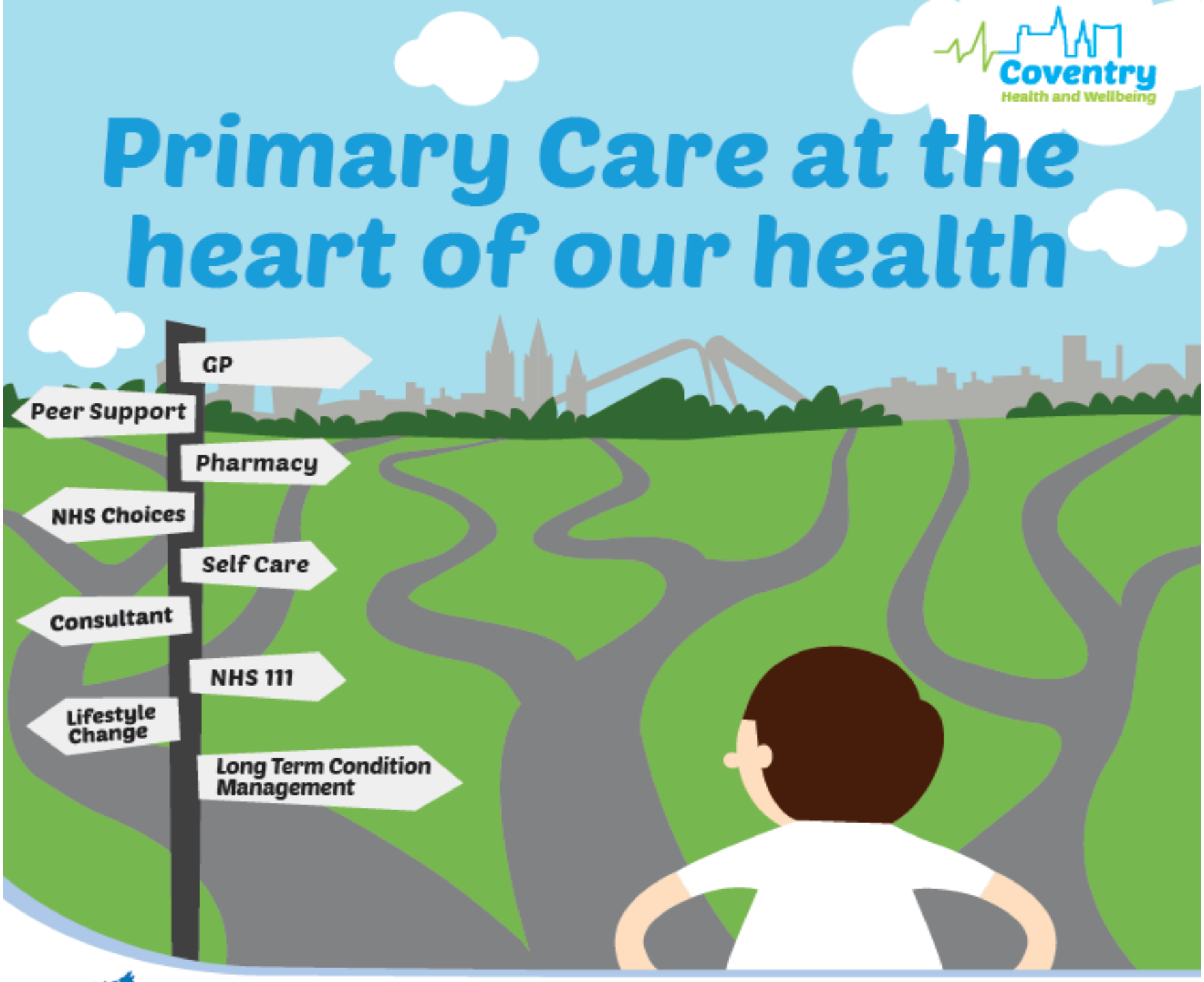
Coventry
Health and Wellbeing

Primary Care at the heart of our health



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Foreword

This is my second report as Director of Public Health for Coventry City Council. Last year I looked at healthy behaviours in the city and how these have changed over time. This year I have chosen to focus on the primary care system and its unique role in addressing health inequalities. As well as providing high quality care and encouraging people to make healthier choices, GPs tackle health inequalities by acting as advocates for patients and providing important links to services including housing, welfare and benefits advice, particularly for more vulnerable groups.

There are differences in life expectancy within almost all cities in England, and Coventry is no exception. Men in the most affluent areas of the city will live, on average, 11.2 years longer than men in the most deprived areas, while for women the difference is 8.6 years. There are many factors which contribute to these health inequalities, including how much you earn and how long you stay in education. We also know that some of the inequality in life expectancy can be addressed by good quality health care.

Primary care has been at the heart of the National Health Service since it was formed in 1948. It is often defined as the first point of contact between individuals and families with the health system, and encompasses a range of community based health professionals including GPs, nurses, pharmacists, therapists and dentists. General practice lies at the core of primary care and is the main focus of my report. I recently spent time with a local GP in their surgery and saw the central role that primary care services play in people's lives. By providing care for the whole person rather than focusing on treating individual conditions, GPs are able to have an impact on a range of factors that affect people's health.

This report has been prepared in consultation with patient representatives, GPs and local and regional organisations that have responsibilities for working together to ensure that everyone in Coventry has access to high quality primary care. However this remains an independent report and the recommendations are my own. It includes a number of case studies highlighting areas of innovative practice in the city, along with detailed feedback from patients on a range of issues. It also highlights areas where there is more work to be done to overcome the persistent challenges that affect primary care provided and health outcomes across the city.

I am very grateful to everybody who has contributed to and commented on this report. I look forward to continuing to work collaboratively to build on the successes of recent years and ensure that good practice is shared and celebrated, whilst also addressing areas for improvement and developing new service models to ensure that general practice is fit for the future.

