

Why is this issue important?

Primary care is many people's first point of contact with the NHS. Around 90% of patient interaction is with primary care services.¹ In addition to GP practices, primary care covers dental practices, community pharmacies and high street optometrists. This summary will focus on primary care in GP practices and will include details on community pharmacies.²

The aim of primary care is to provide an easily accessible route to care, whatever the patient's problem. Primary health care is based on caring for people rather than specific diseases. This means that professionals working in primary care are dealing with a broad range of physical, psychological and social problems. An important role of primary care is acting as the patient's advocate and co-ordinating the care of the many people who have multiple health problems.

Primary health care involves providing treatment for common illnesses, the management of long term illnesses such as diabetes and heart disease and the prevention of future ill-health through advice, immunisation, screening and referral programmes.

The UK has been at the forefront of modern primary care development, and many countries continue to look to the NHS as a model to emulate. However, primary and community care services now face major challenges; with an increasing workload, an ageing population, and increasingly complex medical problems being diagnosed and managed in the community. The relationship between the public and health professionals is also changing – with an increasing focus on giving people information and involving them in decisions about their care.³

The NHS England's Five Year Forward View⁴ published October 2014 considers that the foundation of NHS care will remain list-based primary care. It highlights the pressure primary care is under and calls for a 'new deal' for GPs. It

reports that over the next five years the NHS will invest more in primary care. NHS England has given Clinical Commissioning Groups the option of taking on responsibility from NHS England for commissioning primary care locally. The Five Year Forward View also emphasises the need for investment in both prevention and joining up care and enabling shifts in investment from acute to primary and community services. The report discusses the need for an increase in the number of GPs in training as fast as possible and for new options to encourage retention.

NHS England commission primary care essential and additional services in general practice and pharmacies. They also commission the Quality and Outcomes Framework (QOF) and in 2015/16 enhanced services, including vaccination programmes and proactive case finding and patient reviews for vulnerable people.⁵

The Quality and Outcomes Framework (QOF) rewards GP practices for how well they care for patients rather than simply how many people they treat, based on performance against indicators. QOF focuses on the following domains:

- Clinical indicators relating to key disease areas and their treatment
- Additional services and treatment indicators

Practices can identify a number of patients as "exceptions", who are then not counted towards QOF. Reasons for citing a patient as an exception includes specific clinical reasons, as well as, for example, patients not responding to several requests for a clinical review in the practice.

Key outcomes

NHS Outcome Framework

Primary care has a role across all domains of the NHS Outcomes Framework

- ***Preventing people from dying prematurely (Domain 1)***
- ***Enhancing quality of life for people with long term conditions (Domain 2)***

¹ Health and Social Care Information Centre
<http://www.hscic.gov.uk/primary-care>

² Oral health and sight are addressed in separate JSNAs.

³ Primary Care Workforce Commission "The future of primary care: creating teams for tomorrow" July 2015

⁴ <http://www.england.nhs.uk/ourwork/futurenhs/>

⁵ <http://www.england.nhs.uk/commissioning/gp-contract/>

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- *Helping people recover from ill health or following injury (Domain 3)*
- *Ensuring that people have a positive experience of care (Domain 4)*
- *Treating and caring for people in a safe environment and protecting them from avoidable harm (Domain 5)*

Public Health Outcomes Framework

Relevant domains include:

- *Increased healthy life expectancy (Outcome 1)*
- *Reduced differences in life expectancy and healthy life expectancy between communities (Outcome 2)*
- *Health Improvement (Domain 2)*
- *Health protection (Domain 3)*
- *Healthcare public health and preventing premature mortality (Domain 4)*

Impact in Brighton & Hove

In Brighton & Hove, like elsewhere in England and Wales, there remain substantial gaps between numbers of people on disease registers in general practice and the modelled prevalence for those conditions in the local population.

