliver services that meet the vast majority of patients' physical and mental health care needs. The Agency for Healthcare Research and Quality in the United States defines a medical home 'not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care' (**Agency for Healthcare Research and Quality undated**). It encompasses the following attributes:

- comprehensive care
- patient-centred care
- co-ordinated care
- accessible care
- quality and safety.

## HealthPartners, Minnesota and Western Wisconsin, United States

### Description

HealthPartners is a large consumer-governed, not-for-profit health care organisation in the United States, providing both health care services and health insurance. It is the first large, multispecialty group in the United States to have all of its 55 primary care clinics designated as patient-centred medical homes. Central to this has been its adaptation of the Wagner chronic care model, applying it not only to chronic conditions but also across all primary care delivery, through an approach called the 'care model process'. The aim of this model is to have 'prepared practice teams interacting with informed, activated patients through continuous healing relationships supported by the ongoing availability of health information' (Bisognano and Kenney 2012, p 13).

The care model process has been described as standardising how HealthPartners does care – patients can expect reliable, standardised, high-quality care wherever they go in the system. First, reliable systems and processes are designed, and then care is customised to the needs or preferences of individual patients. Wherever possible, the process starts with planning before a clinic visit – identifying which patients need to attend and what they need in terms of preventive care, as well as any ongoing monitoring of existing conditions. When the patient attends, care is provided by a team and not just the doctor, with each professional working to the 'limit of his or her licence'. The process also requires follow-up after the visit, such as the provision of a written after-visit summary, which the patient takes home with them, and the provision of support between clinic visits.

Part of the system-wide redesign has been the need to improve access, and this is called 'call, click, or come in', utilising the telephone and internet as well as face-to-face contacts. An online portal called 'virtuwell' (www.virtuwell.com) allows patients to access support 24 hours a day. Changes in primary care have also been integrated with the wider system, by creating common, reliable pathways across specialist and primary care, using integrated information systems and common processes.

Over a five-year period, HealthPartners has seen a 7 per cent fall in hospital admissions and an 11 per cent fall in readmissions. There has been a narrowing of inequalities between different ethnic groups in the number of women being screened for breast cancer, with the overall rate increasing; and GP satisfaction scores across a range of measures have increased significantly.

**Lessons learnt**

Leaders of HealthPartners have identified the following key elements of the successful redesign of its care process:

- a clear vision – shared by senior leaders and board members, with ambitious goals and transparent reporting
- the right leadership structure – the pairing of administrative and GP leaders was key
- simple design principles – reliability, customisation, access and co-ordination
- cultural change to support team-based care
- the involvement of patients and families in the change process.

**More information**

www.healthpartners.com

General practices are increasingly coming together in larger groups, either to form super-practices or to work in large networks or federations. In the UK, these groups are mostly in their infancy and the wider NHS does not have a clear approach on how to partner or contract with them. New Zealand is an example where mature networks (federations) of practices have developed over the past 25 years and now have a central role in supporting general practices and delivering community-based care, integrated with the wider system. One of these is Pegasus Health, a key partner in the Canterbury health system, with 500 GP members working from 94 sites (*see* www.pegasus.health.nz). Pegasus was formed in 1992 with a strong clinical education foundation and a focus on reducing wastage on unnecessary laboratory tests and prescriptions. It now functions as a primary health organisation – holding the contract for primary care services from the district health board – as well as supporting general practices and community-based health providers within Canterbury to deliver high-quality services to 400,000 people. The King's Fund has documented the Canterbury story well in previous publications (Charles 2017; Timmins and Ham 2013).