Dr Jane Moore,
Director of Public Health

A note on the data

We have used data from a variety of sources including the 2011 Census, the GP Patient Survey, the Quality and Outcomes Framework, the Public Health Outcomes Framework, the National Cardiovascular Intelligence Network, the Health and Social Care Information Centre, Public Health England, Coventry and Rugby CCG and NHS England. Where possible we have compared Coventry with England, with the West Midlands and with similar areas, such as the 'Centres with Industry' cluster of local authorities or the ten Clinical Commissioning Groups with similar characteristics to those of Coventry. Where possible we have also looked at trends over time to identify where there have been changes and improvements. We use statistical techniques to make sure the conclusions we draw from the data are as robust as possible but in the real world we are not always able to act on the basis of perfect information. We need to draw conclusions based on the best available data combined with sensible judgements, and this is what we attempt to do in this report.

Contributors and commentators

This annual report relies on the time and talent of colleagues whose contributions and comments are acknowledged with grateful thanks:

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Glossary

10 most similar CCGs	10 most similar CCGs from the 'Commissioning for Value Insight Pack': NHS Wakefield CCG, NHS Bristol CCG, NHS Greater Huddersfield CCG, NHS Sheffield CCG, NHS Southern Derbyshire CCG, NHS Stoke on Trent CCG, NHS Hillingdon CCG, NHS Bolton CCG, NHS Hull CCG, NHS Greater Preston CCG
A&E	Accident and Emergency Department
AF	Atrial Fibrillation
ARB	Angiotensin receptor blocker
BMJ	British Medical Journal
BP	Blood Pressure
CCC	Coventry City Council
CCG	Clinical Commissioning Group
Centres with Industry	Cluster of local authorities: Blackburn with Darwen, Bolton, Oldham, Calderdale, Walsall, Coventry, Kirklees, Derby, East Lancashire, Heywood, Middleton and Rochdale, Bradford and Airedale
Cephs	Cephalosporins – broad spectrum antibiotics
COPD	Chronic Obstructive Pulmonary Disease
COVER	Cover of Vaccination Evaluated Rapidly (vaccination statistics)
CRCCG	Coventry and Rugby Clinical Commissioning Group
CWPT	Coventry and Warwickshire Partnership Trust
Decile	A tenth
DPT	Diphtheria, Pertussis and Tetanus

GPPS	NHS England GP Patient Survey
HLP	Healthy Living Pharmacy
HSCIC	Health and Social Care Information Centre
IAPT	Improving Access to Psychological Therapies programme
IMD2010	Indices of Multiple Deprivation 2010
INT	Integrated Neighbourhood Team
JSNA	Joint Strategic Needs Assessment
KPMG	Accountancy Consultants
LGA	Local Government Association
LSOA	Lower Layer Super Output Area
LMC	Local Medical Committee
MMR	Measles, Mumps and Rubella
NSAIDS	Non-Steroidal Anti-inflammatory Drugs
NICE	National Institute for Health and Care Excellence
PCT	Primary Care Trust
PHE	Public Health England
ONS	Office for National Statistics
QOF	Quality and Outcomes Framework
Quins	Quinolones – broad spectrum antibiotics
Quintiles	Fifths
TB	Tuberculosis
UHCW	University Hospital of Coventry and Warwickshire

Executive Summary

Setting the scene

Primary care in England is operating in an increasingly challenging context. Rising patient expectations, an ageing population, the rising prevalence of chronic disease and the emergence of new technologies are putting real pressure on the system. This is combined with a reduction in resources available in primary care and reduced recruitment to GP training schemes. These challenges are also reflected at a local level.

Coventry has higher levels of deprivation and poorer overall health than England as a whole. The population of the city is diverse, with a high proportion of residents from black and minority ethnic backgrounds, and 21% of all residents born outside the UK.

Recent improvements

There have been improvements in several aspects of primary care in Coventry in recent years. Work to improve quality in prescribing has led to notable improvements against national indicators in a short period of time. There has been a substantial increase in the number of Quality and Outcomes Framework points awarded to GP practices in Coventry, which is based on management of chronic diseases, organisation of practices, how patients view their experience and the extra services offered by the practice. In addition, an increase in the number of health checks completed, an increase in the percentage of children immunised against infectious diseases and a reduction in the prevalence of smoking in Coventry are all improvements which will have a positive impact on health inequalities in the city.

Persisting challenges

Whilst there have been improvements in several areas, the report also demonstrates that there is persisting variation in some aspects of primary care in the city. These include variation in access to general practice and patient experience of general practice in Coventry. There is also variation in the way GP practices are structured in Coventry, with a larger proportion of single-handed practices compared to the average for England.

In order to reduce variation and overcome these challenges, it is necessary both to provide support for practices that do least well to make rapid improvements, identify innovative ideas in the practices that are performing well and to share these with others. At the same

time, patients should be educated and encouraged to live healthy lifestyles, look after themselves, and access the most appropriate service for their needs.

Looking to the future

This report considers a number of innovative approaches and examples of areas where general practice and other primary care services provide not only diagnosis, referral and treatment services but influences the wider care system. Examples of these include:

- greater use of telephone consultations in Coventry which aim to reduce the number of face to face GP consultations that take place, to improve access for patients and to ensure that GP time is used to address the most urgent patients
- the development of a primary care safeguarding forum to share good practice in relation to safeguarding in primary care
- the piloting of a new model of delivery in Tile Hill and Hillfields which integrates existing teams and services to improve outcomes for children aged 0-5 years
- projects that aim to support patients to develop strong social networks to reduce isolation and promote wellbeing, independence and stronger connections
- the piloting of a new integrated neighbourhood team model which aims to ensure that the frail elderly population receive the most appropriate level of care within the community and that the reliance on statutory agencies is reduced.

Prescription for change

The following recommendations are a summary of those which are set out in full in the final chapter of this report. They are aimed at celebrating the progress and achievements of primary care in Coventry, but also at reducing the variation and overcoming the challenges that persist in order to improve health in the city. They are aimed at public health, patients, practices, commissioners and the wider care system and they take account of the challenging context within which primary care operates, both nationally and locally, looking to potential future developments that will ensure that primary care can adapt to these challenges.

The Primary Care Quality Group, directly accountable to Coventry's Health and Wellbeing Board, will provide strategic leadership to oversee the further development and implementation of these recommendations, driving forward an action plan in collaboration with wider stakeholders.

Keeping people healthy:

1) Public health should work with GPs and communities to continue to promote healthy lifestyles to ensure people stay healthier for longer.
2) Public health and GPs should work together to enable practices to better understand the population in their local areas.