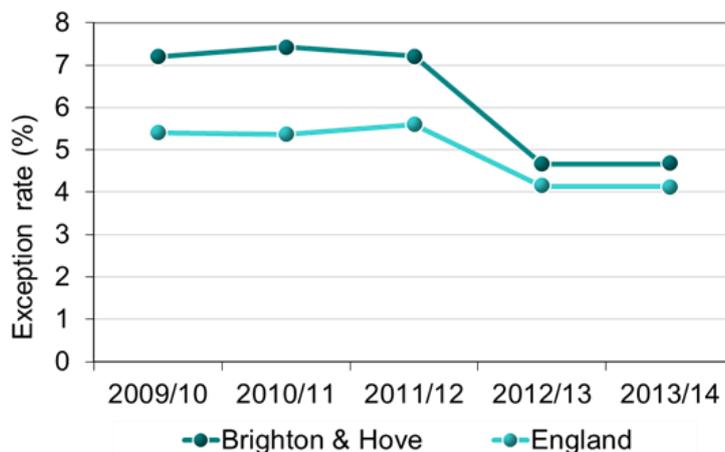
GP practices: There are now 44 GP practices in the city. According to survey completed by 67% of GP practices, Brighton & Hove CCG GP to patient ratio is one GP per 2,163 patients.⁶

In 2015 two GP practices closed, Eaton Place in the East locality and Goodwood Court in the West. Eaton Place withdrew from the core GP practice contract. Goodwood Court surgery was deemed inadequate by the Care Quality Commission across each of its five inspection areas: safe, effective, caring, responsive, well led.⁷ Charter Medical Centre took on the contract to provide care to the surgeries patients.

Exception reporting: For 2013/14 Brighton & Hove's exception reporting was 4.7%, a reduction from 7.2% in 2009/10. This may be influenced by

indicators being both withdrawn and added each year. However, Brighton & Hove has been persistently above the England average for several years, as shown in Figure 9. In 2009/10 Brighton & Hove's position was seventh in national ranking for exception reporting, it's now 43rd out of 211 CCGs. This still represents 46,244 patients and 53% of practices (25 out of 47) have an exception rate higher than the national average. Rates range from 2.3% to 9.1% (excluding Morley Street homeless practice – 20.3%).

Figure 9: QOF exception rates, all domains, 2009/10 to 2013/14 for Brighton & Hove and England.



Source: Quality and Outcomes Framework (QOF)
<http://www.qof.ic.nhs.uk/>

Patient satisfaction: In the most recent City Tracker Survey⁸, satisfaction with public services was highest for pharmacy, 88% of all respondents were satisfied with their local chemist and for residents who had used the services in the past year this increased to 90%. Satisfaction with the local chemist is slightly lower than in 2012 and 2013, but remains at a very strong level of 90%.

61% of all respondents and 74% of those who had been to their local NHS dentist in the last year were satisfied with their services. Older service users report higher satisfaction with their local chemist and their NHS dentist:

- 61% of those in the 55+ age category are very satisfied with their local chemist, compared with 45% of 35-54s and 50% of 18-34s

⁶ Health Education England GP Workforce tool. July 2015

⁷ Care Quality Commission. Inspection report. Goodwood Court. August 2015
<http://www.cqc.org.uk/location/1-614976812>

⁸ Brighton and Hove City Tracker Survey November 2014
<http://www.bhconnected.org.uk/content/surveys>

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- With regard to their NHS dentist, 55% of 55+ users are very satisfied, compared with 36% of 35-54s and 26% of 18-34s

Of all Brighton & Hove respondents, 76% were satisfied with their GP and this increased to 78% for those who had visited their GP in the past year. Older users are significantly more likely to be very satisfied with their GP:

- 60% of 55+ users are very satisfied, compared with 35% of 35-54s and 42% of 18-34s
- There is also significant variation by location: users in BN41 are most likely to be very satisfied (55%), followed by BN1 (50%). Elsewhere, satisfaction levels are lower, standing at 42% in BN2 and 38% in BN3

However satisfaction with GPs has dropped from 91% in 2012 and 90% in 2013 to 78% in 2014.

