# How Primary Care Works

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1

## Content

- History of Primary Care
- A typical GP Day
- GP today
- What are CCGs (and ICSs)?
- Negative Gossip
- GP FAQs

2

2

## History of General Practice

- Before the 20th century general practitioners worked as private traders.
- In 1911 Lloyd George introduced the National Insurance Act, making health insurance compulsory for working people on a low income.
  - Local insurance committees administered the scheme, contracting general practitioners to provide general medical services (GMS).
  - Doctors were paid an annual capitation fee for every insured patient who registered with them.
- When the NHS was created in 1948 everyone became eligible for free primary care.
- In 1966 a new contract improved pay and conditions, instituted a maximum list size of 2,000 patients
- The following years saw an increasing trend for group practice to become the norm.
- 1990s saw trends towards increased scrutiny and evidence-based medicine and launched an era of greater external management for general practice and introduced some performance-related pay.
- The 2004 GP contract represented a new relationship between GPs and the NHS, putting an increased emphasis on performance-related pay, as measured by the QOF.
- 2012: CCGs take on functions of PCTs
- 2019: Primary Care Networks are the start of development of Integrated Care Systems

3

3

# A day in GP

4

4

# Where are they hiding?



5

5

# A day in the life of a GP

0755 – Arrive at Work
0800 – Log onto clinical systems
– Lab results
– OOH notifications
0830 – 5 book-on-the-day tele consults
0900 – 10 prebooked tele-consults
1050 – 5 in-person appointments
1200 – 3 telephone consults
1230 – 1 or 2 home visits
1330 – Lunch doing prescriptions (30-100/day)
1400 - Incoming documents and tasks
1500 - 6 in-person consults
1630 - 6 telephone consults
1730 - any emergency "extra" consults
- complete any letters/forms
- complete prescriptions/incoming mail

6

6


**You can do so much in ten minutes' time. Ten minutes, once gone, are gone for good. Divide your life into 10-minute units and sacrifice as few of them as possible in meaningless activity.**

*Ingvar Kamprad, entrepreneur 1924*

7

7


A "jack of all trades…"

"…but a master of none…"

"…is better than a master of one"

8

8

# What are GPs good at?

**What GPs see & do…**

- Communication skills
  - Our main exams are around efficient consulting and focussed examinations
- Majority of NHS patient contact
  - Often quoted as “95% of contact with 5% of budget”
- Holistic, patient centred care
- Chronic disease management specialists
- Hold the risk of missed/delayed diagnosis

**What others think they see & do…**

- Short consults, no time for anyone
- Just annoying gatekeepers there to do referrals to real doctors
- Just there to chat
- Not specialist enough to know anything
- Refer everything/don’t refer enough

9

9

# Then and now

**Old time GP**

- Hypertension – once diagnosed admit to ward to start ramipril
- Heart attack treatment – home visit for morphine, aspirin (and hope for the best)
- Kitchen table tonsillectomies
- Lloyd George notes
- BNF – a leaflet
- Cardigans and elbow patches!

**GP 2021**

- Almost all hypertension managed by GP/nurse/pharmacist
- STEMIs sent for primary PPI in tertiary centres
- Reduced mortality rates for tonsillectomies
- Electronic Prescribing System
- BNF & CBNF
- Scrubs and suits!


10

10


BUILDING A BETTER GENERAL PRACTICE

11

11




12

12

# The structure of primary care delivery

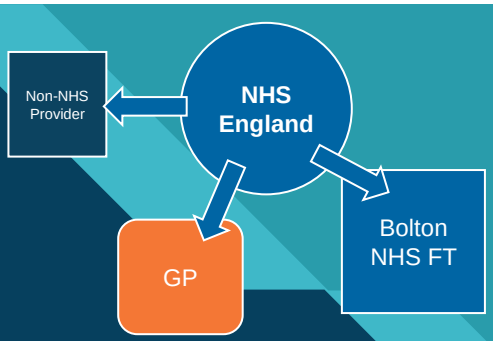
GP, CCGs and the new Integrated Care Systems

13

13

## What are general practices?

- General practices are the small to medium-sized businesses whose services are contracted by NHS commissioners to provide generalist medical services in a geographical or population area.
- While some general practices are operated by an individual GP, most general practices in England are run by a GP partnership.
- This involves two or more GPs, sometimes with nurses, practice managers and others (as long as at least one partner is a GP), working together as business partners, pooling resources, such as buildings and staff, and together owning a stake in the practice business.
- GP partners are jointly responsible for meeting the requirements set out in the contract for their practice and share the income it provides.