Making the right choice:

3) Patients should have a more active role in managing their health.
4) Patients should choose the most appropriate service for their needs.
5) Patients should be involved in co-designing services.

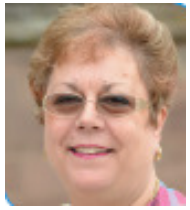
Collaborative and innovative primary care:

6) General practice should be open and accessible.
7) Practices should collaborate and share learning.

A health and social care system that supports good primary care:

8) A workshop should be organised to consider the future reconfiguration of general practice in the city.
9) Mechanisms to celebrate and share success should continue.
10) Communication materials should be developed to engage with and inform the public.
11) Commissioners should continue to provide feedback and support to practices that are most challenged.

Cllr Alison Gingell, Cabinet Member for Health and Adult Services at Coventry City Council and Chair of Coventry's Health and Wellbeing Board



"I welcome the focus of this year's Director of Public Health Annual Report on primary care. GPs are uniquely placed in the heart of our local communities and I know work incredibly hard to change people's lives for the better. My aspiration is for everybody in the city to be able to access high quality primary care services. The Coventry Primary Care Quality Group will ensure that we continue to work together to drive improvements in the city."

Chapter 1: Introduction

Health inequalities

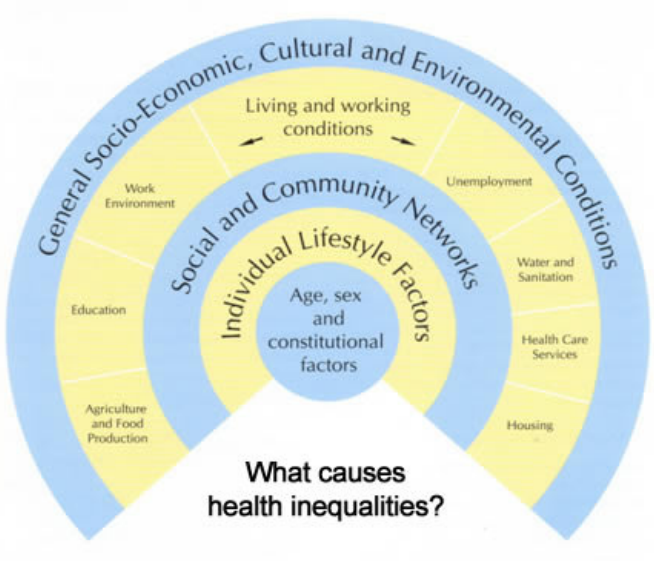
Beyond genetics, our health is determined by exposures to health threats, lifestyles and behaviours we adopt, our access to healthcare and 'wider determinants of health' – our position in society, where we live, whether we work or not, and our occupation (as demonstrated in Figure 1). People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged.[1] [2] Health inequalities are not only apparent between people of different socio-economic status – they also exist between different ethnic groups, between genders and between people who do and do not suffer from a disability or a mental health condition.[3]

"Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work and age"

Sir Michael Marmot, 2010[4]

[1]Acheson D. Independent inquiry into inequalities in health report. London: The Stationery Office, 1998.
[2]Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Institute of Futures Studies, 1991.
[3]U.S. Department of Health and Human Services (HHS), National Health Promotion and Disease Prevention Objectives, conference ed. in two vols, Washington, D.C., January 2000
[4]Marmot M. Fair society, healthy lives: Strategic review of health inequalities in England post-2010. London: UCL/The Marmot Review, 2010.

Figure 1: Wider Determinants of Health



The wider determinants of ill health not only increase the likelihood of illness, but also reduce the likelihood of accessing treatment. Julian Tudor Hart, a Welsh GP, was among the first to identify that those in least need of health care tend to use it more often and more efficiently, while those in most need of care are least likely to receive it.[5] The inverse relationship between the use of healthcare and the need for it may be explained by a number of factors, including barriers to accessing care, less availability of quality care in deprived areas, and differences in the perception of risk between different socioeconomic groups.[6] [7]

[5]Hart JT. The inverse care law. *Lancet* 1971; 297:405-412.
[6]Appleby J, Deeming C. Inverse care law. *HSJ* 2001;111(5760):37.

In addition, even once patients from deprived areas do access healthcare, in order to be successfully treated they need to be correctly diagnosed, prescribed the right treatment and comply with the treatment. Chris Bentley's 'decay' model describes how errors, omissions or barriers to accessing care reduce uptake at each of these stages, with those most likely to be lost at each stage often those who are most disadvantaged. In order to prevent this, it is necessary to:

- Promote awareness and understanding amongst the most vulnerable communities
- Provide opportunities for presentation and assessment through a range of entry points
- Provide a high quality service that delivers the right interventions in the right way
- Support self-management of conditions, including peer support.[8]