The 2014/15 GP Patients Survey for Brighton & Hove shows that 89% of patients thought that reception staff were helpful; 95% of patients were satisfied with the level of care they received from their GP, 98% received from their nurse. 78% would recommend their practice to others. 64% rated out of hours experience as good, 17% as poor. These results closely matched those nationally.⁹

Where we are doing well

Clustering of practices: In 2015 GP practices started to work together in 'clusters.' These are groups of practices covering approximately 40,000 patients. There are six clusters in the city (see appendix 1) covering every GP practice in the city. They have all agreed a Memorandum of Understanding about how they will work together, their values and objectives. There are plans for the future about practices joining together to form a Federation.

New models of working in GP practices: There are a number new innovations happening within GP practices in the city:

Extended Primary Integrated Care (EPIC) was a pilot project which is part of the Prime Minister's Challenge fund to improve access to primary care

services within the city. The project worked on changing five service areas:

- GP Triage – whereby GPs triage patients through a phone consultation;
- Extended hours and skill mix - to provide primary care services 8am – 8pm weekdays and during the weekends and to maximise the role of pharmacists and practice nurses;
- Pharmacy – for patients to have a choice of pharmacies and medical records shared between pharmacies and GPs to improve care and enable the pharmacist to take more of a role in supporting patients. Pharmacists support general practice to manage routine, non-urgent cases and people who struggle to access primary care in working hours.
- Community navigators – volunteers to help patients by supporting onward referral to community activities and personal support.
- Redirection of workflow - looks at how administration work which routinely crosses a GP's desk can be safely redirected to administrative staff in order to increase availability of GP time for clinical work.

Sixteen surgeries and 17 pharmacies were involved in the pilot, which was implemented in phases. The first phase of the pilot started September 2014 for a year.

Proactive Care: The GP practices have initially clustered together to work on a new service model titled 'Proactive care' aimed at transforming the management and care of people at risk of losing their independence within the primary care setting. It aims to support people where possible, to maintain independence through appropriate support, information and tools to empower them and their carers to be more in control of their care journey. Patients identified will be able to access the proactive, integrated and extended primary care services appropriate to their potentially complex needs. Key elements of the new model includes multi-disciplinary working, extended GP time and a new role called a 'care coach' to carry a non-clinical assessment and support patients to self-manage.

Locally Commissioned Services new outcomes based contract: The CCG and Brighton & Hove City Council Public Health Directorate are developing a

⁹ GP patient survey. <https://gp-patient.co.uk/> [Accessed August 2015]

new joint GP practice contract for services that are commissioned locally, called 'Locally Commissioned Services (LCS)' to start in April 2016. The purpose of this new contract and new way of working is to respond to the findings from the premature mortality audit (see local inequalities section), improve the quality and length of life for people with chronic conditions, to address inequalities in health and to improve patient experience. The new outcomes based LCS contract joins up the commissioning and delivery of CCG and public health commissioned services. The new contract will enable clusters of practices to work together differently to design care for patients, focused on improving health and wellbeing outcomes.

As part of the new LCS contract surveys, interviews and focus groups were carried out by a number of voluntary sector organisations.¹⁰ These groups represent and engage with different population and equalities groups in the city.

Key recommendations from across the reports are:

- GP practices to have more information in practices about support available to patients and carers and improved signposting by staff. This theme was mentioned in all reports.
- For all practices to support marginalised groups such as Gypsies and Travellers to register and benefit from GP practice services. Registering was the key issue identified in research conducted by Families, Friends and Travellers in 2013.¹¹
- There is a training need around communication and listening for all primary care staff that values different patient groups explicitly and including: older people, people with lived experience of mental health issues and people with learning disabilities.
- LGBT training for clinical and non-clinical staff is included in the planning for changes to primary care.