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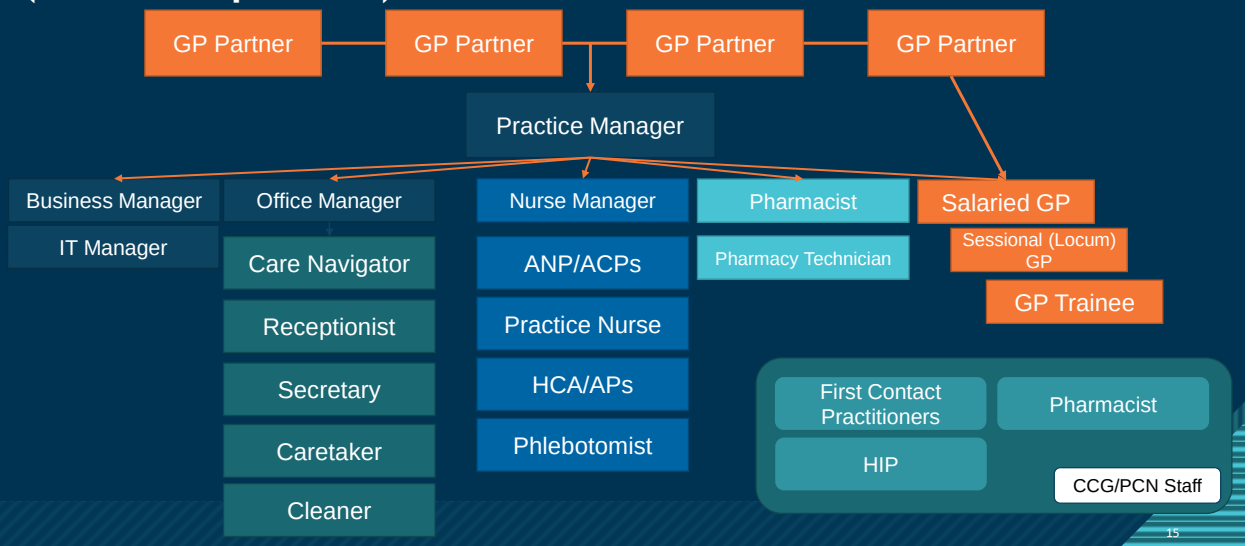
14

# GP Practice Organisation (Partnership Model)




15

# What's in a GP contract?

- The core parts of a general practice contract:
  - agree the geographical or population area the practice will cover
  - require the practice to maintain a list of patients for the area and sets out who this list covers and under what circumstances a patient might be removed from it
  - establish the essential medical services a general practice must provide to its patients
  - set standards for premises and workforce and requirements for inspection and oversight
  - set out expectations for public and patient involvement
  - outline key policies including indemnity, complaints, liability, insurance, clinical governance and termination of the contract.
- In addition to these core arrangements, a general practice contract also contains a number of optional agreements for services that a practice might enter into, usually in return for additional payment.
- These include the nationally negotiated **Directed Enhanced Services (DES)** that all commissioners of general practice must offer to their practices in their contract and the locally negotiated and set **Local Enhanced Services (LES)** that vary by area.

16

16

# What services can practices be contracted to provide?

**Essential services**

Primary care 8-6.30

**Out of hours services**

Can opt-out

Commissioners responsible

**Additional services**

Many provide, but can opt-out (i.e. minor surgery)

**Enhanced services**

Nationally agreed opt-in services (some vaccines, health checks)