Reducing health inequalities

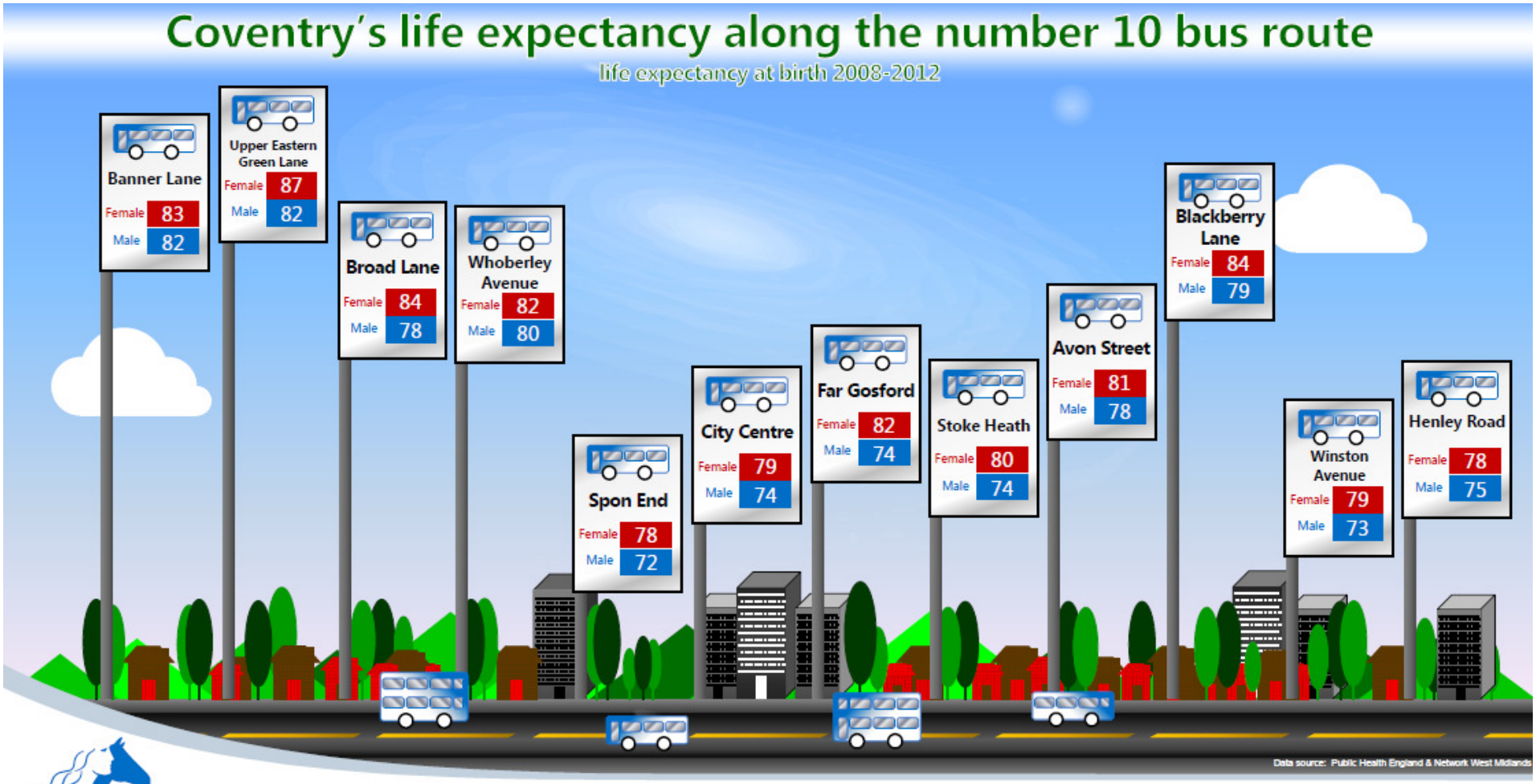
The transfer of public health services to local authorities in April 2013 provided new opportunities to broaden ownership of the health inequalities agenda. Local authority public health services have a statutory duty to provide services that they believe are appropriate to improve public health under section 2B of the NHS Act 2006.[9]

The majority of health inequalities occur due to social and economic factors. There are differences in life expectancy within almost all cities in England, and Coventry is no exception. Men in the most affluent areas of the city will live, on average, 11.2 years longer than men in the most deprived areas, while for women the difference is 8.6 years. Figure 2 shows how life expectancy in Coventry varies along the number 10 bus route. Following a review by Michael Marmot into the impact of health inequalities in the UK, Coventry was one of seven cities in the UK invited to participate in the UK Marmot network and become a Marmot City. This provides Coventry with an opportunity to accelerate action on the wider social determinants of health.

[7]Lee JE, Lemyre L, Turner MC, *et al.* Health risk perceptions as mediators of socioeconomic differentials in health behaviour. *J Health Psychol* 2008;13:1082-91.
[8]Bentley C. Health inequalities in Maidstone: A rapid external review, 2012: file:///C:/Users/cwoma070/Downloads/Addressing%20Health%20Inequalities%20in%20Maidstone%20Final%20(2).pdf

[9]Department of Health, Public health supplement to the NHS Constitution for local authorities and Public Health England, 2013: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/180856/NHS_Constitution-PublicHealthSupp.pdf

Figure 2: Life expectancy variation along the Coventry number 10 bus route



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Inequalities in access and care quality also exist within the NHS, and healthcare can drive, or further compound health inequalities as well as contributing to their reduction.[10] [11] Primary care is often defined as the first point of contact between individuals and families with the health system. It encompasses a range of community based health professionals including GPs, nurses, pharmacists, therapists and dentists. General practice lies at the core of primary care and is positioned in the heart of communities.

General practice and the wider primary care system in which it operates form the subject of this report, as they have a unique role to play in addressing health inequalities. As well as providing high quality care and encouraging people to make healthier choices, GPs tackle health inequalities by acting as advocates for patients and providing important links to services including housing, welfare and benefits advice, particularly for more vulnerable groups. GPs are at the forefront of the interface between the health and social care systems enabling them to take a holistic approach to patient care.[12] By assessing a patient's physical, mental and social needs as well as individual health conditions,

[10] National Audit Office. *Tackling inequalities in life expectancy in areas with the worst health and deprivation*. London: National Audit Office, 2010.

[11] "Healthcare" refers to primary care (healthcare services which play a role in the local community and which act as the first point of consultation with patients) and secondary care (health care services provided by medical specialists such as cardiologists, urologists and dermatologists).

[12] Goodwin N, Dixon A, Poole T, *et al. Improving the Quality of Care in English General Practice. Report of an independent inquiry commissioned by The King's Fund.* London: The King's Fund, 2011.

Dr Jamie Macpherson, Secretary of Coventry Local Medical Committee

"Local Medical Committees are the statutory representatives of General Practice. Coventry LMC is committed to promoting General Practice which can meet the challenges of providing healthcare in the future.

The primary causes of health inequalities such as education, housing, income, employment etc. are well documented. GPs cannot address the causes but they deal with the effects, physical, mental and social on a daily basis both as clinicians and as patient's advocates. This is the unique role of General Practice which is why the profession continues to be held in such high regard by patients.

There is clearly some variation in the quality of care provided by Practices. Coventry LMC will continue to support Practices in their efforts to provide the best possible care for their patients, and in working with public health and other agencies in reducing the disparity in health outcomes across the city."