## Pinnacle Midlands Health Network, Hamilton, New Zealand

### Description

Pinnacle Midlands Health Network is a not-for-profit primary health care management company, which works on behalf of Pinnacle Incorporated (a network of 85 practices in the Midlands region of New Zealand, caring for half a million people). In 2010, in response to workforce and demand challenges, it adopted a health care home model, based on that developed by Group Health in the United States. Like the Group Health model, and other patient-centred medical home models, it focuses on timely unplanned care, proactive care, routine and preventive care, and business efficiency. Key features include:

- a centralised call-centre access point as the first point of contact for patients across several practices, although patients calling the number, even out of hours, will feel it is their own surgery as access to electronic records allows staff to respond
- telephone triage by clinicians to proactively manage acute demand
- clinical 'pre-work' for booked patients to ensure that they need to be seen, that any preliminary tests have been done and that clinicians are aware of any opportunistic actions that are desirable when they are seen – this comprises 'fishing' (ideally done two or three days before an appointment) and a 'huddle' (first thing every morning and focused on smoothing out the day's work)
- the provision of a web-based portal, which allows patients to review selected medical information about them, including any medication they are on and test results, and to securely communicate with their GP about e-consultations
- building changes to support new ways of working, including the standardisation of consulting rooms, with clinicians using whichever room is available, and the creation of an 'off-stage' space, separate from patient areas, where clinicians can take telephone calls, work on the computer, process paperwork and consult with each other
- the development of new professional roles (eg, clinical pharmacist and medical centre assistant) to expand the capacity and capability of general practice.

As well as the work with general practice to proactively manage patients and increase access, the health care home model also supports improved co-ordination of care across the health and social care system, wrapping an integrated extended care team around those people with more complex needs (Ernst & Young 2017).

**Lessons learnt**

A recent evaluation of the model found evidence of improvements, including more planned and productive time with patients, despite similar face-to-face time, and an increase in capacity. However, it also found that the implementation of the model was complex, required significant change management and took time. After five years, there had been a fundamental shift across all areas of the business, but this was incremental and some changes took longer than others to achieve. A key feature was the implementation of a package of changes based on best practice, including: an expansion of the team; a new role of medical centre assistant; a centralised patient access centre; and the use of the 'Lean' quality improvement method to improve efficiency. It is now being scaled up across other regions and practices.

**More information**

www.pinnacle.co.nz/midlands-health-network

In England, the primary care home model, launched in April 2016, has rapidly evolved and spread throughout England to now cover a total population of approximately 8 million people. Primary care homes aim to provide streamlined and co-ordinated care within a community setting to improve the health and care outcomes of local populations of around 30,000–50,000 people. The model has four key characteristics (National Association of Primary Care 2016):

- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
- a combined focus on the personalisation of care with improvements in population health outcomes
- aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards
- provision of care to a defined, registered population of between 30,000 and 50,000.

## Team Bollington, Disley and Poyton (BDP) Primary Care Home, Cheshire and Merseyside, England

### Description

The Team Bollington, Disley and Poyton (BDP) Primary Care Home is a partnership between four GP practices and various health and social care professionals including the local ambulance service, located together and operating out of a 'community hub', which in this case is the GP practice. It covers a population of 33,000, with a significant number of older people, across three villages. The collaboration leading to the creation of the primary care home was founded on a shared desire to tackle local issues of social isolation and the lack of co-ordination within and between health and social services. These issues were particularly affecting frail and diabetic patients, leading to significant variations in hospital admissions and extended lengths of stay.

### Lessons learnt

By working together and, in most cases, members of the team being located in the same place, Team BDP can put its patients at the centre of the services it offers. Regular multidisciplinary team meetings identify frail, complex and multi-morbid patients and proactive care plans are put in place before they become acutely unwell, to reduce their risk of admission to hospital. Through its collaboration with local hospital services and specialists, Team BDP can reduce hospital attendances by providing as much care within the community as is safe.

Services are not only directed at people living with long-term conditions, as exemplified by the plans to create urgent paediatric and minor illness clinics for 12 hours a day, and a call centre where patients can be triaged, given advice or signposted to the most appropriate health or social service. This integrated approach not only enables a holistic provision of care that reduces polypharmacy (the use of several medicines at the same time) and increases safety, but also improves access to care and ensures that patients are seen more quickly by the appropriate person to help with the issues they are dealing with. Staff have reported greater satisfaction with work, there has been a reduction in hospital admissions and there have been cost savings due to holistic medicine reviews.