PCNs

**Locally commissioned services**

Smoking cessation

Homeless service

17

17

# GP income

~~NHS Hospital Contract~~

Global Sum
core parts of contract

Carr Hill Formula
age/sex/needs/list turnover/staff market forces/rurality

OOH

QoF
Quality Outcomes Framework

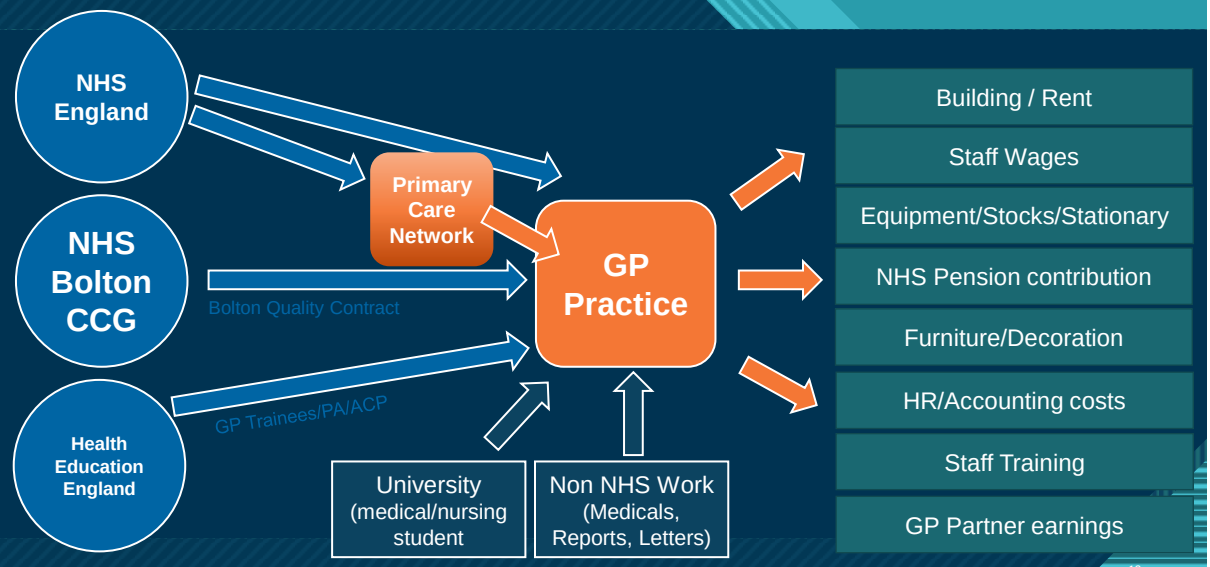
Premises Payment

Primary care organisation administered payments
locum allowances (parental leave)
appraisal costs
LES
Bolton Quality Contract

18

18

# GP Income in Bolton

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19

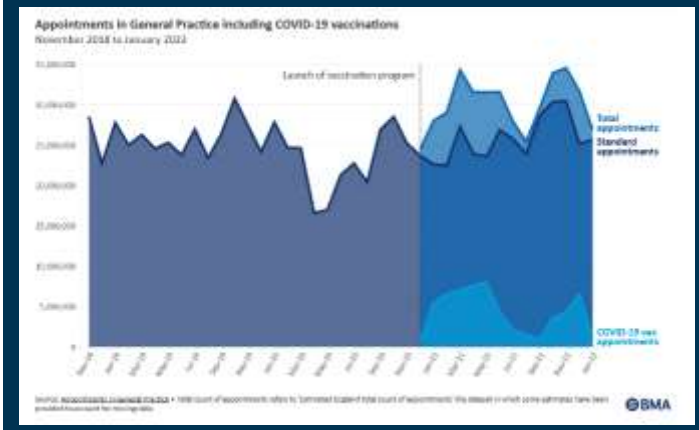
# Views from the front-line...



20

20

# GP Appointment data




**Number of GP Appointments**

- Jan 2022: 26.9 million appointments
  - *(of which 1.2 million were Covid vaccinations)*
- Jan 2021: 24 million
- Jan 2020: 28 million
- Jan 2019: 25.5 million
- Jan 2018: 25.3 million

**Hospital Outpatient Appointments**

2020-2021: 101.9 million
2018-2019: 123.4 million

21

21

# How much does it cost?

**General Practice**

- £148 per patient per year
  - (Bolton, 2020)


**NHS Trusts**

- Average hospital outpatient appointment cost:
  - £120 per appointment
- Average inpatient cost (ward):
  - £400 per patient per 24h