GPs are able to have a wider impact on people's lives. Coventry's Joint Strategic Needs Assessment (JSNA) for 2012-13 identified prevention, partnership working and community engagement as cross-cutting themes in the initial priorities for the city's Health and Wellbeing Strategy. Reducing variation in general practice and tackling challenges in the wider systems which support and manage primary care as a whole were recognised as important factors in improving health outcomes in Coventry.[13] This was also highlighted in a health and wellbeing peer challenge delivered at Coventry City Council in October 2013 as part of the Local Government Association (LGA)'s health and wellbeing system improvement programme. While feedback was positive overall there were some areas for improvement, including addressing variability in primary care quality.[14]

Overcoming the challenges affecting general practice and the system in which it operates while maximising opportunities to celebrate improvements and share innovation is the central focus of this report. This is also the core aim of the Primary Care Quality Group, established in 2014. Members of the Primary Care Quality Group include Coventry City Council (represented by the Public Health department and the People directorate), Coventry & Rugby Clinical Commissioning Group (CCG), the NHS England Area Team, Healthwatch Coventry, the Local Medical Committee, the Coventry GP Alliance, Local Pharmaceutical Committee and Public Health England. The group is directly accountable to the Health and Wellbeing Board, which provides strategic leadership to oversee and guide the initiative.

The context of general practice in the wider health and social care system

The Commonwealth Fund's 2014 report on the performance of health care systems in 11 high-income countries ranked the UK first overall and on a number of indicators based on the views of patients and primary care practitioners.[15] The UK ranked highest for quality care, access and efficiency, and was second only to Sweden for equity of service provision. However, the UK ranked poorly on death rates from conditions amenable to health care.

More than 300 million consultations occur in general practice every year.[16] In 2009, GP practices made 9.3 million referrals to secondary care (specialist services), indicating that around 19 out of 20

[13] Coventry Joint Strategic Needs Assessment for 2012-13: http://www.facts-about-coventry.com/uploaded/documents/JSNA%202012.pdf

[14] Local Government Association. Health and wellbeing peer challenge report, 2013: http://democraticservices.coventry.gov.uk/documents/s15942/Peer%20Challenge.pdf

[15] Davis K, Stremikis K, Squires D, *et al. Mirror, Mirror on the Wall: How the performance of the US health care system compares internationally.* New York: The Commonwealth Fund, 2014.

[16] Gregory S. *Briefing: General practice in England - An overview*. London: The King's Fund, 2009.

consultations with GPs and other practice staff were resolved within general practice.[17]

All GP practices belong to a Clinical Commissioning group (CCG). CCGs commission services such as hospital care, community health services and mental health services and all local GP practices belong to Coventry and Rugby Clinical Commissioning Group. This report focuses on practices in Coventry, rather than on all practices within Coventry and Rugby CCG.

In Coventry, primary care is currently commissioned by NHS England's Arden, Herefordshire and Worcestershire Area Team. The Area Team have developed a strategy to improve the quality of primary care and are further developing mechanisms to identify practices that are not performing as expected against a range of different indicators. Where this is the case, the NHS Area Team are working with practices to understand the underlying issues and supporting practices to improve.

[17]Goodwin N, Dixon A, Poole T, *et al. Improving the Quality of Care in English General Practice. Report of an independent inquiry commissioned by The King's Fund.* London: The King's Fund, 2011.

The changing role of primary care

The ageing population has led to a greater burden of chronic diseases, many of which will be managed in primary care. This has increased demands on GPs' time not just in terms of seeing more patients, but in the average length of consultation time required for each patient.[18] Consultations lasting at least 10 minutes duration are recognised as an indicator of quality in the GP Contract, but the British Medical Association argues that this is insufficient to manage the complex needs of many patients.[19]

At the same time, the emphasis on patient-centred care and improving health literacy means that the doctor-patient relationship itself is changing. Patients are encouraged to be more involved in decisions about their care, and are more aware of the options available to them.[20]

In addition, the increasing focus on mental health and wellbeing has further broadened the role of primary care services.[21] Mental health problems account for almost a quarter of general practice consultations, and cost the health and social care system £21 billion a

[18] Centre for Workforce Intelligence. *In-depth review of the general practitioner workforce.* London: CFWI, 2014.
[19] British Medical Association. Investment key to longer patient consultations, 2013: http://bma.org.uk/news-views-analysis/news/2013/may/investment-key-to-longer-patient-consultations
[20]Gillam S. Managing demand in general practice. *BMJ* 1998;316:1895.
[21] Department of Health. No health without mental health: A cross-government mental health outcomes strategy for people of all ages. Department of Health, 2011.

year. Evidence suggests that people who are living in poverty are more likely to experience mental health problems, and that in addition, living with a mental health problem can itself cause social disadvantage. Poor mental health outcomes are 2.5 times higher among those experiencing the greatest social disadvantage.[22] A mental health needs and assets assessment will be undertaken by public health in Coventry over the coming months to establish any gaps in mental health service provision and to identify assets which need to be preserved, developed or shared to improve mental health in Coventry.

It has been claimed that inadequate capacity in general practice leads to unmet need and increased demand on other services such as accident and emergency (A&E) units and walk-in clinics.[23] The gap between need and supply is thought to be increasing. However, perspectives of clinical urgency differ among health care providers and patients, with patients being more likely to view non-urgent conditions as being urgent, suggesting that there is a difference between 'need' and 'demand'.[24]

[22]Goldie I, Dowds J, O'Sullivan C. *Mental Health and Inequalities.* Mental Health Foundation, Background Paper 3: http://www.mentalhealth.org.uk/content/assets/PDF/publications/starting-today-background-paper-3.pdf

