

Herefordshire Health Scrutiny Committee

**Report by the
Herefordshire GP Services
Review Group**

(For Presentation to the Health Scrutiny Committee on 1 March 2010)

Contents

	<i>Page</i>
Introduction	3
Executive summary	4
Rationale for review	6
Methodology	6
Background to Herefordshire – a rural county.....	7
Background to Herefordshire GP services	8
Links to the Herefordshire Community Strategy, and legal and policy framework	9
Findings and recommendations	10
* Continuity of care	10
* Equitable access	11
* Preventive services	16
* Rurality	18
* Extended hours	19
* Out of hours services	20
* Appointments	21
* Quality of service/patient experience	22
* Collaboration/co-ordination/integration/communication	25
* Relations between GPs and NHS Herefordshire and how they affect patients	28
Recommendations	30
Appendix A Visits and interviews.....	34
Appendix B A&E GP triage pilot 2008 report.....	35
Appendix C Scoping document	37
Appendix D World Class Commissioning GP service data	42
Appendix E Herefordshire GP access survey results.....	46

Acronyms

A&E.....	Accident and Emergency
BMA	British Medical Association
CAMHS	Child and Adolescent Mental Health Services
DMHOP	Department of Mental Health for Older People
GMS.....	General Medical Services contract
GP.....	General Practitioner
HSJ	Health Service Journal
IT.....	Information Technology
LMC	Local Medical Committee
NHS	National Health Service
NICE	National Institute for Clinical Excellence
OOH.....	Out of Hours services
PBC.....	Practice Based Commissioning
PCT.....	Primary Care Trust
PMS	Personal Medical Services contract
PWLD	People with Learning Disabilities
QOF	Quality and Outcomes Framework
WCC	World Class Commissioning
WRVS	Women's Royal Voluntary Service

A note on terminology used in this report:

Two different terms are used synonymously throughout this report:

- 1 'PCT' and 'NHS Herefordshire' and
- 2 'surgeries' and 'practices'.

This is because GP and patient sources tended to refer to 'PCT' and 'surgeries', whereas NHS Herefordshire staff tended to refer to 'NHS Herefordshire' and 'practices'.

Introduction

I have pleasure in presenting this health scrutiny review of General Practitioners' (GP) services in Herefordshire.

May I start by thanking the review group members, Cllr Philip Cutter, Cllr Brigadier Peter Jones, Cllr Gordon Lucas, Cllr Glenda Powell and Cllr Peter Watts for all their help, input and support during the review process.

I would also like to thank every GP practice in the county and the Local Medical Committee. They have all contributed in one way or another and to those who hosted us and gave of their time, a very special thanks indeed. The staff of NHS Herefordshire also supplied many of the demands we have made of them. Finally, a very special thanks to the greatest supporter of our work during the review, Sara Siloko. This document would have been much harder to produce without her tireless enthusiasm and extremely hard work.

The GP's surgery is the first point of contact with the health service for most people. It was satisfying to find that GPs, almost universally, enjoy a very high standing in the communities they serve. The theme that emerged was that of the importance of continuity of personal contact in nearly all aspects of the service. From the relationship between GPs and NHS Herefordshire to the services provided by community nurses, social workers and mental health nurses, continuity proved to be a vital part of any treatment programme.

One area that is cause for some concern is in the field of mental health care. You will find a number of references to this subject throughout the report. The group is aware that changes in the delivery of this service are being made. However, when a GP stated that they had been told only to refer patients in crisis, some alarm bells rang. The question of how this situation came about should be asked so it may be avoided in future.

It may seem that the report has overly focused on the relationship between GPs and NHS Herefordshire. This issue dominated some conversations we had at surgeries and with NHS officers. The group felt that this was an area of concern even though this relationship has not yet had a significant impact upon the service GPs provide. It was thought that there were issues in the longer term that would eventually be felt by patients and that it would be better to highlight these issues now rather than wait for a crisis.

Finally, there may be some that find an over emphasis on anecdotal evidence. I make no apology for this. The aim of the report is bring together all strands of opinion as they may all be of equal validity.

I commend our report and its findings to you.

Councillor Alan Seldon
Chairman of the Herefordshire GP Services Review Group

Executive summary

The review group believes that the **qualitative evidence** it has gathered and analysed for this report has its own great power in illuminating issues that may otherwise be swept aside in the quest for hard data. It has used statistics where relevant and available. Its recommendations are suggested in the light of these findings.

This report reflects the group's conclusions, and sets them in context. The review group wishes to emphasise that this is a **complex area of work** and would not claim that its report is comprehensive. It does, however, hope that the report provides some useful and impartial observations on the service and basic recommendations for improving the excellent work already undertaken by GPs in Herefordshire.

One overall recommendation is that NHS Herefordshire and GP practices more openly acknowledge, support and resource the entrenched and much-respected role of **GPs as key community gatekeepers**. One way of achieving this might be to locate an advocacy/co-ordination/signposting worker in each surgery who would act as a 'key worker' for patients, or by co-located multi-disciplinary team working. This is especially important because more local/community resilience could be an effective weapon to combat the growing economic pressures under which services are provided. In conjunction with the above, GP surgeries could offer more effective signposting to housing services, nutrition advice and other wellbeing information.

Continuity of care has emerged as one of the most vital cross-cutting themes among the review group's more specific findings. Patients, GPs and other service providers alike acknowledge that it is a key element in achieving patient satisfaction and good outcomes. Lack of continuity between GPs and NHS Herefordshire, between patients and their doctors, and between GPs and other services, have all been raised as issues of concern which inhibit the effective delivery of GP services to their patients.

Most GPs interviewed stated that the **relationship between GPs and NHS Herefordshire** was cause for some concern but that this was not having a tangible adverse affect at this stage on patient outcomes. It is clear from both sides that there is friction between them. However it is clearly not in anyone's interests to continue in a state of barely restrained antagonism when managing and delivering one of the most important services to the citizens of Herefordshire. So it is vital that better partnership working, to improve that relationship, be undertaken effectively without delay. Continuity of contact between staff would go some way towards improving this.

Budget 'silos' - particularly the divisions between health and social care budgets – should be dismantled where possible. This would help avoid confusion and misguided attempts to conserve money in a particular 'pot', and would be in the interests of a smoother patient pathway.

Related to **preventive activity**, GP practices could routinely add more minutes to their appointment times in order to ask more opportunistic questions of patients, and offer advice, on issues such as risk of falling, diet, exercise etc. Public education programmes that are properly targeted could help prevent some conditions, such as obesity, and some unnecessary visits to A&E.

As NHS Herefordshire rethinks how to strengthen **vulnerable mental health services**, health scrutiny and service user groups should be involved in throughout this process, which should have begun before consultation even started, before the tender process got under way, to ensure the questions asked are those that are important to service users and family carers.

Apart from participating in statistical surveys, **patient and public involvement** in shaping GP services appears minimal. GP surgeries could ask patients to contribute the questions they consider important, when formulating their annual patient surveys, in order to ensure real concerns are addressed. More surgeries could also form patient groups which have sufficient independence to act as 'critical friends'.

GP practices should work more closely with school clinics and youth-led organisations to improve access to services for **young people**.

Rationale for review

The health scrutiny committee decided to undertake this review of GP services in Herefordshire at its meeting on 23 March 2009 because it was keen to determine if these highly-regarded services were able to meet equitably the needs of all groups and individuals in the county in the light of changing county demographics, changing service provision and resourcing levels, and of organisational changes affecting the county. The committee also wanted to find out the extent to which GP services were meeting the preventive challenges outlined in the Director of Public Health's 2008 report.

Methodology

The review is based on a scoping document (see Appendix C) that outlines desired outcomes, key questions, timetable and members of the review group. As the group's investigations proceeded, it became apparent that some of the questions set in the original scoping document were less relevant than others in terms of achieving the review's overall outcomes.

The principal work of the review was conducted between April and November 2009.

This report reflects the conclusions reached, and sets them in context. The review group wishes to emphasise that this is a complex area of work and would not claim that its report is comprehensive. It does, however, hope that the report provides some useful and impartial observations on the service and basic recommendations for improving the excellent work already undertaken by GPs in Herefordshire.

The review group is aware that the quality of Herefordshire's GP services are contingent upon many related aspects of health and social care provision – such as acute (hospital) care, residential and intermediate care, out of hours medical provision, public health education, minor injuries units, communications technology, NHS local, regional and national influences, etc – which are beyond the scope of this review to examine in detail.

See Appendix A for a full list of visits and interviews undertaken, and data and information supplied, for this review.