Cost of 1 appt/visit

| GP | ED visit | Ambulance |
|---|---|---|
| £39 | £77-£359 | £292 |

22

22

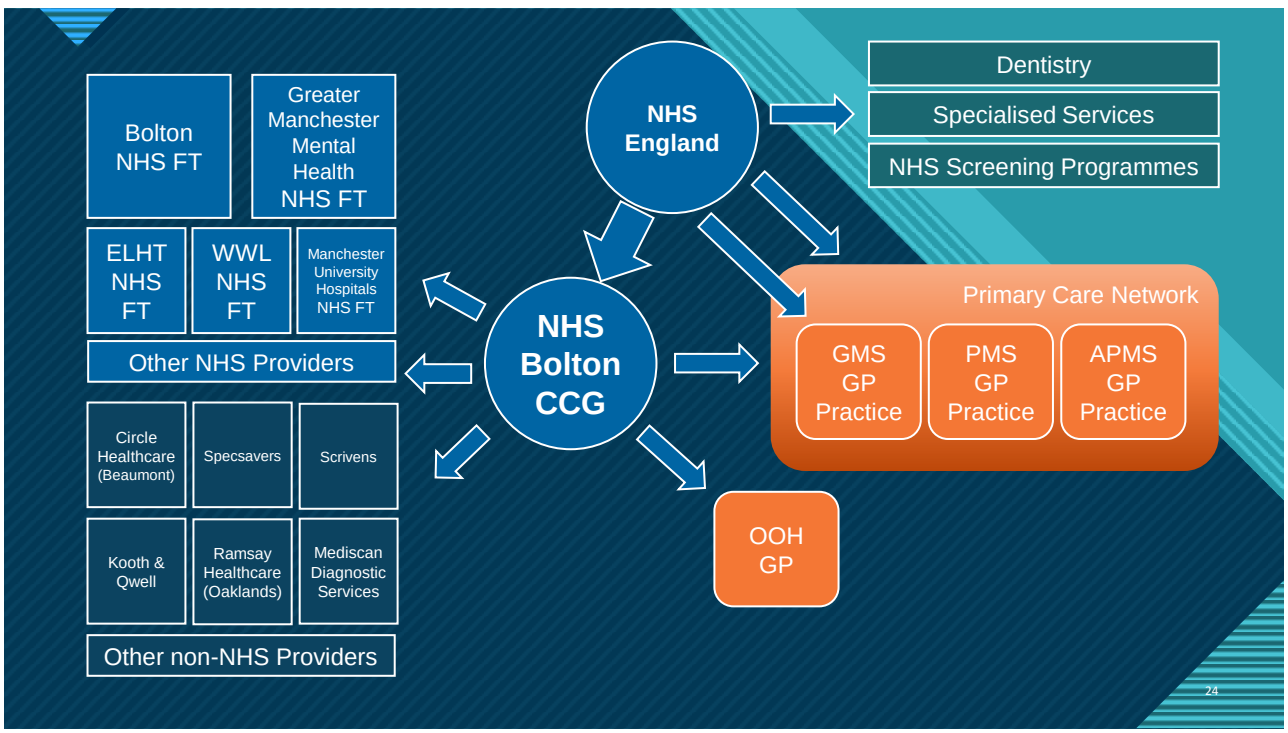
# What is a CCG?

- Clinical Commissioning Groups commission most of the hospital and community NHS services in the local areas for which they are responsible.
- Commissioning involves deciding what services are needed for diverse local populations, and ensuring that they are provided.
- CCGs are assured by NHS England, which retains responsibility for commissioning primary care services such as GP and dental services, as well as some specialised hospital services.
- All GP practices belong to a CCG, but CCGs also include other health professionals.

- Services CCGs commission include:
  - most planned hospital care
  - rehabilitative care
  - urgent and emergency care (including out-of-hours)
  - most community health services
  - mental health and learning disability services.

23

23




24

# Who does what?

| Bolton FT provides | General Practice provides |
|---|---|
| • District Nursing<br>• Allied Health Professions<br>  • Physiotherapy, OT, SLT, Dietetics<br>• Adult phlebotomy*<br>• Children's phlebotomy<br>• Minor Injuries<br>• Cardiorespiratory investigations<br>  • ECG, spirometry | • Primary care<br>  • By GPs & ACPs<br>• Chronic disease monitoring<br>  • Largely by primary care practice nursing<br>• Adult phlebotomy* |

25

25

# Bolton Quality Contract

**Section 4. The Bolton Standards**



NHS Bolton Clinical Commissioning Group

LET'S MAKE IT... Better Bolton.