### More information

https://napc.co.uk/wp-content/uploads/2017/09/NAPC-case-study-Team-BDP.pdf

In 2015, NHS England selected 50 health and care systems to take a lead on the development of new care models, with the intention that these 'vanguards' would act as blueprints for system change for the NHS moving forward. Nearly all of these vanguards had general practice as a core component of the system redesign, but many have simply focused on integrating existing practice delivery models with the wider system. However, a small number have included the redesign of general practice care as a key element of overall system change.

## Symphony Programme, South Somerset, England

### Description

The vanguard South Somerset Symphony Programme is a partnership between 19 GP practices, Yeovil District Hospital, Somerset Partnership Community and Mental Health Trust, Somerset County Council and Somerset Clinical Commissioning Group, along with a number of third sector and voluntary groups, delivering care to a population of 135,000. The programme is supporting the implementation of new models of care within primary and community care and Yeovil District Hospital, with a particular focus on patients with more complex needs but also supporting people more generally to improve their health and wellbeing.

Leaders from south Somerset have worked closely with colleagues from Iora Health in Boston, United States (described earlier) in developing what they have called 'enhanced general practice'. This approach uses mainly non-clinical staff as health coaches who work alongside other members of the practice team and provide support to patients with long-term conditions. This support helps patients to modify their lifestyles and manage their conditions. The coaches also help to co-ordinate their care. The practice teams have internal meetings or 'huddles' several times a week, with some practices meeting every day. All members of the practice attend, including reception and administrative staff. At the huddles, patients who are causing concern are discussed – these could be people just discharged from hospital, people who have attended A&E or contacted the GP out-of-hours service, people with a new cancer diagnosis, cases where there are child protection concerns or people who are at risk because of a change in their social circumstances. The health coaches help other staff to co-ordinate these meetings.

Somerset CCG has invested around £1 million in health coaches (43 whole-time equivalents) who are allocated to practices based on one full-time coach for approximately every 3,000 patients. A further addition to the primary care system has been the creation of three complex care teams, with each team supporting a cluster of practices and consisting of an 'extensivist' (a GP with further training in

caring for older people with complex needs), a complex care nurse and a keyworker, who is normally the first point of contact for patients with the team. These teams were initially standalone teams but now each cluster has a complex care support practice, with the complex care team integrated with the practices and working from three bases shared with the community nursing teams.

### Lessons learnt

Working with a partner organisation, in this case Iora Health, provided external knowledge and advice particularly around implementation. In addition, Symphony had input from an international expert in large-scale change, which was invaluable, and external support was provided to practices to help introduce the changes. They also drew on lessons from the Nuka model of care in Alaska and the Canterbury health system in New Zealand. Before implementing this new care model the local system invested significantly in population health analytics to understand the health of the local population and where the money went. This data was broken down to practice level and each practice was able to see the total system cost, with a detailed breakdown, of delivering health and social care to their registered list of patients. This information was important in engaging local practices in the redesign programme, with the prospect of releasing resources from elsewhere in the system into primary care.

Interviews with GPs involved in this system reveal a new mindset of moving from reacting to issues that arise through the day, to a proactive, forward-planning approach to care. They have also seen their workload reduce, with one practice seeing a 29 per cent fall in the percentage of appointments being carried out by GPs, following the introduction of team 'huddles' and health coaches. One GP described the change in his working life as 'bringing back the joy into general practice'. For a video description of a day in the life of a Symphony GP, *see* Symphony Healthcare Services (2017).

Along with other initiatives introduced in local nursing homes and at Yeovil District Hospital, in the past year the system has seen a 3.1 per cent fall in non-elective admissions to the hospital for south Somerset residents, and an 11.5 per cent fall in non-elective hospital bed days. The hospital has also been able to close 18 beds. Local health leaders are convinced that the enhanced general practice initiative is a major contributor to this.

### More information

www.symphonyintegratedhealthcare.com

# 6 Design for the future

We found many innovative examples of general practice during our research, with different approaches being used to tackle similar problems. Any new model of care for general practice will need to ensure that all five core attributes of general practice that we have identified in this report can be provided for the population it serves: access, continuity, co-ordination, a community focus and patient-centred care. While some of these elements may be more important for some patients than for others and at different times, models that focus on just one of these at the expense of the others risk providing a less effective and equitable service.