Background to Herefordshire – a rural county

Herefordshire is a predominantly rural county of 840 square miles situated in the southwest corner of the West Midlands region bordering Wales. The city of Hereford is the major location in the county for employment, administration, health, services, education facilities and shopping. The five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington are the other principal centres.

Herefordshire has limited access to the motorway network via the M50, which starts near Ross-on-Wye and joins the M5 north of Tewkesbury in Gloucestershire. The other main road links which all pass through Hereford City are the A49 (running from north to south) the A438 (running from east to west) and the A4103.

The most recent estimate of the population of Herefordshire is 178,400. This is the Office for National Statistics' (ONS) 2007 mid-year estimate, published in August 2008. It is the most sparsely populated unitary authority in England and only two other English counties have lower population densities. About one third of the population lives in Hereford city and a little more than a fifth in the market towns. However, using the official rural definition, 55% of the population live in a rural area.

Many key services therefore are further away from residents compared to other parts of the country. Only about half of Herefordshire's residents are within 4km of a cash-point (56%) or GP surgery (48%). NHS Herefordshire has undertaken a service mapping exercise to identify those areas where travel times and access to services is particularly challenging.

Herefordshire has an older age population than England and Wales as a whole. The county has become a popular destination for relocation, particularly from the southeast, and there is net out-migration of young adults probably in search of wider employment opportunities and higher education. Between 2004 and 2011 Herefordshire's population is expected to increase at roughly the same rate as that of England and Wales as a whole.

Both nationally and locally the population aged 60 and over is expected to grow more rapidly than the total population, but the rate of growth of this age group in Herefordshire is expected to be higher (21%) than in England and Wales as a whole (13%). Most dramatically, the number of people over 80 is expected to rise by a further 20%, to 11,800 residents, compared with a national increase of 11%. However, the number of under 18s is expected to fall by 12% (nationally 4%). Herefordshire's working population is approximately 85,000, of whom 15% work outside Herefordshire.

There are areas of poverty and deprivation within the county concentrated in Hereford city (South Wye and Central wards), Leominster and Bromyard. The least deprived areas tend to lie to the east of the county, on some of the fringes of Hereford city, directly north of and west of the city, and around Ross-on-Wye. However most parts of the county fall within the 10% most deprived nationally in terms of geographical access to services.

Background to Herefordshire GP services

- GP services in Herefordshire are commissioned by NHS Herefordshire (formerly the Primary Care Trust, or PCT).
- Each of the 24 GP practices in the county is a signatory to the national GP services contract and is obliged through this to provide certain services.
- Each is an independent business which can choose to take on additional services beyond the basic contract if it wishes and is able to.
- Herefordshire has 113 GP principals (partners in a GP practice), 20 salaried GPs (working in GP practices), 98 non-principals (not a partner/locum), and 19 GP registrars (May 2009).
- There is approximately one GP per 830 people in Herefordshire (0.73 per 1000 – national median 0.58 per 1000).
- The number of registered patients in Herefordshire is over 180,000. This figure exceeds the population of Herefordshire because the county's GPs also serve out-of-county residents, travellers and migrant workers.
- QOF (Quality and Outcomes Framework) is the set of indicators by which GPs earn their funding. NICE (National Institute for Clinical Excellence) is reviewing QOF indicators but BMA (British Medical Association) and NHS Employers will have the final say. NICE says it is opposed to axing exception reporting (the system which allows GPs to exclude certain patients from the scheme without missing out on bonuses).
- All practices must provide management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable.
- They must also provide general management of patients who are terminally ill, and management of chronic disease in the manner determined by the practice and in discussion with the patient.
- All Herefordshire practices also provide 'additional services' which comprise cervical screening, contraceptive services, childhood vaccinations, child health surveillance, maternity services and minor surgery.
- NHS Herefordshire also commissions other services from GP practices: directed enhanced services such as flu vaccinations; national enhanced services such as fitting contraceptive coils; and local enhanced services such as extended hours' opening.

Links to the Herefordshire Community Strategy, and legal and policy framework

The GP service is integral to the delivery of an effective health service. The review therefore supports the Community Strategy theme of “Safer and Stronger Communities” by improving the availability of sustainable services and facilities and access to them, particularly in rural areas. It also supports the theme of “Healthier Communities and Older People” by helping vulnerable people to live safely and independently in their own homes. These important links are also reflected in the main themes of the Council’s Corporate Plan namely; ‘Health and Well-being’, ‘Older People’, ‘Safer and Stronger Communities’ and ‘Sustainable Communities’.

The review group is cognisant of national mandates and policies such as the Department of Health’s Constitution (2009), Darzi’s Next Stage Review (2008), World Class Commissioning (WCC) (2007), Practice Based Commissioning (PBC), Choose and Book, and National Service Frameworks. It is also mindful of regulatory bodies and mechanisms such as the General Medical Council (GMC), the Quality and Outcomes Framework (QOF), the Care Quality Commission (CQC), and of the role of regional bodies such as the West Midlands Strategic Health Authority. The review also takes into account Herefordshire’s Joint Strategic Needs Assessment, Local Area Agreement, and Director of Public Health Annual Report 2008.

Findings and recommendations

Findings - Continuity of care

Continuity of care – meaning personal contact for patients throughout their pathway along the health and social care system - has emerged as one of the most vital cross-cutting themes among the review group's more specific findings. Patients, GPs and other service providers alike acknowledge that it is a key element in achieving patient satisfaction and good outcomes. Lack of continuity between GPs and NHS Herefordshire, between patients and their doctors, and between GPs and other services, have all been raised as issues of concern which inhibit the effective delivery of GP services to their patients.

Recommendations – Continuity of care

One overall recommendation is that NHS Herefordshire and GP practices more openly acknowledge, support and resource the entrenched, familiar and much-respected role of GPs as key community gatekeepers. One way of achieving this might be to locate an advocacy/co-ordination/signposting worker in each surgery who would act as a 'key worker' for patients. This is especially important in the light of the increasing need for local/community resilience as one effective weapon to combat the increasing economic pressures under which services are provided.

Findings - Equitable access

1. Herefordshire's Place Survey 2008 (see page 13) found that 17% of respondents found it difficult to access GP services. It does not ask why they find access difficult. See Table 1 below for further analysis. The survey has no data to explain why there are discrepancies, for example, between genders or between certain wards.
2. There is also anecdotal evidence that some population groups do not enjoy equitable access to GP services in the county. These include:
 - working people who are unable to attend appointments at their 'home' surgeries during GP opening hours;
 - young people who fear for their confidentiality by meeting family or friends while at the surgery, or who do not attend for other reasons. There are 4US young people's clinics at six secondary schools and the Sixth Form College, with three more in development;
 - travellers;
 - people who do not understand or are unable to use the appointments system so resort to attending Accident and Emergency (A&E) at the hospital;
 - men (who are less likely than women to consult a GP)
 - patients who wish to see a female GP – there are fewer female GPs (see below)

	<i>Male</i>	<i>Female</i>
Total	114	89

- the 'currently well' who do not attend surgery but might benefit from preventive screening or advice;
- those who need out of hours (OOH) services. A number of respondents to GP patient surveys express dissatisfaction with OOH and surgery opening hours;
- people at the end of life – 80% of people want to die at home but only 40% do at present. The Palliative Care Bill, currently on its second reading in Parliament, would make provision for patients to request where they received palliative care: in a hospital or specialist hospital, in a hospice or at home. It would require the relevant NHS body to take all reasonable steps to fulfil such requests;
- migrant workers;

Case study – a GP's experience of a migrant worker patient

'Once we had a Chinese worker from a farm who was in his 50s. We found he had severe liver failure. He spoke no English and had no interpreter. We got him referred to Birmingham where he had a transplant. They wanted him back here, where he had no support system at all. As a temporary resident, we deregistered him and didn't have to pick up the tab.'

- carers (a recent Adult Social Care scrutiny review of support to carers found their access to GP services was 'patchy')
- the housebound elderly with multiple needs;
- people with mental health problems;
- people who live in rural areas;
- people with disabilities

**Feedback from staff and public for the
Disability Equality Scheme 2009**

- Training needed for GPs around disability issues – especially mental health.
- Disabled people get a standard 7 min slot at the GP*, when they may need longer. Flexibility in GP and hospital appointments (eg. allow 12 mins instead of 7).
- GPs' attitudes to people with learning disabilities. Some GPs are very good and do know that some patients need a longer appointment. Others seem to think they can give a lower standard of care, and can get impatient.
- Inability to book GP annual reviews in advance (very frustrating when working).
- Sometimes there is an urgency to see doctors (my allocated GP) but find I have to wait over a week.
- Making contact with GP/nurses - answer phones unanswered. Doctors do not return calls. Staff attitude is that the professional always knows best.
- GP appointments: 'I know myself better than anyone when I need to see Dr, and not be fobbed off with a nurse practitioner eight hours later. I am not assertive enough'.