26

26

# Integrated Care Systems

- **Integrated care systems (ICSs)** are new partnerships between the organisations that meet **health and care needs** across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
- NHSE say
  - "**Integrated care** is about giving people the support they need, joined up across local councils, the NHS, and other partners."
  - "It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services."
  - "In the past, these divisions have meant that too many people experienced disjointed care."

NHS in Greater Manchester

GMCA GREATER MANCHESTER COMBINED AUTHORITY

27

27

# Case Study

Hundreds of children in South Yorkshire get timely emergency surgery during pandemic thanks to new integrated pathway

- **What was the problem?**
  - The pandemic saw workforce pressures increase, trusts converting operating theatres into critical care beds, and anaesthetists re-allocated to focus on intubation of critical patients. Clinicians recognised this environment may impact negatively on care for children.
- **What was the solution?**
  - A new integrated care pathway saw children assessed on pickup by the ambulance crew, supported remotely by a clinician at Sheffield Children's Hospital to help decide where to take them. This ensured children got timely emergency surgery and freed up space in general hospitals for COVID patients and elective care.
  - All children under 16 needing emergency surgery went to Sheffield Children's Hospital; those needing time-critical surgery continued to the nearest district general hospital emergency department. Any patients walking into their local ED or GP practice were assessed and transferred to Sheffield Children's Hospital if they needed surgery.

28

28

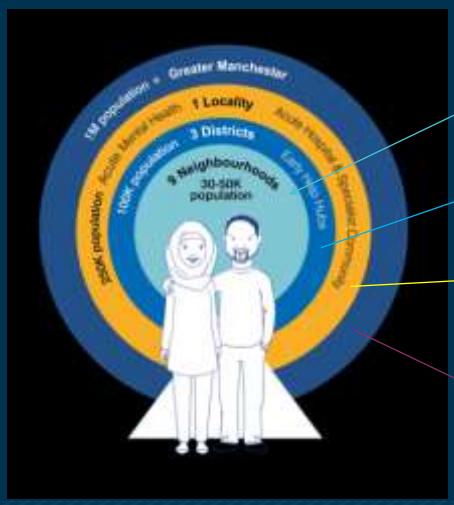
# Case Study

- **Growing up in Greater Manchester is more challenging than most parts of England.**



29

# Integrated Care System components




- **GP Practices**
  - 1 000-20 000 registered patients with defined boundary
- **Neighbourhoods**
  - 30-50 000 people
  - "cornerstone of integrated care"
- ***Districts***
  - *100 000 people*
  - *Bolton specific*
- **Places / Locality**
  - Matches natural geography/boundaries
  - Place-based commisioning
  - 250-500 000 people
- **Systems**
  - 1-3 million people
  - Overall planning

30

30

# Primary Care Networks (Neighbourhoods)

- Each neighbourhood is different and people living in Farnworth will experience different health challenges to those living in Turton. The aim for each neighbourhood will be to improve the health of its population and to ensure a better experience for patients.


31

31

# Our local ICS

Bolton Council

Bolton CVS

Bolton HEALTH AND CARE PARTNERSHIP

NHS Bolton NHS Foundation Trust

NHS Greater Manchester Mental Health NHS Foundation Trust

NHS Bolton Clinical Commissioning Group

Primary Care

32

32

# Colleagues

33

33

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I’ve come to A&E because GPs are useless, they don’t do anything except refer and they missed my friend’s possible cancer so I want to be seen by a proper doctor

34

34



35

35

## Negative Gossip

- Controlling for negative affect, negative gossip is positively related to burnout.
- Negative gossip is negatively related to job engagement.
- Controlling for burnout, negative gossip is positively related to suboptimal care.
- Controlling for burnout, negative gossip is negatively related to patient safety.

- Georgantaa K, Panagopouloub E, Montgomery A (2014); **Talking behind their backs: Negative gossip and burnout in Hospitals**; Burnout Research 1(2): 76-81

- Gossip creates a feeling of connection with everyone else who is struggling similar feelings of frustration
- We use gossip as a way to collect evidence that confirms our beliefs, satisfying our confirmation bias
- When we get confirmation for our existing beliefs, and the satisfaction that comes from "being right"
- The flood of adrenaline and dopamine that accompanies "feeling right" becomes addictive

- Ask yourself or others why you need someone else's confirmation about a behaviour that you're noticing in a third person
- Create a feedback-rich environment around you.