While there is unlikely to be a single model of general practice for the future, we have identified common design features – set out in this section – that we believe will be important. Some of the innovations we have described have struggled to achieve the objectives they set for themselves. Reasons given for this include insufficient capacity to introduce the changes needed; lack of high-level commitment to change; and workforce challenges. These issues that hinder implementation and spread of innovation echo those raised by research in other sectors (Dougall *et al* 2018; McCannon and McKethan 2013) and will need to be addressed if general practice is to innovate to meet rising demand and to support people to live healthy lives.

## Building and maintaining strong relationships

Common across most of the models we studied was a renewed focus on relationships – between patients and professionals, between professionals within general practice and beyond, and between general practice and wider communities.

### Between patients and professionals

Despite the recent policy emphasis on access to care, which has prioritised speed of access over other dimensions of access, we found that many innovative models had focused first on building stronger, more proactive and continuous relationships with patients. These team-based approaches to relationships had in turn enabled

better access by freeing up time for GPs to see patients with more complex need, either for diagnosis or significant changes to their management plan. This approach is underpinned by improved relational continuity which in turn builds trust between patients and professionals.

Producing better health and health services with the involvement of patients was a common feature of many of the models we studied and any future model of community-based care should be designed to empower people to take control of their own health and care as far as possible (**Charles *et al* 2018**). This could involve approaches that seek to understand people's desire and ability to manage their own health and then find the most appropriate intervention for them (**Hibbard and Gilburt 2014**). Interventions include health coaching and peer support and might also involve digital solutions to help empower and engage people, such as giving them access to their medical records.

Models of care that are developed jointly by both professionals and patients, such as the 'house of care' model for people with long-term conditions, require professionals to work with and understand the patient's goals, motivations and personal assets to produce a personalised care plan for that individual (**Coulter *et al* 2013**). This form of proactive partnership between clinician and patient is not just applicable to those with long-term conditions but is also appropriate for many patients with more complex problems who are seen in general practice. Working in this way requires time, either in a single consultation or over a series of consultations with the same health professional or small team. 'Transactional' models, which aim to ease access demands by providing quicker access to a GP – such as via walk-in centres or instant online GP access – do not support this trust to develop. When trusting and respectful relationships exist, professionals are better able to work in partnership with their patients, for example to support health-promoting behaviours or to negotiate effective antibiotic prescribing. This in turn helps general practice to meet population and public health, as well as individual health needs (Rosen 2018).

### Between professionals

Common to many of the models was the creation of stronger relationships between professionals by moving away from the traditional one-to-one patient–practitioner interaction to a micro-team approach, which involves a core team of professionals

working together to support a registered list of patients. These teams appear to provide a number of benefits, including:

- better relational continuity of care for patients
- improved access (as patients know they can access advice and support through routes other than a GP consultation)
- longer appointments, as GPs and nurses are freed up to focus on those issues where their skills can add the most value.

Having professionals located in the same place was also important, providing multiple opportunities for informal handoffs and discussion rather than going through more transactional referral processes.

The examples we found suggested that micro-teams comprising 4 staff, caring for around 1,400 patients, were the most effective, but these teams needed to be part of a larger group to provide patient access to a wider range of extended services (such as physiotherapy, pharmacy and behavioural health). There is as yet limited evidence of what patient list size or team membership is ideal in a UK setting, and also what wider network of support is best. We discovered practices testing different models with the aim of both delivering better outcomes for patients and creating working conditions for staff who are looking to restore their 'joy in practice' (Sinsky *et al* 2013).

### Between professionals and communities

Many of the innovative models we studied had invested time and money in working with their local populations to determine the best model for that population and saw ongoing involvement with their communities as key. From Alaska, to the Scottish Highlands, to Somerset and Surrey, we found good examples of community engagement and patients being involved in the development of services. This echoed findings from previous research, which identified communities driving health and care innovations and providing ideas that shaped completely new models of care (Dougall *et al* 2018). These communities were able to use information such as stories, experiences, recounts, enquiry and dialogue as powerful tools for the transformation of general practice. Empowering local people to become effective representatives who can be involved in wider system developments will

also be important if general practices are to truly generate patient-centred services. This requires ongoing investment and support, including appropriate training and recognition.