* *The review group found that most GPs offer 10 minute slots*

3. GP comments included:
 - 'We are prolonging people's lives but then failing to look after them at the end of life'.
 - 'Local services should be kept local. Continuity and neighbourhood care is important to sustain an adequate support network for vulnerable people living at home'.
4. 10% of those registered with GP practices across the county take up 40% of their time. A risk stratification tool is to be trialled in two practices shortly: this will identify patients at highest risk to that practices can work with their local teams to manage their needs proactively. Initially this will look at specific long term conditions where the practices believe early identification and active management could pay dividends in terms of health gain and need in the medium to long term. NHS Herefordshire says most practices can probably readily identify their top 10 patients but it is hoped this tool will enable identification of those in the next 10-20 to minimise their risk in future.
5. A senior NHS Herefordshire officer said 'Patient feedback always favours continuity of care – they want to see doctors that they know. There is also evidence that this leads to better patient outcomes'.
6. One practice pointed out that it offers 10 minute appointment time as standard, and that patients can book at least one month in advance.

Table 1 (pages 13 and 14)
Difficulty in accessing GP services
By gender, age group, disability, ward group, rurality and deprivation quartile

Overall result

Find it difficult to access GP	17%
--------------------------------	-----

By gender

Male	Female
20%	15%

By age group

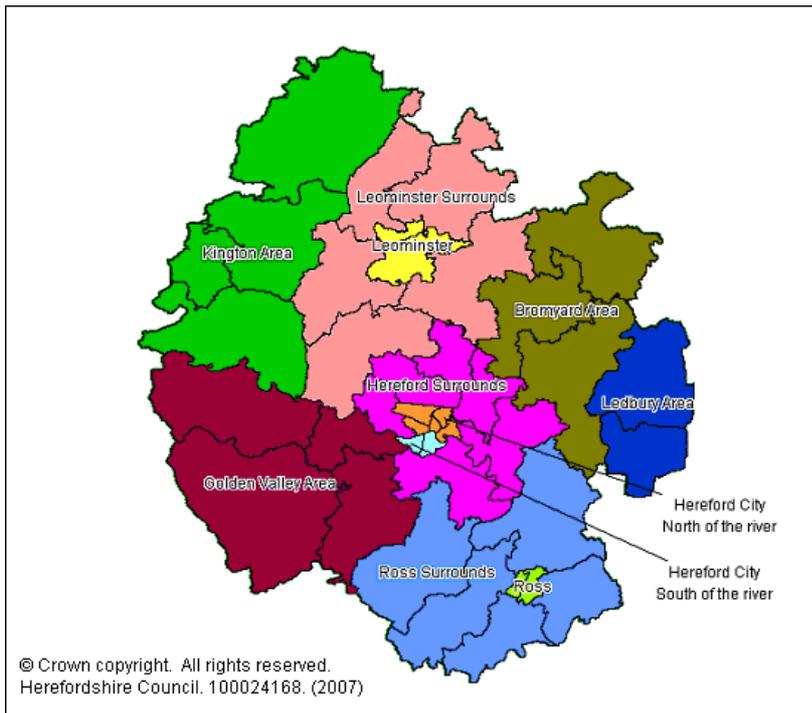
18 to 44	45 to 64	65 to 74	75 and over
22%	15%	14%	18%

By disability

Disabled	Not disabled	Mobility difficulties
16%	18%	18%

By ward group

Bromyard Area	Golden Valley Area	Hereford City North of the river	Hereford City South of the river	Hereford Surrounds	Kington Area	Ledbury Area	Leominster	Leominster Surrounds	Ross	Ross Surrounds
18%	13%	16%	24%	17%	24%	20%	19%	18%	4%	13%



By rurality

Urban	Town & fringe	Village	Hamlet & isolated dwelling
16%	18%	18%	19%

By deprivation quartile

1st quartile - most deprived	2nd quartile	3rd quartile	4th quartile - least deprived
15%	21%	17%	17%

By deprivation quartile, amongst those living in urban areas

1st quartile - most deprived	2nd quartile	3rd quartile	4th quartile - least deprived
12%	30%	18%	15%

By deprivation quartile, amongst those living in rural areas

1st quartile - most deprived	2nd quartile	3rd quartile	4th quartile - least deprived
17%	15%	14%	17%

Rurality by deprivation quartile

	1st quartile - most deprived	2nd quartile	3rd quartile	4th quartile - least deprived
Urban	34%	14%	21%	32%
Town and fringe	23%	9%	24%	44%
Village	9%	38%	27%	26%
Hamlet and isolated dwelling	14%	48%	27%	10%
Rural	14%	36%	27%	23%

Source of information for Table 1 above: Herefordshire Place Survey 2008 (Herefordshire Council)

Recommendations - Equitable access

1. Ensure the GP-led walk-in centre, when open, offers a full range of services with excellent communications between it and the patient's registered practice to ensure continuity of care, to cater better for workers who commute to Hereford city – without destabilising vulnerable rural practices
2. GP practices should more closely with school clinics and youth-led organisations to improve access to services for young people.
3. Sustainable funding should be secured to enable school clinics to run in every secondary education establishment.
4. GP practices should simplify, streamline and better publicise their appointments and triage systems and make patients more aware that the practice is their 'first port of call', and that they will be welcomed and seen by a doctor that day if patients consider it necessary
5. GP practices should issue more frequent invitations to registered patients who have not attended the surgery recently, for preventive consultations, where resources allow, after undertaking cost/benefit analysis
6. NHS Herefordshire should work closely with hospices, the individualised health budget pilot, hospitals, social care and GPs to ensure people can die at home if they wish to
7. As above with reference to the housebound elderly with multiple needs
8. GP practices should facilitate people with learning disabilities to monitor and evaluate the new arrangements for working with them to establish if they are meeting needs
9. As above with reference to people with mental health problems
10. NHS Herefordshire should move with all possible speed and in consultation with service users to improve the services available to people with mental health problems, with a view to making them more robust, more joined-up between medical and social models, more readily available, and more accessible to people who are not in crisis (e.g. talking therapies)

Findings - Preventive services

1. GP comments included:
 - 'GPs play a small part in people's health – what really determines their health is their housing, their jobs, their education, their relationships, their diet ...'
 - 'It is of concern that the amount of money we get in future might be partly dictated by how many fat people we have on our books. The reasons people overeat are very complex and GPs can't have much impact on this on their own.'
 - 'We are now (September 09) told not to refer anyone to mental health services unless they are in crisis, due to staff shortages'. If this is true, it must be asked how people in need of services can access them? And further, how did the service reach such a stage without sufficient warning to enable pre-emptive action to forestall shortage of services?
 - 'We have been told that counselling services for 19-25 year olds will no longer be paid for by NHS Herefordshire'.
2. An officer in provider services told the review group 'Definitions between social care and health are very unclear – for example when does a housing issue become a health issue? Deprivation leads to poor health. The lack of a coherent accommodation strategy is making for disjointed working.'
3. GPs offer regular screening clinics. All practices contact registered patients who haven't been in for a certain number of years, offering them a check-up. Opportunistic screening is done by most GPs e.g. blood pressure checks and smoking cessation advice (but not, for example, to ascertain/advise those at risk of falling). Practices will also be introducing health checks under the vascular health checks scheme for people 40+ starting from 2010.
4. All GP practices receive guidance on who should be referred to mental health services.
5. No GPs in Herefordshire have a Special Interest in mental health issues.
6. CLD, a local youth counselling service, is commissioned to provide a service for young people who are pregnant, substance misusers or with a particular level of need in terms of Child and Adolescent Mental Health Services (CAMHS). NHS Herefordshire says over the last couple of years the service had also been accepting referrals for young people outside these parameters, but this service had not been formally commissioned or funded, and CLD has identified that it cannot continue to provide this service without additional funding.
7. All GP practices now have a counsellor who provides talking therapies. The hours allocated are proportional to the size of the practice. However, some practices have waiting lists. Each practice also has a link person within Community Mental Health services, to close the gap between social care and medical health.
8. Mental health service users started to be consulted on their views in December 2009, when the tender process had already been narrowed down to five potential new host organisations.
9. Regarding general preventive activities, one GP said 'It would be difficult to take on monitoring of patients for extra issues during regular appointments. Already (average nationally) doctors deal with 3.5 problems during each 10 minute appointment, so there is little opportunity to do more'.

Recommendations - Preventive services

1. GP surgeries, acknowledging their role as an important community gatekeeper, should offer more effective signposting to housing services, nutrition advice, obesity, alcohol abuse, smoking cessation and other information about well-being.