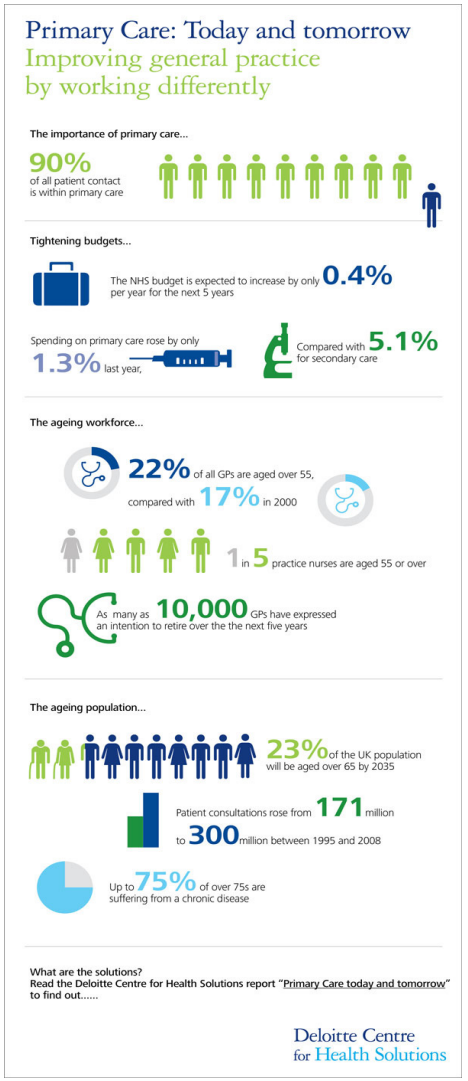
[23] Rosen R. Meeting need or fuelling demand? Improved access to primary care and supply-induced demand. London: Nuffield Trust, 2014.

[24] Monitor. Advice and recommendations for commissioners: Deciding the future of walk in centres. London: Monitor, 2014.

Figure 3: Facts and figures on primary care[25]

In addition, the outcomes measured by professionals and decision makers do not always reflect what patients feel they need from health care services.

The way in which GPs are expected to work has changed. One example of this is that 25% of income now comes from pay-for-performance incentives, and the GP role has become broader and more complex; GPs now spend more time on non-clinical tasks. Demands on GPs are competing as well as increasing, and these additional demands reduce their availability for direct patient



[25]Deloitte LLP. *Primary Care Today and Tomorrow,* 2014: *http://www.deloitte.com/view/en_GB/uk/research-and-intelligence/deloitte-research-uk/deloitte-uk-centre-for-health-solutions/7d5e211e9bc27310VgnVCM1000001956f00aRCRD.htm*

contact, creating difficulties in providing high quality care.

At the same time, resources available to primary care have decreased. Since 2009 there has been a 3% reduction in numbers of GPs; this is in part due to the fact that the proportion of NHS funding for general practice has decreased from 12% to 8.4%,[26] but also due to reduced recruitment to GP training schemes and increasing cohorts of GPs who are retiring. In addition, the age-gender balance in general practice is shifting, and women in their 30s are expected to make up the majority of the GP workforce by 2030. Given that women are more likely to work less than full-time, a larger number of GPs will be needed. In Coventry, the number of GPs per head of the population is lower than the average for England and the proportion of GPs has not increased over time.[27]

Changes in both the volume and the nature of demand, patient expectations and available resources pose considerable challenges to primary care. In order to contribute to a reduction of health inequalities and an improvement in health outcomes in Coventry, primary care is faced with the challenge of adapting to these changes while also developing more innovative approaches to caring for patients.

[26] Royal College of General Practitioners . *GPs warnings over impact of funding cuts on patient care,* 2014: http://www.rcgp.org.uk/news/2014/may/gps-warnings-over-impact-of-funding-cuts-on-patient-care.aspx

[27] Centre for Workforce Intelligence. *In-depth review of the general practitioner workforce.* London: CFWI, 2014.

[27] Royal College of General Practitioners . *GPs warnings over impact of funding cuts on patient care,* 2014: http://www.rcgp.org.uk/news/2014/may/gps-warnings-over-impact-of-funding-cuts-on-patient-care.aspx

Perspective of a local GP: Dr Alison Payne, GP, Willenhall Primary Care Centre

When I became a GP in 1988, the majority of what I now deal with either was not treatable or was managed by hospital clinics. Most of my work was acute disease management, along with paediatrics, contraception, sexual and maternal health. HIV was a terminal illness and hepatitis C was unknown. Chronic disease management was mainly hypertension, asthma and palliative care. Even in hospital, little was done compared to the twenty first century - with our exponential growth in drug treatments and our expertise in prolonging life, combined with patient expectations at an all-time high, encouraged by government and media. Patients are more demanding and despite their access to information, frequently attend wanting a 'quick fix' whilst not recognising the part they play in their health problems.

I write this with the background that GP practices receive only 9% of the total NHS Budget, but carry out 90% of all patient contact. There is a background of increasing complexity of care with the ageing population and multiple morbidities meaning that most of our consultations with over 65's are extremely complex. The ten minute consultation is now obsolete as so much care has been moved from secondary to primary care.

In my own practice area there is a very high incidence of COPD, Type 2 diabetes (obesity related), mental health disorders including alcohol and substance misuse, and other health problems that are related to deprivation as well as ageing. Mental health issues form an increasing part of our workload as benefit cuts, 'austerity' and the demands of modern life take their toll in a deprived area. More patients are requiring home visits both due to complexity and the ageing population but also as palliative care increases. We work closely with the community matron, district nurses and the palliative care team.

Many of us use phone and email to manage consultations. A day at the surgery does not just involve seeing patients; we also have to process outpatient and inpatient letters from colleagues as well as DWP correspondence, child protection reports and requests for reports from other departments. Patients ring with queries, hundreds of repeat prescriptions need to be signed and checked, and two to three batches of results come in from the labs each day. I generally will view 60 - 100 pathology results in a day (many of which require action) and sign up to 150 repeat prescriptions - all of which have to be checked. Referrals are often generated by our surgery appointments and referral letters including two week wait referrals have to be done in a timely fashion.

Many of the problems that we see are related to social deprivation and inequality, and it is not helpful to penalise GPs when we're unable to make progress on these difficult issues. Lifestyle issues such as obesity, lack of exercise and drug / alcohol misuse, as well as the high usage of painkillers and antidepressants in an area like Willenhall, are very difficult for a primary care team to address, particularly when junk food and alcohol are so cheap and easily available.

Most GPs love their work and love the reward that the ongoing relationship with our patients brings. However many of us feel we are buckling under the strain – and morale amongst GPs is at an all-time low. Many doctors over 55 are retiring early and there is a recruitment crisis as young doctors no longer feel drawn to a speciality where 'the buck stops' and there is an expectation that we must know a lot more than 'a bit' about everything.

The system needs to change, and quickly.