With a growing recognition of the role of place and community in people's lives, new models of general practice will need to find creative ways of connecting people to the wider range of resources that communities can offer. They will also need to see general practice as a broker between the patient, the community and wider health and care services and a facilitator of health and wellbeing. Such models often combine a range of initiatives, including volunteers and support for people to use their own skills and capabilities within their community (Gilburt *et al* 2018).

## A shift from reactive to proactive care

A feature of many of the models we studied was a shift towards proactive and planned care as opposed to reactive and transactional care. For many this was a fundamental shift in their ethos of care. This shift involved using electronic records to their full potential, with administrative staff contacting patients before their appointment to check that any necessary tests had been done and to see whether anything else might need to be done, and contacting them to prompt them about follow-up care or immunisations. It often involved health care assistants or medical assistants greeting and 'rooming' patients as they arrived at the practice, taking basic observations, checking records again for any preventive measures that are due and preparing the patient for their consultation, leading to a more effective use of time for both patients and health professionals. A number of models used staff working as health coaches or similar, to provide ongoing support and follow-up for patients after their clinic visit. Models that focus on more reactive, transactional approaches may be less able to provide such timely, comprehensive care, and are likely to require repeated clinic attendances to complete preventive measures such as immunisations or follow-up.

## Developing skill-mix

Multiple studies have focused on new roles and the appropriate skill-mix for general practice, not least because of the ongoing shortage of GPs but also because of the growing number of different issues and tasks that general practice has to tackle. Key to making the new roles work will be to understand their place in the

core general practice team, or wider team, and to build relationships between professionals so that patients do not face multiple handoffs or get confused about how to access care. We found that systems that promote informal referral, advice and consultation were more effective than transactional form-based referral processes. In choosing what additional roles to add to the team, it is essential that practices have a deep understanding of the needs of the population they serve and employ/train the right professionals with the right skills, supported by appropriate governance structures, to provide that care (**Primary Care Workforce Commission 2015**). It is also important to recognise that changing the skill-mix in a team usually requires the redesign of work processes. This can be threatening for those whose roles are changing and significant people skills are required to implement this type of change effectively.

## Using technology

Our case examples suggest that there are many ways in which digital solutions aid effective general practice, but these innovations should underpin ways of working rather than replace them. Much recent policy is focused on digital access, and many patients will benefit from this, but it should complement rather than replace teamworking. A small but significant proportion of the population in England is digitally excluded or has communication difficulties that would make digital access less appropriate for them.

Effective information-sharing systems are fundamental to the success of networked models of care, with professionals able to access and share information easily, including out of hours and on home visits.

The regular use of data for quality improvement and development was a feature of many of the models we studied, and evidence from high-performing health care systems shows how often change begins by using data to expose issues (*see* **Alderwick *et al* 2017**).

## General practice working within a wider health system

While this report has not focused on general practice working at scale or system-wide organisational models, the ability to access a wider network of care services is important if general practice is to deliver comprehensive, patient-centred care.

For too long general practices have worked in isolation and initiatives such as Primary Care Home are beginning to connect practices with the wider health and care system in an exciting way. NHS England expects local health systems to ensure that all general practices are working within a wider network of practices covering a population of 30,000 to 50,000 people by April 2019, wherever possible (NHS England and NHS Improvement 2018). There is increasing recognition that general practice must be a core component of efforts to integrate health and care services through the emerging integrated care partnerships and systems. The most ambitious of these plans are focused on improving population health by tacking the causes of illness and the wider determinants of health (Ham 2018), and general practice has a key role to play in those plans. Bringing practices together to work at scale and in partnership with other health and care providers must not be at the expense of redesigning the way in which care is delivered to individuals and families; or the need to build collaborative partnerships with immediate local communities and to improve the working lives of the professionals working within general practice.