2. GP practices should routinely add more minutes to their appointment times in order to ask more opportunistic questions of patients, and offer advice, on issues such as risk of falling, diet, exercise etc.
3. Public education programmes that are properly targeted could help prevent some conditions, such as obesity, smoking cessation, alcohol abuse, and some unnecessary visits to A&E. Community engagement must be undertaken, as it is important in the context of achieving good public health behaviour change.
4. As NHS Herefordshire rethinks how to strengthen vulnerable mental health services, health scrutiny and service user groups should be consulted in throughout this process, which should have begun before tender documentation was finalised and bidders chosen, to ensure that the questions asked and the solutions that are proposed are those that are important and useful to service users and family carers.

Findings - Rurality

1. Targets and procedures seem to take little account of sparsity and rurality. Little account is taken of the extra cost involved in providing services to remote rural communities.
2. Care must be taken not to impose urban solutions on a rural area when considering initiatives such as the GP-led walk-in centre, or GP extended hours. We need to be able to freely adapt, or reject, national agenda according to our Herefordshire context.
3. GPs in rural practices have to spend more time undertaking home visits than urban GPs.
4. Patients visiting rural surgeries face particular challenges if they lack private transport. One surgery said they would not be able to manage without the assistance of voluntary associations such as WRVS (Women's Royal Voluntary Service), Ride and Dial and Age Concern.
5. 11 out of 24 practices have dispensaries. They are all rural.

Recommendations – Rurality

1. Account must be taken of the extra transport needs rural people have in accessing GP services.
2. Public transport needs to be planned with the needs of vulnerable rural people – especially elderly people – in mind.
3. A study should be undertaken of their future community and transport needs, as demands on these increase with a growing elderly population.
4. GP practices should consider being more flexible with their opening hours to help increase access for some rural patients.

Findings - Extended hours

1. Access to GP services outside normal working hours is not similar across rural and urban parts of the county. A recent national initiative to encourage extended opening hours has not been taken up enthusiastically in Herefordshire. Only 50% of the county's surgeries now offer this service (West Midlands average 70%, South West average 85%). According to NHS Herefordshire, of the 16 surgeries outside Hereford city, 9 offer extended hours and seven do not. Of the city surgeries, four offer extended hours and four do not.
2. According to Pulse magazine (25 Feb 09) 'the extended hours initiative has deprived small GP practices and those in the poorest areas of the country, of millions in funding ... some groups of patients miss out twice over, because they don't get access to longer hours, and neither does their practice get as much money for their health care. It is often the poorest patients who are missing out, and it is they who often find it hardest to take time off work to see a GP'.
3. The LMC told the review group that the national 'offer' regarding extended hours was 'inflexible and dogmatic', and inappropriate for many surgeries in Herefordshire.
4. If the GP-led walk-in centre in Hereford city finds premises and opens, as now hoped, in March 2011, this could improve access to services for a number of groups who are in the city for other reasons, such as working people, young people, migrant workers, inappropriate A&E attenders. An interim walk-in centre was opened in December 2009.
5. Some GPs fear their patients will use the walk-in centre in preference to their registered surgeries, thus depriving the surgery of business, as well as jeopardising the patient's continuity of care. Some GPs fear the walk-in centre could be more expensive than envisaged through having to serve many 'second-opinion seekers' and the 'worried well'.

Recommendations - Extended hours

1. Further consideration be given to encouraging rural practices who have patients with access problems in particular to offer extended opening hours
2. Further research may need to be undertaken to establish why 17% of people find it difficult to access GP services

Findings - Out of hours services

1. One patient said: 'Since GPs opted out of working weekends and after 6pm, many people who need medical help are confused as to who to call and just call 999 for an ambulance, resulting in unnecessary A&E attendance'.
2. The review group asked NHS Herefordshire for information on the current cost of Herefordshire's out of hours (OOH) service, but this was not available. Nationally, there is a threefold variation in costs across various parts of England – with rural areas being the most expensive. For the OOH contract that expired in 2008, the cost to NHS Herefordshire was £2.2 million per year. In 2006, Herefordshire PCTs' OOH service cost marginally more, at approximately £11 per head of population, than the average £10.76 for rural PCTs. The national average is given as £8.65 but that includes major conurbations.
3. One GP told the review group that their Monday morning surgeries were over-subscribed because the OOH provider tells patients over the weekend to go and see their GP on Monday. However, OOH is an urgent care service and if patients do not require urgent care it is appropriate they see their GP on the next available working day.
4. GP comment: 'Our doctors are no longer retiring early in poor health because of the extra work entailed by OOH duties, but the current OOH service does give a poorer quality of service to patients. For example, the provider is trying to use more nurses and fewer doctors'.
5. 'By sacrificing £6,000 a year GPs have been able to hand over OOH care to PCTs. We regularly hear of patients experiencing difficulties in obtaining a GP appointment or a poor service when trying to access out OOH care.' (national data from the Patients Association)
6. The introduction of separate OOH services may have reduced the personal investment of GPs in ensuring patients were seen in hours and that OOH requests were 'reasonable', and may have compromised the role of the GP in core urgent care.
7. The GP patient survey 2008-9 for Herefordshire found, regarding OOH services: easy to contact 77%, right speed of response 59%, good care received 60%. However, there were many comments in surveys conducted by individual GP surgeries that expressed dissatisfaction with OOH services.

Recommendations - Out of hours (OOH) services

1. Undertake a more effective education programme to make the public aware of the differences between GP services, A&E services, and OOH services
2. Improve the effectiveness of the OOH provider. Would it be preferable, for example, to recruit more local GPs to serve it, with the aim of improving both quality and continuity of care for patients?
3. That every effort be made to maintain the stability of the OOH workforce, both clinical and non-clinical
4. That NHS Herefordshire undertake more work to investigate whether it is fully capturing the patient experience of the OOH service
5. That the OOH service continues to be subject to ongoing careful monitoring, evaluation and review

Findings - Appointments

1. Herefordshire Council's 2009 research among the public for its Disability Equality Scheme found that disabled people (see page 12) felt GP appointments for them should be more flexible and longer. Most of the comments on GPs related to difficulties with the appointments system.
2. Inappropriate attendance at A&E is currently over 30%. The review group found some reasons for this are: people don't know about the OOH service and think their GPs are only open Mon-Fri; the OOH service may refer people to A&E if they have no-one available to see patients; patients may have tried to make an appointment at their GP and failed, or do not understand the appointment system; people don't know there are minor injuries units and some OOH services at community hospitals.
3. A Herefordshire Patient and Public Involvement Forum survey in 2007 found that out of 145 A&E attendees, 33 had tried their GP first. 38 said they would have used a 'sit and wait' surgery had one been available at their GP practice.
4. Even conditions that are not severe may demand an early response. Anecdotal evidence suggests that some surgeries operate triage systems which appear to cause patients to resort to A&E, some do not have enough telephone operators to cope with demand for appointments.
5. A recent national survey by the Primary Care Foundation (June 09) suggested that one third of practices 'appear to have insufficient staff to respond reliably and quickly' to calls on a Monday morning, a time of peak demand. However, the National Patient Survey 2009 found that 91.85% of Herefordshire patients were satisfied with phone access to their GP practice. Herefordshire is in the top 20% of this survey's results. However, negative GP surgery patient survey results have prompted several surgeries to improve their phone systems.
6. One GP practice made the distinction that patient need must be met, but that it may not be possible to meet patient demand with limited health care funds.
7. The Primary Care Foundation survey also says some practices have no same-day slots left within 30 minutes of the practice opening, leading to some friction with patients, difficulties for reception staff and clinicians, and to patients developing techniques to get round the system. Reforming the approach to in-hours urgent care can reduce avoidable admissions and A&E attendances (Primary Care Foundation research June 2009). The review group obtained anecdotal evidence that appointment systems cause similar difficulties in several Herefordshire GP practices.
8. The review group asked surgeries for the number of patients who failed to keep appointments, but this information was not available in sufficient quantity to detect any trends or issues.
9. It is thought there may have been an increase in referrals from GPs, but the review group has been unable to obtain information about this from NHS Herefordshire.