36

36

# If you seek, you shall find…

Positive GP experience

Wow, even though they're busy I still got an appointment

It only took 2 ten-minute appointments for them to diagnose and treat me

Typical, you can never get an appointment

They had no idea when I first went to see them – I had to make a second appointment to get a treatment

Negative GP experience

Don't reinforce incorrect beliefs

Consider whether the story is true

Promote realistic expectations


37

37

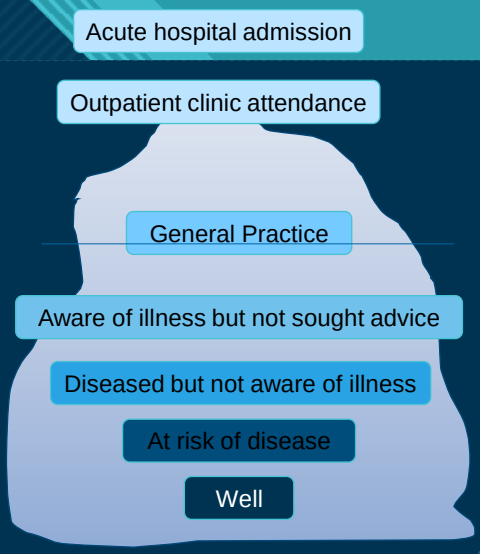
# Why are they "hiding"?


- The art of diagnosis lies mainly in the history
  - *Think about the diagnosis of a simple mole vs melanoma*
- Examination forms a small part of consultations
  - Unexpected findings are unusual
  - Management plans usually derive from the story
  - Examination is often part of the "theatre" of a consultation
- Pre-pandemic drive for remote consulting
  - GP at Hand/Babylon
  - Many patients want convenience

38

38

## The Clinical Iceberg




39

39

## GP FAQs

- Why don't GPs do OOH?
- Why do GPs not refer properly?
- Why won't GPs just do the prescription?

40

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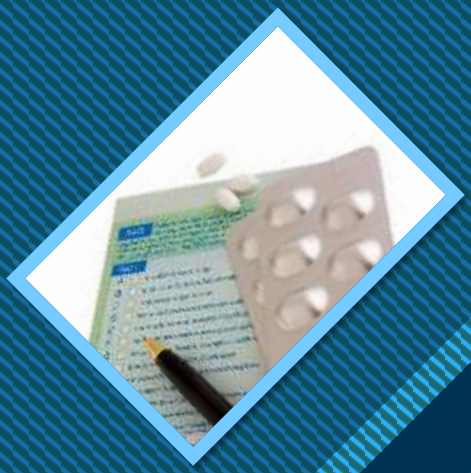