Common to many of the models we investigated was the move away from a transactional referral process to a more collaborative model of care. The ability to locate specialist advice and support alongside general practice was also important, as this enabled informal discussion and support. Patients may also be more likely to engage with wider services if they are located in a familiar setting. Focusing on particular populations through segmented models of care may make this more cost effective, for example providing a focus for the care of groups who need a common set of specialist inputs, such as frail older people or homeless people.

## Supporting general practice to change

Making radical changes to the model of general practice, such as those undertaken by the case examples in our study, is complex and takes time, leadership and resources. We have previously emphasised the importance of the time needed to build local relationships and transform local services, and this was echoed in our study, as was an iterative approach that built on the energy and engagement of the local community, allowing time for continual testing and refinement of plans (Dougall *et al* 2018).

We learnt in our research that while general practice in England has potentially more freedom to 'get on and do' than in the past, it often has less access to the financial or human resources needed to undertake the kinds of change we have highlighted in this report than other NHS organisations. For example, it has less access to the management skills required, such as organisational development intervention, improvement expertise and experience in the use of techniques such as 'Lean'. There are, however, some good examples of support for general practice to gain access to these skills, such as the EQUIP programme developed by Tower Hamlets CCG which provides a quality improvement programme for its practices, including coaching, training and collaboration (EQUIP Tower Hamlets undated) and the Cumbria Learning and Improvement Collaborative (CLIC), developed by Cumbria CCG in partnership with the county council and the NHS trusts in Cumbria.

Key to any successful intervention is understanding the motivations of the different stakeholders involved, and ongoing engagement with professionals, patients and communities. This takes a significant investment in leadership time, which is hard when general practice is under pressure. While we have not addressed wider structural or organisational issues in this report, it may be that opportunities to work at a larger scale will be the means by which time can be freed up for clinicians and managers to implement change both within practices and in the wider community, without losing the local community focus that is core to general practice.

# 7 Conclusion and recommendations

We realise there is a real tension in developing a model of general practice that:

- provides person-centred, holistic care
- is easily accessible
- provides long-term relational continuity of care where this is important
- co-ordinates care for those patients who need this
- grounds everything in local knowledge and a commitment to the local area without a significant increase in capacity.

We think that while more resources are still required, the challenge is for practices to have the organisation and structure to enable all of these elements to be in place, while having the flexibility to find the unique 'sweet spot' across these dimensions for each individual patient. But as our research has demonstrated, there are many practices delivering innovative, creative services.

Delivering person-centred and holistic care requires general practice to be at the heart of the development of new models of care and integrated care systems across the NHS. These models and systems should start with individuals and families, and the communities in which they live, and general practice must maintain its position within these communities. New models of general practice may be the key to unlocking the potential of new system-wide models of care; grounding them in local communities and providing holistic, continuing and co-ordinated care for patients, which is based on strong, trusting relationships with professionals who know them and their communities. The evidence is clear that this approach delivers benefits to the whole system, reducing pressure on specialist services, delivering better health outcomes for patients and improving the working lives of those working in general practice.

Based on our research we now set out a series of recommendations for general practice, system leaders and commissioners, and national policy-makers.

## General practice

- Practices should endeavour to produce new models of care in partnership with patients and their wider community. The design principles we have highlighted in this report may provide a useful guide to these discussions, drawing on evidence of best practice.
- Models based on co-located micro-teams have the potential to provide general practice with the means to deliver accessible, high-quality, person-centred care. General practice leaders should learn from the evidence about these models when designing new approaches, making the most of the wide range of skills within practices that will best meet the needs of the local community.
- Access to a wider set of skills and resources – including pharmacy, mental health expertise, maternity and specialist advice – is also critical, and practices will need to collaborate to develop services that can provide effective access to these resources.
- Practices will need to access support for service development, including organisational development, to help them develop effective models of care. Piloting, testing and refining models organically is likely to be an appropriate approach.
- There has not been the same investment in general management in primary care as there has in secondary care, and practice managers on the whole remain isolated and unsupported. There should be greater efforts to support practice managers, particularly in accessing quality and service improvement skills.
- With access to appropriate support, GPs should seek to work with technology partners who can support these new ways of working, prioritising partners and technologies that are most useful to their patient population.
- As practices merge and grow in size, it is important for them to reflect on the five core attributes that we have described and to consider what impact any structural changes may have on these attributes of care. New processes and models of care may need to be introduced to improve or maintain, for example, relational continuity of care for patients with complex problems.