Recommendations – Appointments

1. GP practices should review call handling and access to urgent appointments
2. Public education and/or improvements in urgent care services are needed to reduce inappropriate attendance at A&E
3. To avoid a patient ending up in hospital or resorting to A&E, it is important to regard any request for same-day care as potentially urgent until assessed by a clinician, so basic access to general practice is vital

4. GP practices should review who handles incoming calls and ensure adequate training to ensure staff spot and accommodate potentially urgent cases
5. GP practices should review number of appointments available each week to ensure they meet patient demand, and ensure balance of same-day slots matches the pattern of demand

Findings - Quality of service/patient experience

1. The Royal College of GPs has been piloting an accreditation scheme which will test 'organisational' quality (Health Service Journal (HSJ) May 08) and the Care Quality Commission is to require GPs to register with it for the first time. But neither organisation will be analysing quality of care explicitly from a patient's perspective.
2. The King's Fund has started an 18-month enquiry which will attempt to define the most appropriate role for GPs in delivering high quality patient care. Royal College of GPs chair Steve Field hopes the enquiry will also help unpick some of the reasons why GPs are less engaged with Practice Based Commissioning than they could be. A member of the enquiry Ursula Gallagher (director of quality and clinical practice at Ealing PCT) says there is considerable variation in the quality of GP services that is not picked up robustly in the QOF.
3. Patient surveys undertaken nationally and locally give consistently high scores to GP services in Herefordshire. The 2009 National Patient survey questions include: whether patients find receptionists helpful (very helpful 64%), if they had confidence in the doctor they saw (yes definitely 79%), and how they rate the overall care they receive (very satisfied 67%).
4. In 2008, Herefordshire was in the national top 20 per cent in the country in terms of access to and quality and safety of local NHS services. Patients scored GPs particularly highly for their communication and listening skills, treating patients with respect and dignity, getting an appointment quickly and the cleanliness of GP centres.
5. The only issue raised by patients in 2008 was that a sizeable minority - nearly one in five - wanted better access to their GP outside of normal office hours.
6. However one practice said its extended hours services are the last to be booked and the first to be cancelled, often without notice.
7. The 2008 Herefordshire Place Survey (see page 13) found that 83% of respondents did not have difficulty in accessing GP services in the county.
8. Three GP surgeries in Herefordshire have patient groups. Is the patient voice really being heard, beyond pointing out that the door needs oiling? Some GP practices told the review group that the results of patient surveys, comments books, verbal feedback etc are regarded as valuable indicators of quality and are acted on appropriately. Some GP practices have, for example, taken on a salaried GP to improve access to a doctor, bought new telephone systems to improve call handling, begun to establish a patient group, extended their opening hours, applied for funding and planning permission for extra car parking, etc, as a result of patient feedback.
9. PALS (Patient Advice and Liaison Services) has dealt with 26 cases concerning GPs since April 2009. Of those, two patients went on to make a formal complaint and one other may do so.

10. Numbers of complaints:

<i>2007-8 complaints against GPs</i>	
<i>Subject</i>	<i>Total 133</i>
Communication/attitude	18
Premises	0
Practice/surgery management	30
General practice administration	20
Clinical	38
Other	27

<i>2008-9 complaints against GPs</i>	
<i>Subject</i>	<i>Total 174</i>
Communication/attitude	42
Premises	1
Practice/surgery management	25
General practice administration	21
Clinical	61
Other	23

- *It has not been possible to obtain information to explain the variation in numbers of complaints from 2007-8 to 2008-9.*

Recommendations - Quality of service/patient experience

1. Local services should be delivered as close to residents as possible. This has major implications for the safe delivery of services locally. Herefordshire Public Services is reviewing the way local NHS and social care services are provided. The review describes a new 'landscape' for local services focused on a more integrated, effective and efficient local service across public service providers in the county (see panel below). Many of its proposals are similar to the independently-made recommendations of this review. It is hoped the new Transition Board will ensure that the process of implementing new ways of working will be led not only by clinicians but by patients, service users and carers.

**Excerpt from Herefordshire Provider Services Review – Next Steps
(October 2009)**

It is proposed that:

- integration of primary and secondary health and social care services in and around a local team will be best placed to deliver effective joint working, a simplified system of access and a shared focus on achieving wellbeing for the local population;
- to deliver the high levels of care for specialist services in mental health and learning disability proposed in these models we will need to seek the expertise and greater capacity of a specialist provider who will offer a local service to our specification;
- while proposals on possible configurations that will support our service aims are explored we need to begin to put in place our new models of care;
- a programme of work to develop, commission and implement some of the models in the next 12 months will be started, including opportunities for staff, service users and their families / carers to contribute their own experience and suggestions for improvement to service delivery;
- locality groups will have a role to play in the review, planning, commissioning and delivery of some of these processes.

2. GP surgeries should ask patients to contribute the questions they consider important, when formulating their annual patient surveys, in order to ensure real concerns are addressed. This could be done by a non-medical staff member canvassing patients in the waiting room.
3. GP surgeries should form patient groups which have sufficient independence to act as 'critical friends'.

Findings - Collaboration/co-ordination/integration/communication

1. The need for care and services for older people is set to increase. Particular challenges for service planning will include how to maintain adequate access to services and facilities, and how to promote inclusion and avoid isolation of older people living alone or in rural areas.
2. It is also clear that there is a need to 'add life to years' in our elderly population by promoting health and wellbeing and preventing injuries and ill-health. Herefordshire residents, in their feedback to both the Council and NHS Herefordshire, are keen to see an increased level of support and personalised care for people with long-term conditions.
3. There is a disconnect between acute services and GPs (discharge notes are often late or illegible), and between them and intermediate care services. After-hospital procedures are poorly co-ordinated and inadequately resourced. Funding 'silos' between health and social care can work to the detriment of patients when neither health nor social care bodies will take responsibility for payment of services.
4. GP comment: 'A whole team approach is vital – not only within the surgery (nurses, GPs, admin) but with other health and social service workers – to ensure patients' needs are met'.

Case study – Harry

Harry worked as a packer in Hereford until five years ago. He was doing really well and was up for promotion, but his colleagues started bullying him. After a while he couldn't take it any more and he left. Harry hasn't really worked since. He's been anxious, depressed and unable to cope with much of the outside world. He has a mild learning disability and lives in supported housing.

In 2008 Harry was assessed by a doctor at an assessment centre. He told the assessor he had been feeling a bit better recently. On the basis of this information, the doctor told the benefits office to stop Harry's benefits. The worry of this made Harry ill. What would he live on? His support worker contacted Harry's regular GP, who wrote to the benefits office explaining Harry's situation and asking them to reverse their decision.

There was a lot more suffering to come for Harry. It was a long and anxious time of unnecessary delays and poor communications between the benefits office, the assessment centre, mental health services workers, his GP and support worker, and Harry himself before his benefits were restored and he felt secure again.

Why was Harry assessed by a non-specialist doctor, and not a specialist worker in mental health and/or learning disability issues? Why was Harry assessed by someone who knew nothing about him or his history? Why is communication so poor between the various agencies that have such power over vulnerable lives? What would Harry have done without the support of his regular GP and his support worker?

5. A senior adult social care officer said 'Budgetary pressures are immense and increasing, and there is insufficient understanding among both health and social care staff, and the public, of this'.
6. It was also stated that better integration is needed between private facilities (such as care homes) and others such as GPs and community hospitals, and that caution is needed so as not to draw workers into using the medical model – social care focuses on independence, whereas NHS Herefordshire focuses on medical issues.
7. GP comment: 'Services should be returned to GPs with integrated teams working under the control of the practice (especially including social care)'.
8. Incompatibility of computer systems and data protection issues impede the flow of smooth patient pathways through the system. GPs have told the review group that patient matching,

for example, goes awry between the hospital and surgery information technology (IT) systems – this is confusing and potentially dangerous. Also social care and health IT systems do not ‘talk’ to each other.

9. Barriers to effective co-working between GPs and other parts of the health and social care system include lack of communication between them. For example, the lack of GP-based social workers means it is more difficult to co-ordinate patient care. One surgery has a practice liaison nurse (funded from PBC) who performs some of these functions: she keeps a vulnerable patient list, and checks how patients are after discharge from hospital. Another surgery said sometimes there are 3-4 social workers per patient, which makes it hard to work out who is responsible for that patient. Workers are not physically co-located, which adds to the communications challenges. A further surgery said it had fought tooth and nail to retain its social worker, who works one day a week from the surgery and performs a vital liaison/advocacy/signposting role for patients.
10. Lack of communication between NHS Herefordshire and the Council is a problem. At a local level, one surgery told the review group that it had to organise a meeting between DMHOP (Department of Mental Health for Older People) and Adult Social Care to get them to make a joint visit to a patient. Another said when NHS Herefordshire had its own chief executive there was a stronger sense of leadership, and that a clearer definition of the organisation and firmer management are needed.