# Prescribing in Primary Care

41

# An Urgent Request

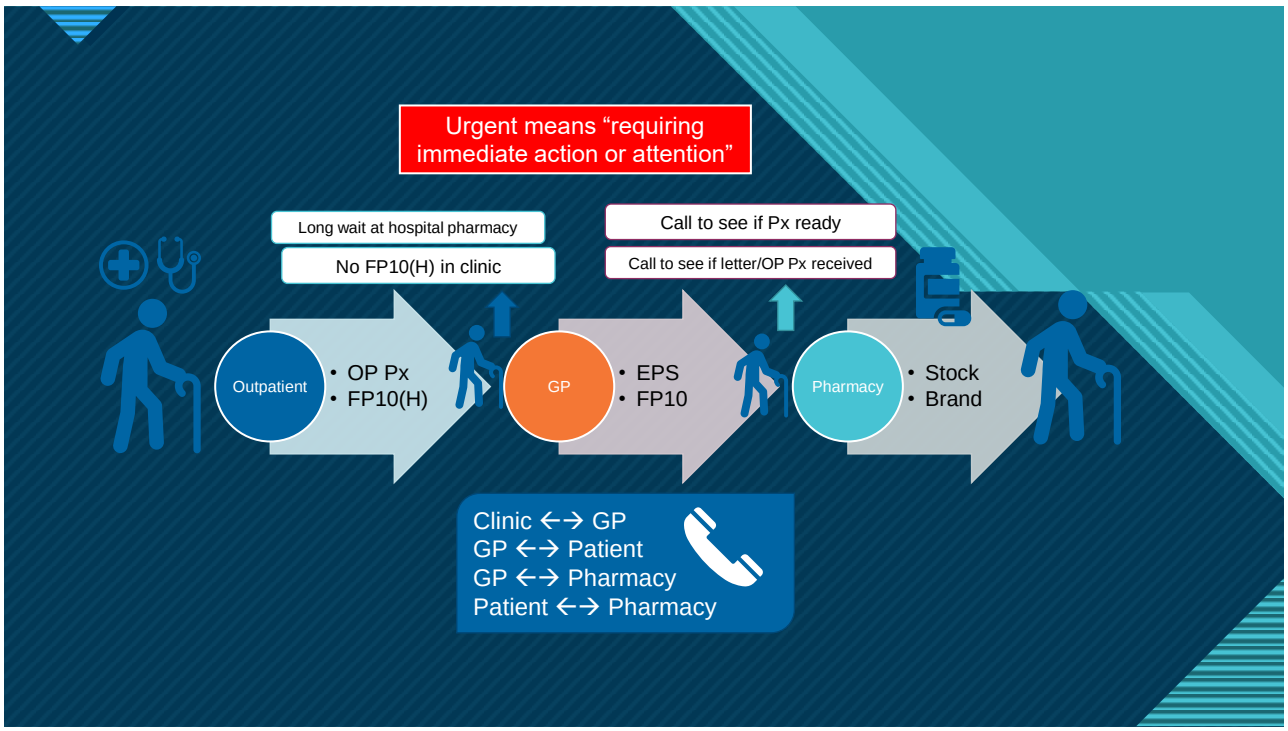
42

# An Urgent Request

- "Urgent" telephone triage request
- "I've seen the specialist, they want me to start a new medication straight away, is it ready yet?"
  - No fax/letter received
  - Patient unsure what medication is
- Call to clinic, message left and call back later
  - Irate patient
- Prescription issued via EPS later that day.
  - Collected by patient 2 days later


43

43




44


45

# A Home visit

46

# Home visit

- Visit to Betty, 82 and “can’t move as dizzy”
- Diagnosis of a flare of BPPV
  - Needs a prescription for betahistine
- No carers, relatives or neighbours


47

# EPS (electronic Prescription Service)

- EPS has saved the NHS £130 million over three years (2014-2017)
  - Practices save an average of **43 minutes per day** by not having to locate paper prescriptions
  - Practice staff save an average of **39 minutes every day** by not having to wait for GPs to sign urgent paper prescriptions
  - Pharmacists reported on average they were saving around 54 minutes a day as result of faster dispensing

NHS Electronic Prescription Service

48

# Community Pharmacy

- Pharmacy contractors receive funding via their contract to the NHS:
  - Establishment Payment
  - Practice Payment (staffing*)
  - Reimbursement for items at a set drug tariff
  - a professional fee for each item dispensed (currently 90p per item)
- NHSE/Local CCG may also provide funding to encourage dosette boxes, medication reviews, common ailment schemes etc

*based on number of dispensed items/month


49

# Shared care

50

# Shared care

NHS

Dear Dr,

Re: Peter Brown; 01/01/1980

*Peter* was seen in clinic today. A full letter will follow, but please start:

*aripirazole and titrate dose upwards for this patient.*

Yours sincerely,

Dr Psychiatrist

- Peter attends reception to collect medication for his borderline personality disorder.
- The clinic has faxed across the following request.

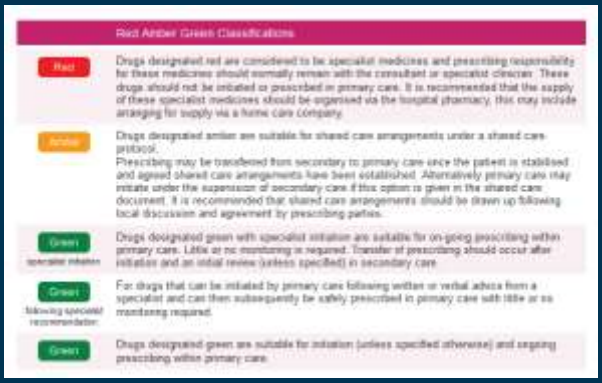

51

http://gmmmg.nhs.uk/


http://gmmmg.nhs.uk/

52

# RAG List




- The RAG list provides a framework for defining where clinical/prescribing responsibility should lie through categorisation of individual drugs.
- The criteria used for defining status are based on:
  - the specialist nature of the drug,
  - the complexity of the assessment and monitoring arrangements required for the care of the patient,
  - clinical responsibility and competency associated with the prescribing of a medicine
- They are not based on the cost of a medication.