## System leaders and commissioners

- System leaders must understand the centrality of effective and high-quality general practice in delivering system-wide change. Investment in new models of care has system-wide benefits as well as securing a strong primary care base and system leaders should actively engage general practice at all levels of planning and delivery.
- System leaders working with local voluntary, community and social enterprise organisations should facilitate the building of strong links with general practice. Clinical commissioning groups that are involved in and work with local communities to transform how care is provided are well placed to support innovation in general practice, both through supporting the development of helpful conversations and relationships with local communities and in any necessary shifting of resources.
- System leaders should consider opportunities to develop and support professional roles that span care settings, providing varied, flexible and attractive roles that also support an integrated approach to patient care.
- Commissioners should seek to foster and support digital innovation in their local practices, particularly technologies that go beyond just improving access – looking for those that promote self-care, shared decision-making and the co-ordination of care. Technologies to support the sharing of clinical information and the promotion of communication between practices and across the wider system are also needed.
- Clinical commissioning groups should take a range of approaches in supporting general practice. They should work with general practice leaders to identify priorities for their local area and support them to develop and test appropriate new models. This support should include funding to support the training of practice staff in change management processes.
- Capital funding should be easily available to support the required transformation. This may include investment in estate to enable the co-location of professionals and in technology to support information-sharing and improve access.

## National policy-makers

- National policy-makers should continue efforts to support the transformation of general practice, offering easy access to funding for general practices to invest in the activities required to undertake that transformation, including leadership and organisational development support, project management expertise and capital funding. This should be reflected in ongoing contract negotiations.
- Policy initiatives focused on improving access should be mindful of the unintended effects of this on the ability of general practice to deliver continuity of care and community-focused and co-ordinated care.
- There should be investment in ongoing research and evaluation of new models and initiatives, to share learning and support change leaders.
- Workforce development strategies should reflect the need for a multidisciplinary team approach in general practice, creating a workforce that is flexible enough to respond to local needs and offer local solutions and providing multidisciplinary approaches to training.
- Workforce strategies will also need to take account of the need to support sustainable and attractive careers in general practice, reflecting changing work preferences among health care professionals, for example a desire for flexible working and for portfolio careers.
- Funding for technology should go beyond monies and procurement frameworks for specified technologies; it should also support practices in using digital technology to interact with their patients. National policy-makers should provide clarity about what they expect from general practice with respect to the many existing digital initiatives, which include the outdated Patient Online programme, NHS England's digital experience and the NHS Apps Library.

Underpinning all of these recommendations will be access to adequate resources to meet rising demand. While changes to the model used in general practice may unlock efficiencies and reduce expenditure on hospital admissions, it will require more investment in general practice and other community health and care services to make those changes happen.

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The King's Fund Ideas that change health care

General practice is in crisis. Previous work from The King's Fund found general practitioners (GPs) dealing with a rising, more complex workload. Funding has not been growing at the same rate as demand, leading to a profession under enormous strain and facing a recruitment and retention crisis. But how can general practice address these challenges?

*Innovative models of general practice* draws on national and international literature and interviews with primary care leaders in the UK and internationally to develop a set of principles to guide the development of new models of care that might address the challenges facing general practice.

The authors provide examples of a range of innovative models and conclude that building strong relationships – between patients and professionals, between professionals within general practice and beyond, and between general practice and wider communities – is central to the success of many of the models they studied and suggest that any new model of care for general practice will need to include five core attributes:

- person-centred holistic care
- accessible care
- co-ordination
- continuity
- community focus.

Models that focus on just one of these at the expense of the others risk providing a less effective and equitable service. Based on the research the authors set out recommendations for general practice, system leaders and commissioners, and national policy-makers. Underpinning the recommendations will be access to adequate resources to meet rising demand.

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