Recommendations – Collaboration/co-ordination/integration/communication

1. With continuity in mind, patients and service users would benefit from a) co-located multi-disciplinary team working and/or b) a single key worker who would be the patient’s main contact and would co-ordinate all the other work needed for that patient. This concept and its costs should be investigated/quantified as soon as possible,
2. Care tracking and management could be organised within GP catchment areas, possibly using a predictive tool that identifies people at most risk of needing medical or social care.
3. If the number of people in residential care reduces, the efficiency of intermediate and domiciliary care will have to be improved to enable vulnerable people to live safely and in dignity in their own homes.
4. The Welsh Assembly government is developing a ‘rural practitioner’ role that would make GPs in parts of Wales responsible for social care services as well as health. The proposal is that the primary care workforce would be re-evaluated so that practitioners could fulfil more than one role for the convenience of the patient.
5. 16 pilots started in April 09 to have GPs working with care homes, social services, acute trusts and charities to improve patient care in areas ranging from improving the co-ordination of end of life care, preventing cardiovascular disease and encouraging more self-care for people with long-term conditions. This could be investigated with a view to replication in Herefordshire.
6. NHS Herefordshire needs to clearly define the role it envisions for community services, its priority areas for expansion and any important partnerships it wants – such as joint health and social care teams for older people, greater links with GPs and the appropriateness of GP referrals.
7. Involve patients and service users in the whole cycle of planning, commissioning, and delivery through to review of GP services

8. Budget 'silos' - particularly the divisions between health and social care budgets – should be dismantled where possible. This would help avoid confusion and misguided attempts to conserve money in a particular 'pot', and would be in the interests of a smoother patient pathway
9. Information 'silos' also should be dismantled
10. Effective use of IT systems could provide so many opportunities for improved patient outcomes. Therefore, throughout the patient pathway, IT systems should be made practicable and compatible, and data protection/confidentiality issues preventing this should be resolved with all speed

Findings - Relations between GPs and NHS Herefordshire and how they affect patients

1. Surgeries' comments included: 'hit and miss', 'deteriorating', 'unclear funding streams', 'frequent personnel changes', 'fewer visits' (eg contract monitoring, Practice Based Commissioning (PBC) reviewing), 'unclear communications', 'lack of support', excessive bureaucracy', 'NHS Herefordshire is governed by national priorities'.
2. NHS Herefordshire comments included: 'wear a flak jacket before going into LMC meetings', 'there is always lively debate at locality meetings',
3. Innovative surgeries have obstacles put in their way – 'NHS Herefordshire is nervous of innovation because it fears establishing inequalities'. One surgery ran a programme in collaboration with a leisure centre to tackle obesity, funded by a pharmaceutical company because 'to get the money from PBC would have taken for ever', and funds a prescription delivery service from bequests for the same reason. GP comment: 'PBC has stalled. The PCT is reluctant to let go of control. Innovation is stifled. GPs try hard to deliver new ideas appropriate for their localities but the PCT fears change, and making mistakes'.
4. 'Despite the rhetoric of "quality" "safety" and "equality", the Next Stage Review (Darzi) is underpinned by the levers of a market based system i.e. Payment by Results, Choose and Book, purchaser/provider split, World Class Commissioning, Foundation Trusts, patient-held budgets ...' (Clive Peedell, GP, Health Service Journal 14 July 09)
5. 'PCTs will be restricted to the lowest score in World Class Commissioning unless they can prove they are supporting PBC' (David Colin-Thome, national clinical director for primary care). GPs have told the review group that they have had PBC business cases turned down for inexplicable reasons, agreements changed without notice so PBC payments are not made, proposals sent in and no feedback given by NHS Herefordshire about them.
6. A senior NHS Herefordshire commissioner told the group that of 109 PBC applications currently outstanding, some 70% of them had been approved.
7. A senior commissioner told the review group 'As adult social care and health services increasingly integrate, GPs will have a widening role which could include care tracking and management within their catchment areas, increased awareness of personalisation and individualised budgets and eligibility criteria, input into the development of an effective Single Assessment Process, GPs to have provision of records on all treatment or services given to their patients'.
8. Mental health teams try to work closely with GPs, to close the gap between social care and medical health. Each practice now has a counsellor (hours depend on size of practice), and a link person in the Community Mental Health team. The review group requested data on numbers of referrals to the community mental health team but these were unavailable.
9. GPs have said that mental health services are so depleted at present in one geographical area that they have been told to refer only crisis cases, and that 'virtually the whole department has left'. Community alcohol and youth counselling services are also said to be understaffed. The review group asked NHS Herefordshire for information on the current staffing levels against established structure (how many staff there should be) in mental health services, but were unable to obtain this. This lack of information was a cause of considerable concern for the review group, especially when need for services appears to be increasing, such as the increasing prevalence of alcohol-related issues, for example.
10. NHS Herefordshire says it is aware that Herefordshire's mental health services are too small to be robust, and are vulnerable to staff changes. In view of this, it is planned to join forces

with others in the region to create a Mental Health Trust which will see the county's local services continue, strengthened by the increased governance a larger organisation can provide.

11. A mental health services manager said that the recent staff shortage in one particular geographical area was a temporary problem only while new staff were recruited.
12. LMC would like to see smoother pathways for patients and reduced delays between social care and medical services. Closer links between social care services and medical services would be the best way to achieve success in preventive work.
13. GP comment: 'The restructure is a nightmare. There is no institutional memory left. There are not enough staff to cope – for example there has not been a meeting about governance and quality since February, which is a risky gap. The restructure looks good on paper but the organisation is now process-driven and there is not enough concern for outcomes'.
14. Some of the governance and quality meetings involving GPs that take place are: QOF visits yearly; Family Health Service contractor panel quarterly; GP clinical governance leads twice yearly (as of October 09, the second one for 2009 had not yet taken place).
15. Herefordshire is one of 68 pilot sites for personal health budgets. The county will focus initially on people with long term conditions.

Recommendations - Relations between GPs and NHS Herefordshire and how they affect patients

Most GPs and NHS Herefordshire officers interviewed stated that this relationship gave cause for concern but that, so far, this was not having a tangible adverse affect on patient outcomes. It is clear from both sides that there is friction between them. However it is clearly not in anyone's interests to continue in a state of barely restrained antagonism when managing and delivering one of the most important services to the citizens of Herefordshire. So it is vital that better partnership working to improve that relationship be undertaken effectively without delay. Continuity of contact between staff would go some way towards improving this.

Recommendations

The review group believes that the qualitative evidence it has gathered and analysed for this report has its own great power in illuminating issues that may otherwise be swept aside in the quest for hard data. It has used statistics where relevant and available. Its recommendations are suggested in the light of these findings.

Continuity of care

One overall recommendation is that NHS Herefordshire and GP practices more openly acknowledge, support and resource the entrenched, familiar and much-respected role of GPs as key community gatekeepers. One way of achieving this might be to locate an advocacy/co-ordination/signposting worker in each surgery who would act as a 'key worker' for patients. This is especially important in the light of the increasing need for local/community resilience as one effective weapon to combat the increasing economic pressures under which services are provided.

Equitable access

1. Ensure the GP-led walk-in centre, when open, offers a full range of services with excellent communications between it and the patient's registered practice to ensure continuity of care, to cater better for workers who commute to Hereford city – without destabilising vulnerable rural practices
2. GP practices should work more closely with school clinics and youth-led organisations to improve access to services for young people
3. GP practices should simplify, streamline and better publicise their appointments and triage systems and make patients more aware that the practice is their 'first port of call', and that they will be welcomed and seen by a doctor that day if patients consider it necessary
4. GP practices should issue more frequent invitations to registered patients who have not attended the surgery recently, for preventive consultations, where resources allow
5. NHS Herefordshire should work closely with hospices, the individualised health budget pilot, hospitals, social care and GPs to ensure people can die at home if they wish to
6. As above with reference to the housebound elderly with multiple needs
7. GP practices should facilitate people with learning disabilities to monitor and evaluate the new arrangements for working with them to establish if they are meeting needs
8. As above with reference to people with mental health problems
9. NHS Herefordshire should move with all possible speed, involving service users at the earliest possible stage, to improve the services available to people with mental health problems, with a view to making them more robust, more joined-up between medical and social models, more readily available, and more accessible to people who are not in crisis (e.g. talking therapies)

Extended hours

3. Further consideration be given to encouraging rural practices who have patients with access problems in particular to offer extended opening hours

Out of hours (OOH) services

6. Improve effectiveness of OOH provider. Would it be preferable, for example, to recruit more local GPs to serve it, with the aim of improving both quality and continuity of care for patients?