53

# Safe prescribing

- Medication errors account for approximately 20% of all clinical negligence claims against doctors in both primary and secondary care.
- The costs associated with adverse events and inappropriate prescribing has been estimated at more than £750 million per year.

- It is common for GPs to be asked to continue prescribing a medication started in the secondary care setting. The following information needs to be communicated from specialist to GP before prescribing :
  - Aim of treatment
  - Mechanism of action
  - Dose and frequency
  - Risks and benefits
  - Any monitoring that is required
  - Potential side effects
  - What the patient has been told.

54

## Shared Care Guidelines

- A shared care guideline outlines ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and a primary care prescriber.
- Primary care prescribers are invited to participate. If they are unable to undertake these roles, then he or she is under no obligation to do so.
  - In such an event, the total clinical responsibility for the patient for that diagnosed condition remains with the specialist.

55

# A Discharge Letter

56

# A Discharge Letter

- Patient admitted for 3 days, told to see GP after discharge for medication review, brings discharge summary:
  - Diagnosis unclear; states NSTEMI, but later states coronary spasm
  - Started on dual antiplatelet therapy
- How long should he be on it?
  - No angiography/stent mentioned
- What is the diagnosis?

57

# Transfer of care

- Before the transfer of responsibility of prescribing takes place from secondary to primary care, the patient's condition must be stable or predictable. Primary care must consent to take on that responsibility and training and resources need to be in place.
- Legal responsibility for prescribing lies with the health professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence.
- Hospitals should provide patients with enough medicine to last a **minimum of seven days** after discharge, or until a communication can be provided to enable safe ongoing prescribing.[1]


1. NHSE (2018) Responsibility for prescribing between Primary & Secondary/Tertiary Care

58

## Discharging patients

- If a medicine has been stopped during admission:
  - State why, this will help GP understand if can/should be restarted
- If a medicine has been started during admission:
  - State why, this will help GP understand:
    - How long needs to continue for
    - Whether can be stopped if not tolerated
- If a medication change requires monitoring:
  - When does it need doing (within 14 days, hospital should arrange)
  - What parameters should the test fall within, and what should GP do if outside these?

Why?

59

# How much?

60

# Prescription costs

1. Atorvastatin 80mg tablets, ONE taken each day
2. Ramipril 10mg capsules, ONE taken each day
3. Bisoprolol 2.5mg tablets, ONE taken each day
4. Aspirin 75mg tablets, ONE taken each day
5. Omeprazole 20mg capsules, ONE taken each day

One-third of people with long-term conditions not exempt from charge don't collect their prescription

61

# Prepayment certificate

- £9.35 per item (as of April 2021)
- Secondary Prevention [Tariff]:
  - Aspirin 75mg [£1.13]
  - Atorvastatin 80mg [£1.77]
  - Ramipril 10mg [£1.29]
  - Bisoprolol 2.5mg [£0.61]
  - Omeprazole 20mg [£0.75]


| Pre-Payment Certificate | |
|---|---|
| 3 months | £30.25 |
| 12 months | £108.10 |


62

- https://www.pulsetoday.co.uk/views/copperfield/let-me-refer-you-to-my-previous-answer

63

63

# Antibiotic Prescribing


- **Expectations for consultations and antibiotics for respiratory tract infection in primary care: The RTI clinical iceberg**
- Br J Gen Pract 2013; DOI: 10.3399/bjgp13X669149
- One-fifth of those with an RTI contact their GP and most who ask for antibiotics are prescribed them.
- A better public understanding about the lack of benefit of antibiotics for most RTIs and addressing concerns about illness duration and severity, could reduce GP consultations and antibiotic prescriptions for RTI.

64

64