- More publicity about opening times and in particular about the Weekend Surgeries is needed
- The role of the Community Navigators should be strengthened as part of the preventative agenda and addressing the expressed need for information and signposting.
- Community navigators are trained in equalities training
- Due consideration should be given to patients who have a trusted relationship with their GP. Changes to Primary Care should not jeopardise this relationship and individuals should be given the opportunity to make an appointment with their designated GP.
- GP practices to ensure patient records are up to date and include key groups on registers such as carers and people with learning disabilities, this is to ensure patients are contacted and have access to annual and other health checks
- Longer GP appointments for those that need it
- To use GP telephone consultations as appropriate, it increases access for many but some groups with more complex needs benefit more from face to face consultations. Email communication where appropriate could also be helpful.
- Improving communications about medicines and services provided by pharmacies.

Local inequalities

As Brighton & Hove has significantly poorer (higher) mortality rates for causes considered preventable than England and the South East, and in particular under 75 mortality from respiratory disease a Preventing Premature Mortality Audit¹² has been carried out using data from all GP practices in the city for patients dying of cardiovascular diseases (CVD) or with diabetes or chronic obstructive pulmonary disease (COPD). Key findings from the first stage of the audit are:

Age, gender and deprivation: The majority of deaths were in patients aged 55-74 years and two thirds were males. There is a relationship with deprivation, with 46% of the variation in mortality rates by practice explained by the variation in

¹⁰ Carers Centre, Family Friends and Travellers, Age UK, Right Here, LiVE – Listening to the Voice of Experience, Speak Out, Amaze and Parent Carers Council, LGBT HIP

¹¹ Families, Friends and Travellers. Report of the intelligence gathered from Gypsy and Traveller communities-Summary of feedback and actionable recommendations. 2013. Submitted as part of the JSNA call for evidence 2015

¹² Preventing Premature Mortality Briefing, CCG Clinical Strategy Group, July 2015

deprivation by practice but it is not the whole story. The rate in the east locality is almost double that in the central locality, and is significantly higher than the overall premature mortality rate for the city. Rates were significantly higher in Queen's Park, East Brighton, Hollingdean and Stanmer, and Moulsecoomb and Bevendean wards.

Lifestyles: Rates of smoking, alcohol consumption above recommended levels and overweight/obesity were significantly higher than in the general adult population aged 18-74 years. Those who were still smoking and drinking above recommended levels died significantly younger than ex or non-smokers and those drinking below recommended limits. There was little recording of advice or referral for lifestyles issues.

Practice disease registers: Around a third of patients dying from CVD were not on a related disease register in primary care and whilst most patients dying with COPD or Diabetes were, around a third were excepted from registers and may have been missing out on preventive care. The care of those who were on disease registers and *not* excepted was generally good. A high percentage of patients on relevant disease registers were also on a depression register.

Secondary care: Contact with secondary care services was high with the majority of patients having had at least one hospital inpatient admission in the two years prior to their death (60%), this was much higher for patients who died with COPD (81%) or diabetes (80%). This emphasises the importance of this audit not just in terms of preventing death, but also time spent in ill health. Though small in number, there were patients not on disease registers in primary care who had had hospital admissions coded for the disease and so should have potentially been investigated further in primary care and placed on registers – the in-practice audit is looking at the details of these cases further. A sizeable percentage of admissions were mental health or alcohol related, tying in with the findings from the primary care records and emphasising the need to support people with chronic conditions and alcohol and/or mental health issues better in the city.

The second phase of the audit covered an in-practice audit where each patient's (within the audit) notes and communication were reviewed. Emerging themes from the in-practice audit show that the most common contributory factors are smoking, mental health issues, alcohol or substance misuse and isolation/vulnerable patients.

The findings and recommendations derived from the PPMA are being incorporated within commissioning of primary care locally.

Pharmacy services: The latest Pharmaceutical Needs Assessment (PNA) published March 2015 found our population has better access than most to pharmacy services with more pharmacies per head of population than neighbouring areas. There are currently 60 community pharmacies within the city. This translates to 22 pharmacies per 100,000.¹³

There is good coverage across the city of advanced and public health commissioned locally commissioned services such as smoking cessation in pharmacies. The PNA has not identified any significant gaps in the current pharmaceutical provision.