Preventive services

5. GP surgeries should offer more effective signposting to housing services, nutrition advice, obesity, alcohol abuse, smoking cessation and other information about well-being
6. GP practices should routinely add more minutes to their appointment times in order to ask opportunistic questions of patients, and offer advice, on issues such as risk of falling, diet, exercise etc
7. GPs should 'weight' referrals to A&E by severity, thus helping smooth the path and reduce unnecessary waiting times for patients
8. Public education programmes that are properly targeted could help prevent some conditions, such as obesity, smoking cessation, alcohol abuse, and some unnecessary visits to A&E. Community engagement is important in the context of achieving good public health behaviour change.
9. As NHS Herefordshire rethinks how to strengthen vulnerable mental health services, health scrutiny and service user groups should be consulted in throughout this process, which should have begun before public consultation even starts when the tender documentation was being devised, to ensure the questions asked are those that are important to service users and family carers

Appointments

6. GP practices should review call handling and access to urgent appointments
7. GP practices should review who handles incoming calls and ensure adequate training to ensure staff spot and accommodate potentially urgent cases
8. GP practices should review number of appointments available each week to ensure they meet patient demand, and ensure balance of same-day slots matches the pattern of demand

Quality of service/patient experience

1. Local services need to be delivered as close to residents as possible. This has major implications for the safe delivery of services locally. Herefordshire Public Services is reviewing the way local NHS and social care services are provided. The review describes a new 'landscape' for local services focused on a more integrated, effective and efficient local service across public service providers in the county (see panel below). Many of its proposals are similar to the independently-made recommendations of this review.

**Excerpt from Herefordshire Provider Services Review – Next Steps
(October 2009)**

It is proposed that:

- integration of primary and secondary health and social care services in and around a local team will be best placed to deliver effective joint working, a simplified system of access and a shared focus on achieving wellbeing for the local population;
- to deliver the high levels of care for specialist services in mental health and learning disability proposed in these models we will need to seek the expertise and greater capacity of a specialist provider who will offer a local service to our specification;
- while proposals on possible configurations that will support our service aims are explored we need to begin to put in place our new models of care;
- a programme of work to develop, commission and implement some of the models in the next 12 months will be started, including opportunities for staff, service users and their families / carers to contribute their own experience and suggestions for improvement to service delivery;
- locality groups will have a role to play in the review, planning, commissioning and delivery of some of these processes.

2. GP surgeries should ask patients to contribute the questions they consider important, when formulating their annual patient surveys, in order to ensure real concerns are addressed. This could be done by a non-medical staff member canvassing patients in the waiting room.
3. GP surgeries should form patient groups which have sufficient independence to act as 'critical friends'.

Collaboration/co-ordination/integration/communication

11. With continuity in mind, patients and service users would benefit from a) co-located multi-disciplinary team working and/or b) a single key worker who would be the patient's main contact and would co-ordinate all the other work needed for that patient.
12. Care tracking and management could be organised within GP catchment areas, possibly using a predictive tool that identifies people at most risk of needing medical or social care.
13. If the number of people in residential care reduces, the efficiency of intermediate and domiciliary care will have to be improved to enable vulnerable people to live safely and in dignity in their own homes.
14. The Welsh Assembly government is developing a 'rural practitioner' role that would make GPs in parts of Wales responsible for social care services as well as health. The proposal is that the primary care workforce would be re-evaluated so that practitioners could fulfil more than one role for the convenience of the patient.
15. 16 pilots started in April 09 to have GPs working with care homes, social services, acute trusts and charities to improve patient care in areas ranging from improving the co-ordination of end of life care, preventing cardiovascular disease and encouraging more self-care for people with long-term conditions. This could be replicated in Herefordshire.

16. NHS Herefordshire needs to clearly define the role it envisions for community services, its priority areas for expansion and any important partnerships it wants – such as joint health and social care teams for older people, greater links with GPs and the appropriateness of GP referrals.
17. Involve patients and service users in the whole cycle of planning, commissioning, and delivery through to review of GP services
18. Budget ‘silos’ - particularly the divisions between health and social care budgets – to be dismantled where possible. This would help avoid confusion and misguided attempts to conserve money in a particular ‘pot’, and would be in the interests of a smoother patient pathway
19. IT systems throughout the patient pathway should be made practicable, and data protection/confidentiality issues preventing this should be resolved with all speed

Relations between GPs and NHS Herefordshire and how they affect patients

Most GPs interviewed stated that this relationship gave cause for concern but that, so far, this was not having a tangible adverse affect on patient outcomes. It is clear from both sides that there is friction between them. However it is clearly not in anyone’s interests to continue in a state of barely restrained antagonism when managing and delivering one of the most important services to the citizens of Herefordshire. So it is vital that better partnership working to improve that relationship be undertaken effectively without delay. Continuity of contact between staff would go some way towards improving this.

Appendix A

Visits and interviews

- Ann Hughes, Head of Primary Care Governance, Quality and Clinical Leadership Directorate
- Catherine Blackaby, Head of Locality Support, Integrated Commissioning Directorate
- Chris Bull, Chief Executive Officer Herefordshire Council/NHS Herefordshire
- Dr Akeem Ali, Director of Public Health
- Dr Richard Dales, Secretary, Herefordshire Local Medical Committee
- Euan McPherson, Interim Head of Customer Experience, Quality and Clinical Leadership Directorate
- Paul Edwards, Associate Director, Integrated Commissioning Directorate
- Sally Simmonds, Operational Manager, Community Mental Health Services
- Sara Keetley, Head of Adult Social Services, Provider Services Directorate
- Simon Collings, Associate Director of Information,
- Wendy Fabbro, Associate Director, Integrated Commissioning Directorate
- Yvonne Clowsley, Head of Planning, Integrated Commissioning Directorate

The review group interviewed GP principals, practice managers, practice nurses and patient group representatives at:

- Fownhope Surgery
- Greyfriars Surgery
- Nunwell Surgery
- Pendeen Surgery
- St Katherine's Surgery
- Weobley Surgery

Data and other information

- *Better, Safer Doctors: Implementing Medical Revalidation*, NHS Employers, 2009
- *General Practices offering Extended Opening Hours under a Local Enhanced Service Agreement in Herefordshire*, NHS Herefordshire, May 2009
- *GP Earnings and Expenses Enquiry 2006/07 Report*, NHS Information Centre, May 2009
- *Health Select Committee Alcohol Report*, House of Commons, March 2009
- *Hereford A & E Pre-Reception Triage 2nd Pilot Report*, NHS Herefordshire, August 2008
- *Hereford Hospitals Trust Board Paper: Market Report (incorporating GP Survey Results), Quarter 1 2009/10*
- *Herefordshire Disability Equality Scheme*, Herefordshire Council, 2009
- *Herefordshire Place Survey*, Herefordshire Council, 2009
- *Herefordshire Provider Services Review*, Herefordshire Council and NHS Herefordshire, April 2009 (accessed on Herefordshire Council Intranet October 2009)
- *Survey of Patients Attending A&E*, Herefordshire PPI Forums, 2007
- *Survey of Local Health Services Herefordshire PCT*, Healthcare Commission, 2008
- *Personal Health Budgets: Expression of Interest*, Herefordshire Council, March 2009
- *Practice Based Commissioning GP Practice Survey: Wave 1-8 Results*, Dept of Health, September 2009
- *Primary Health Care for Social Excluded Groups, Call for Evidence*, Cabinet Office, April 2009
- *Quality and Outcomes Framework Guidance for GMS contract*, NHS Employers, 2008/09
- *Rural Health Planning – Improving Service Delivery across Wales*, Welsh Assembly consultation document, April 2009
- *Rural Proofing for Health: A Guide for Primary Care*, Institute for Rural Health, 2005
- *Use of Resources Profile Herefordshire PCT*, Audit Commission, Nov 2008
- *Results of various GP surgeries' annual patient surveys 2007-8-9*

Appendix B

Hereford A & E Pre-Reception Triage

2nd Pilot August 1,2,3 &4 2008

An analysis of 327 attendances/presentations at the DGH A&E is below.

For the purposes of the analysis, in hours is defined as 08.30 to 19.00 weekdays (despite GP hrs finishing at 17.30, GPOOH does not start until 19.00. This is unfortunate as on weekdays there is a definite peak in inappropriate attendance at 18.00)

Only 327 pts accepted for triage as due to staff sickness and pt workload a full 24hr triage presence could not be maintained from within existing staffing.

In Hours Attendances Disposals

A&E	Eye Cas	GP	OPD	Nil needed	TOTAL
65	36	16	3	2	122

This suggests **17.2% inappropriate A&E attendances.**

2 pts were sent by GP receptionists (according to pts) with abdo pain and diarrhoea !!

Out of Hours A&E Attendance Disposals

A&E	Eye Cas	GPOOH	GP/Pharmacy	OPD	TOTAL
126	13	30	34*	2	205

* it is accepted that of 34 patients referred to their own GP or pharmacy a percentage may well and probably did contact GPOOH services despite advice given.