Defining and measuring quality

The definition of quality in primary care has evolved as the role of primary care has changed over time. In 2008, the Darzi NHS Next Stage Review highlighted patient safety, clinical effectiveness and the experience of patients as measures of quality in the NHS.[28] In assessing the quality of primary care in Coventry we have considered these three key measures, and looked at the Quality and Outcomes Framework as an overall measure of quality in Coventry.

Patient Experience: patients who feel that they are able to access primary care services in a suitable way and in a timely manner, patients who have confidence and trust in their GP, are able to see their preferred GP or at least have an experience of continuous care, and patients who feel involved in decisions about their care are more likely to visit their GP at an earlier stage, more likely to take advice, more likely to adhere to treatment and therefore more likely to have better health outcomes.[29] This report considers responses to the GP Patient Survey about overall patient experience and access in Coventry.

Clinical Effectiveness: effective primary care ensures that problems are identified early and treated efficiently and is linked to improved health outcomes and lower costs, as well as fewer avoidable hospital admissions and potential years of life lost.[30] This report considers management of stroke, diabetes, heart disease, rates of two week wait referrals and avoidable emergency admissions in Coventry.

Patient Safety: practices and clinics should be clean and safe, medicines should be managed properly, people should be supported by practice staff, and practices should learn from safety incidents. This report considers information from Coventry and Rugby CCG on prescribing and over-medicalization.

[28]Darzi A. High Quality Care for All: NHS Next Stage Review (Final Report). London: Department of Health, 2008.
[29]NHS England. *NHS Outcomes Framework:* http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-4/

[30]Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *Milbank Q* 2005;3,:457–502.

Chapter 2: The Coventry context

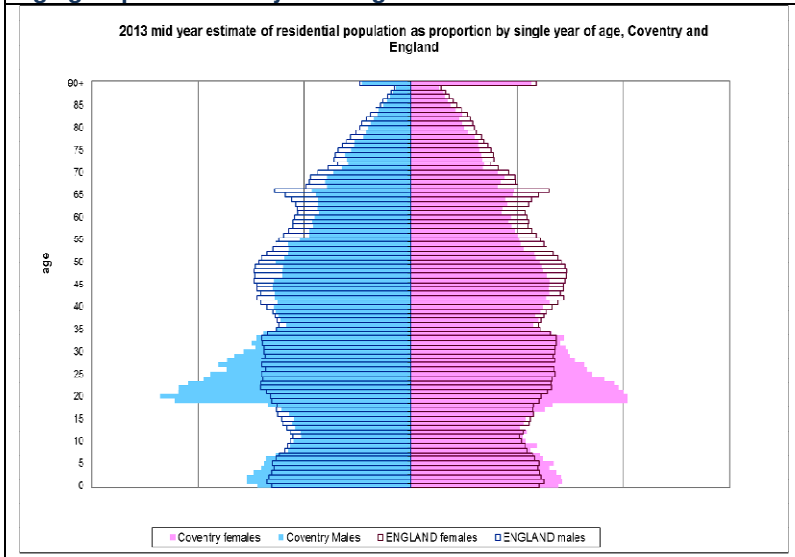
Demographics

In mid-2013, 330,000 people were estimated to be resident in Coventry, while 373,000 were estimated to be registered with a GP practice in the city.[31] [32] As illustrated by Figure 4, The population of Coventry is younger on average than for England as a whole, due to the two universities (Coventry and Warwick) and the comparatively high birth rate (66.4 births per 1,000 women aged 15-44, compared with 64.9 in England).

The total number of births in Coventry has increased by 30%, with 40% of births occurring in the most deprived quintile of the population.

There is a high level of population churn in Coventry. In 2013, 15,670 people came to Coventry from other areas of the UK and over the same year, 16,270 people left Coventry for other parts of the country. 1,060 people came from Warwickshire to Coventry, and over double that number (2,230) left Coventry for Warwickshire. This can create challenges for primary care in building relationships and ensuring that patients are registered with GPs.

Figure 4: Residential population of Coventry 2013 and the proportion in each age group for Coventry and England



This Figure shows that the population of Coventry is younger on average than the population of England.

Source: ONS mid year population estimates

[31] Office for National Statistics. *Annual Mid-year Population Estimates*, 2013: http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/2013/stb---mid-2013-uk-population-estimates.html

[32] Open Exeter

Dr Steve Allen, Chief Clinical Officer, NHS Coventry and Rugby Clinical Commissioning Group

"It is heartening to see the progress that General Practice in the city has made in recent years. Practicing in an urban deprived area with a vibrant multi ethnic culture is both challenging and stimulating. I see the pressure of increasing workload and the launch of clinical commissioning and yet many of my GP colleagues rise to these challenges with a resilience that never ceases to amaze me. As a CCG leader I will do everything I can to create an environment amongst local health and social care providers and voluntary organisations that will allow my GP colleagues to deliver their ambition of providing first class care all the time."

Coventry has a larger proportion of residents from black and minority ethnic backgrounds than England or the West Midlands. In the 2011 census, 33% of residents reported that they were not of 'White British' origin, compared to 21% of the West Midlands and 20% of the English population. The proportion is even higher amongst school children, with 40% of primary school pupils and 36% of secondary school pupils from non-white British ethnic origin.[33] Figure 5 demonstrates the proportions of Coventry residents from each ethnic group compared to the English average.