Respondents to the public survey were largely (83%) satisfied that existing pharmacy opening hours met their needs. However some respondents to the survey found it difficult to access a pharmacy between 9.00am and 5.00pm on a weekday. The PNA recommends that information about pharmacies opening after 6pm and during the weekends should be made more readily available to residents in different ways to ensure local people are aware of where and when services are available.

The PNA survey with residents and GPs showed that there is a lack of knowledge and understanding about the services delivered by community pharmacies. The report recommends that information on all pharmacy services should be made more readily available locally to different audiences, including GPs and residents.

Twelve Healthy Living Pharmacies have been established and are active in the city. They are

¹³ Brighton and Hove Pharmaceutical Needs Assessment 2015

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focused on efforts to reduce health inequalities and addressing needs of vulnerable groups; actively promote public health campaigns and information on access to local authority, voluntary sector and other primary care services including GPs and dentists.

Predicted future need

The resident population of the city is predicted to increase to 298,400 by 2024, a 6.7% increase compared to 2014 (an increase of 18,700 people). This is lower than the predicted increases for the South East (7.8%) and England (7.1%).¹⁴

The greatest projected increase (37%, 9,300 extra people) will be seen in the 55-64 year age group. The population of 77 - 79 year old is also predicted to increase by 34% (2,300 people) and those aged 90 or older by 25% (600 people). School aged children (5–14 years) are predicted to increase by 8% or 2,200 people.

Estimates suggest that one in six patients in the United Kingdom has more than one of the conditions outlined in the Quality and Outcomes Framework, and these patients account for approximately one third of all consultations in general practice.¹⁵ Research shows that approximately 65% of those aged 65 years or over and almost 82% of those aged 85 years or more had two or more chronic conditions. Although prevalence increases substantially with age, in absolute terms multi-morbidity is more prevalent in those aged less than 65 years and is much more common in socioeconomically deprived areas.¹⁶

Addressing the health needs of the city's patients with complex needs, as well as ensuring equity of primary care provision, is a priority. Primary care will need to respond to the needs of a changing population and people living longer with multiple conditions.

What we don't know

We do not currently have information on primary care or disease prevalence use by all protected characteristics.

We have relatively low stroke mortality in Brighton & Hove but a high level of modelled hypertension. We cannot explain this at this point in time.

We do not know what impact the city's level of ghost¹⁷ patients has on modelling of prevalence for specific conditions.¹⁸ The modelling uses standard national tools based on practice register populations rather than resident population figures from the Office of National Statistics based on census data.

Key evidence and policy

Preventing Premature Mortality Audit, Brighton and Hove 2015

Wallace E, Salisbury C, Guthrie B, Lewis C, Fahey T, Smith S "Managing patients with multiple morbidity in primary care" *BMJ* 2015;350:h176 doi: 10.1136/bmj.h176

2014 - 2015 GP Patient Survey, Brighton & Hove

2014-15 Annual Report of the Director of Public Health Brighton and Hove "Look, inequality"

Last updated

September 2015

¹⁴ Office for National Statistics. 2012 based sub national population projections. Available at: <http://www.ons.gov.uk/ons/publications/reference-tables.html?edition=tcm%3A77-335242> [Accessed 09/07/2015]

¹⁵ Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. *Br J Gen Pract* 2011;61:e12-21.

¹⁶ Barnett K, Mercer S, Norbury M, Watt G, Wyke S, Guthrie B. The epidemiology of multimorbidity in a large cross-sectional dataset: implications for health care, research and medical education. *Lancet* 2012;380:37-43.

¹⁷ 'Ghost' patients are patient who have moved away from the area in which they registered with a General Practice, but the Practice was either not informed or the patient was not removed from the register.

¹⁸ NHS Brighton and Hove / Brighton & Hove City Council. Vital: Annual Report of the Director of Public Health. 2011