Further to the above, 4 pts were incorrectly triaged to A&E and 7pts refused to leave A&E!

4 further pts were sent by Primecare to A&E as no doc present:

- 1 toothache
- 1 needed tetanus injection
- 1 had noticed BP had risen
- 1 had hip pain for 6 months

2 were sent back by Primecare as deemed inappropriate for them, I do not concur.

- 1 old pencil wound to face
- 1 allergic dermatitis

This gives a figure of at least 36.6% inappropriate attenders in A&E at least.

Further to this, several pts after further A&E assessment were deemed GP pts (12-15 in total). This leads to a figure of **at least 40% inappropriate.**

Looking at hourly attenders >45% were non A&E at peak times – Sat & Sun afternoons. The main reasons for inappropriate attendances were:

- Pregnancy related

Old Injury (maximum over 6 mnths!)
 Insect bites and stings
 Abdo Pain
 Soft tissue infection

During the period of study 6 medically expected and 4 surgically expected pts were excluded from analysis.

Conclusions

The study replicates the findings of the previous pilot.

Patients do not appear to know (or do not wish to know) how to access the appropriate care pathway...

At least 35% of A&E attendances are inappropriate and better dealt with by other HCPs.

Public Education of how to access the health service is not getting through.
 (Of those asked why they did not contact the GP service, the standard answer was "they only work Monday to Friday", there appears to be ignorance of the OOH service.)

Few patients had taken self medication or sought other advice.

Only 1 pt admitted to having contacted NHS Direct and had been wrongly sent to A&E.

Proposal

Funding should be sought for an extended trial of the 24 hour pre-reception triage, preferably over a 6 month period.

Funding would be available from savings to PCT made by not booking in 35-40% of pts in A&E (@£54 each). It is accepted that this would cause a loss of income to HHT but partially offset by less investigations due to inexperienced docs outside their remit.

The word would soon spread that going to A&E is not the correct way to gain access to all HCPs.

Reducing inappropriate attenders to A&E would allow better care to true A&E pts.
 (The Sunday of the trial, despite being in August, reduced the workload of A&E to 100. The staff of the dept remarked that this was the best Sunday in A&E for some time.)

NB

The present design of A&E does not lend itself to full pre-reception triage (lack of confidentiality).

Consideration of utilising present GP OOH desk for such or similar at entrance to A&E would be preferable.

Ideally combining A&E and GP reception/triage would be the best solution but would require some limited building alterations.

Can I thank my nursing staff for their hard work and also for putting up with abusive patients trying to short circuit the system.

A.Ballham 06.08.2008

Appendix C

Scoping document

REVIEW:	GP Services in Herefordshire	
Committee:	Health Scrutiny Committee	Chair: Councillor Patricia Morgan
Lead support officer:	Sara Siloko	

SCOPING

Terms of Reference
This review assesses the service levels and subsequent performance of General Practitioner (GP) services in Herefordshire, with particular focus on the provision of extended practice hours and the provision of preventive intervention measures and screening initiatives for their registered patients.

Desired outcomes
<ul style="list-style-type: none"> • To assess levels of overall service provided to Herefordshire residents by GPs under the Herefordshire Primary Care Trust (PCT) contract in order to: <ul style="list-style-type: none"> ○ seek assurance that the county's residents are receiving the level of service they need and deserve ○ identify and analyse any particular areas for improvement in the county's GP service provision • To ascertain the current level of access to GP services across Herefordshire with particular emphasis on identifying issues pertaining to access to out-of-hours across population groups and localities • Given the increasing emphasis on lifestyle choices and population wellbeing the review will examine GP involvement in preventive activities particularly for the major causes of disease and premature death in the county • To ascertain the governance arrangements for performance managing and changing the service when necessary • To ascertain the level of involvement of GPs in planning services

Key questions

- Do all population groups in Herefordshire enjoy a similarly high level of satisfaction as suggested by the overall figures from recent surveys?
- Are there specific population groups dissatisfied about their experience of GP services in Herefordshire?
- Do all population groups and localities enjoy equitable access to GP services in the county?
- Is access to GP services outside normal working hours similar across rural and urban parts of the county?
- Are there specific areas or population groups experiencing difficulties with accessing GP services in the county?
- Are there specific areas or groups in the county that are disadvantaged by the current arrangements for extended opening hours for GP services?
- Are there national targets relating to preventive services, and if so what are they?
- How are Herefordshire GPs involved in delivering effective preventive actions aimed at reducing diseases and premature deaths due to cancers, stroke and diabetes?
- What specifically are GP practices throughout the county doing to support the effort to reduce smoking, promote sensible alcohol use, and reduce the levels of obesity and sexually transmitted infections?
- How are local GPs currently engaged in the delivery of services such as social care and mental health in their communities?
- What impact will ongoing and planned changes in health and social care service provision - such as the push to reduce numbers in residential care, individualised budgets, etc - have on GP services?
- To what extent are local GP practices involved in identifying and meeting the extended needs of the patient population they serve by using the opportunities offered by Practice Based Commissioning?
- How do GPs in the county interact and support the community hospitals, nursing homes and Intermediate Care Units in their locality?
- How, and how often, do the commissioners of the service assess the needs of the county's population for GP services?
- How are resources to meet these needs allocated to GP surgeries in Herefordshire and how does this process compare with national guidelines?
- What is the process for meeting needs above and beyond those identified in the basic GP contract?
- How are local GP services financed, and how is that money allocated to basic services and

other services?

- What criteria have to be met in order for a GP surgery to agree to provide a new service?
- How does the PCT ensure and monitor that there is equitable access to services for all?
- How does the PCT measure the outcomes for Herefordshire patients?
- Are there any plans locally or nationally (intended or already under way) which will change the preventive and/or screening services provided by GPs for Herefordshire? What are these plans, and when and how will they be implemented?
- Are there any plans intended or already under way to change extended hours GP service provision for Herefordshire? What are these plans, and when and how will they be implemented?
- What feedback do GPs receive from the PCT regarding the results of its annual patient survey?
- If there are discrepancies in service levels in different parts of the county, what action do GP surgeries take, or propose others take, to ensure that more equitable and efficient services can be achieved?
- How does the PCT interact with the Local Medical Council (LMC) and ensure involvement of the local GPs in the planning of future services?
- How could communication between GP providers and the commissioners of services be improved?

Links to the Community Strategy

The review group will identify how the outcome of this review contributes to the objectives contained in the Herefordshire Community Strategy, including the Council's Corporate Plan and other key plans or strategies.

Links to the PCT commissioning of GP services

The review will include questioning of the PCT management on the level of commissioning for GP services and their evaluation of the service provider.

Proposed Methodology

- Desk based review of evidence, data and source documents
- Evidence review sessions and briefing from key informants
- Briefing from expert witnesses, officers, and selected informants
- Identification, collation, analysis and interpretation of locally available data
- Visits to model GP practices of renowned excellence outside the county
- Visits to a selection of GP practices in the county
- Focus group discussions with key informers, community members, patients and selected groups
- Obtaining the views of all GP practices directly via written response

Timetable	
<i>Activity</i>	<i>Timescale</i>
Agree approach, programme of consultation/research/provisional witnesses/dates	By Friday 10 April 2009
Brief review group	By Friday 24 April 2009
Collect current available data	By Friday 1 May 2009
Collect outstanding data	By Friday 15 May 2009
Analysis of data	By Friday 29 May 2009
Final confirmation of interviews of witnesses	By Friday 15 May 2009
Carry out programme of interviews	During first two weeks of June 2009
Agree programme of site visits	By Friday 15 May 2009
Undertake site visits as appropriate	During June 2009
Final analysis of data and witness evidence	By Friday 10 July 2009
Prepare draft report including options/recommendations	By Friday 17 July 2009
Test assumptions with informants	By Friday 31 July 2009
Prepare final report	By Friday 14 August 2009
Present final report to Health Scrutiny Committee	On ?? September 2009
Implementation of agreed recommendations	
Members	Support Officers
Councillor Brigadier P Jones Councillor P J Watts Councillor A Seldon - chairman Councillor G Lucas Councillor G Powell Councillor P Cutter	Sara Siloko

Appendix D

World Class Commissioning data

Attach

- 1) WCC 2009 diagram portrait.pdf
- 2) Appendix wcc1.pdf
- 3) WCC toolkit 2.pdf
- 4) WCC toolkit 3.pdf

Appendix E
Herefordshire GP access survey results
(supplied by NHS Herefordshire in July 2009)

Attach

1) WMSHA patient survey results Hfdshire PCT-GP access.pdf