Only 79% of the Coventry population reported that they had been born in the UK at the last census (2011), compared with 86% of the population of England. 12% of Coventry's residents arrived in the UK since 2001, and this represents the highest proportion of recent arrivals in the West Midlands. Of these, the vast majority of people arrived at prime working age: 39.9% arrived at age 16-24 and 24.1% at age 25-34. Around a quarter (26.3%) arrived at age 0-15; 9.2% at age 35-64 and 0.4% arrived at age 65+. People in Coventry born outside the UK are more likely to have a degree: 27%, compared to 22% for those born in the UK. Educated, working-aged people are less likely to

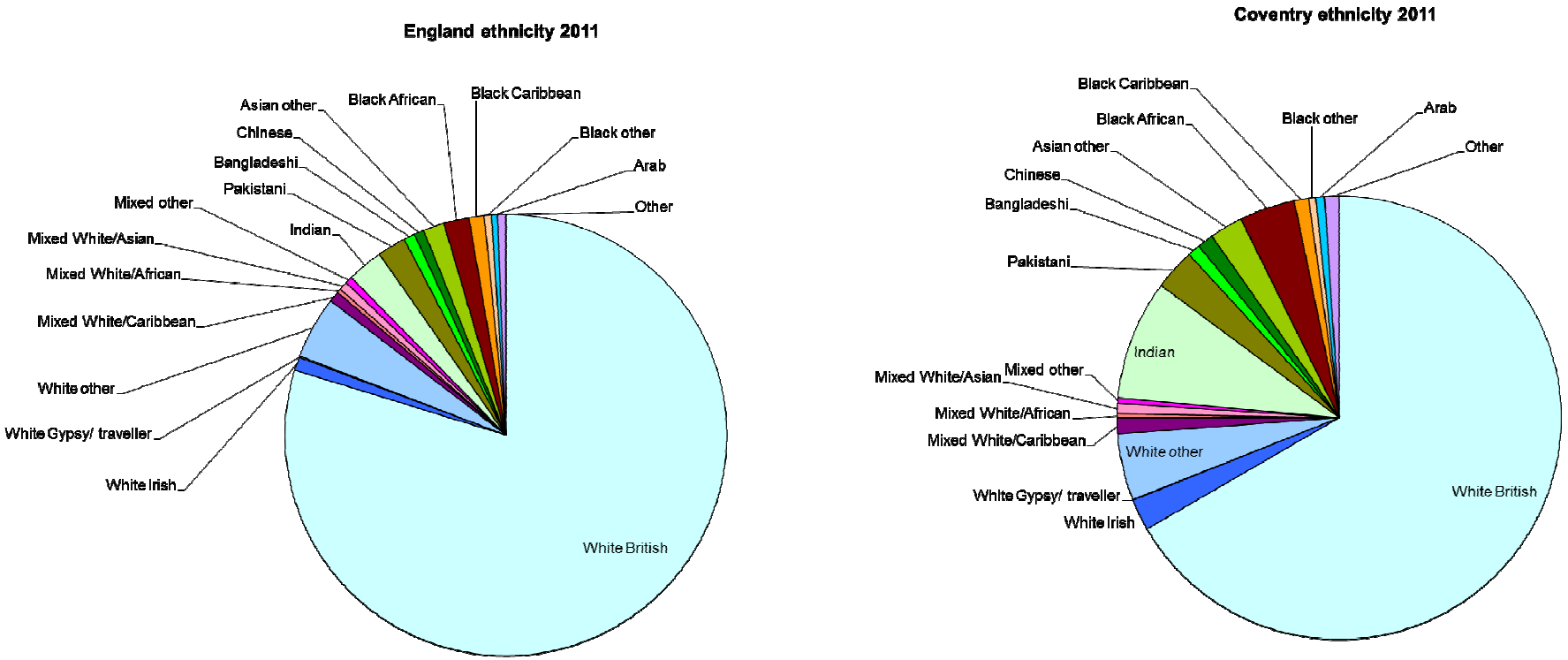
[33]Department for Education, *Schools Census,* 2013: https://www.gov.uk/government/collections/school-census

use services such as schools, hospitals or welfare, and this suggests that migrants are less likely than the general population to use services.[34]

The 2011 census also shows that nearly 9% of households in Coventry do not have any person resident with English as their first language, and 28% of primary school children and 24% of secondary school children had a first language other than English. In total there are over 100 languages spoken in Coventry. This creates a number of challenges for primary care, such as the requirement for translation and interpretation services and the time taken for GP consultations.

[34] Local Area Migration Indicators, 2013 & Migration Statistics Quarterly Report, August 2014 Release

Figure 5: Ethnicity reported in census 2011



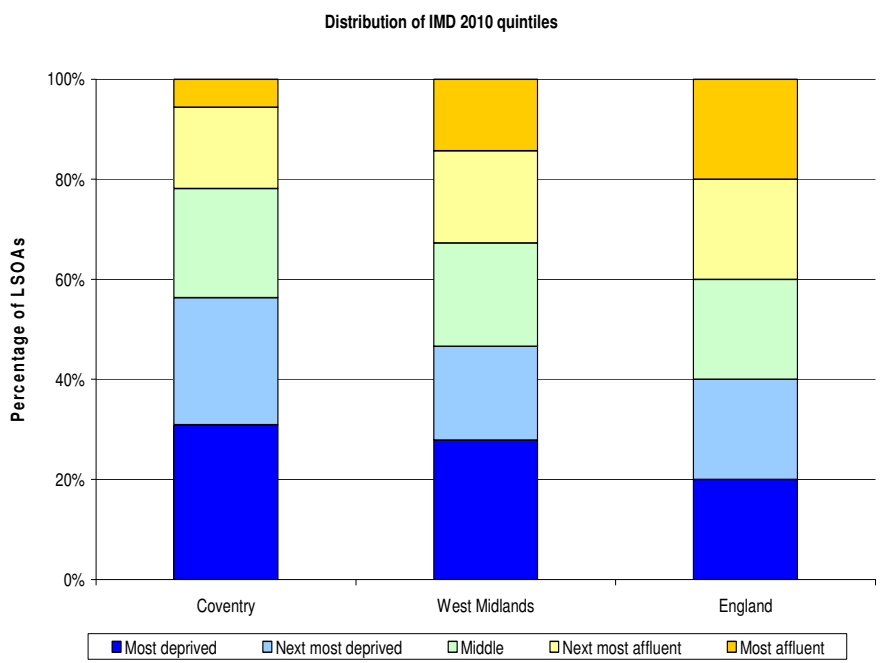
This figure shows that Coventry has a larger proportion of residents from black and minority ethnic backgrounds than England. In the 2011 census, 33% of residents reported that they were not of 'White British' origin, compared to 20% of the English population.

Source: 2011 census

Deprivation

According to the Indices of Multiple Deprivation (2010), a measure based on income, education, housing, employment, crime, health and environment, Coventry is amongst the most deprived fifth of all local authorities in England.

Figure 6: Distribution of quintiles of Indices of Multiple Deprivation 2010



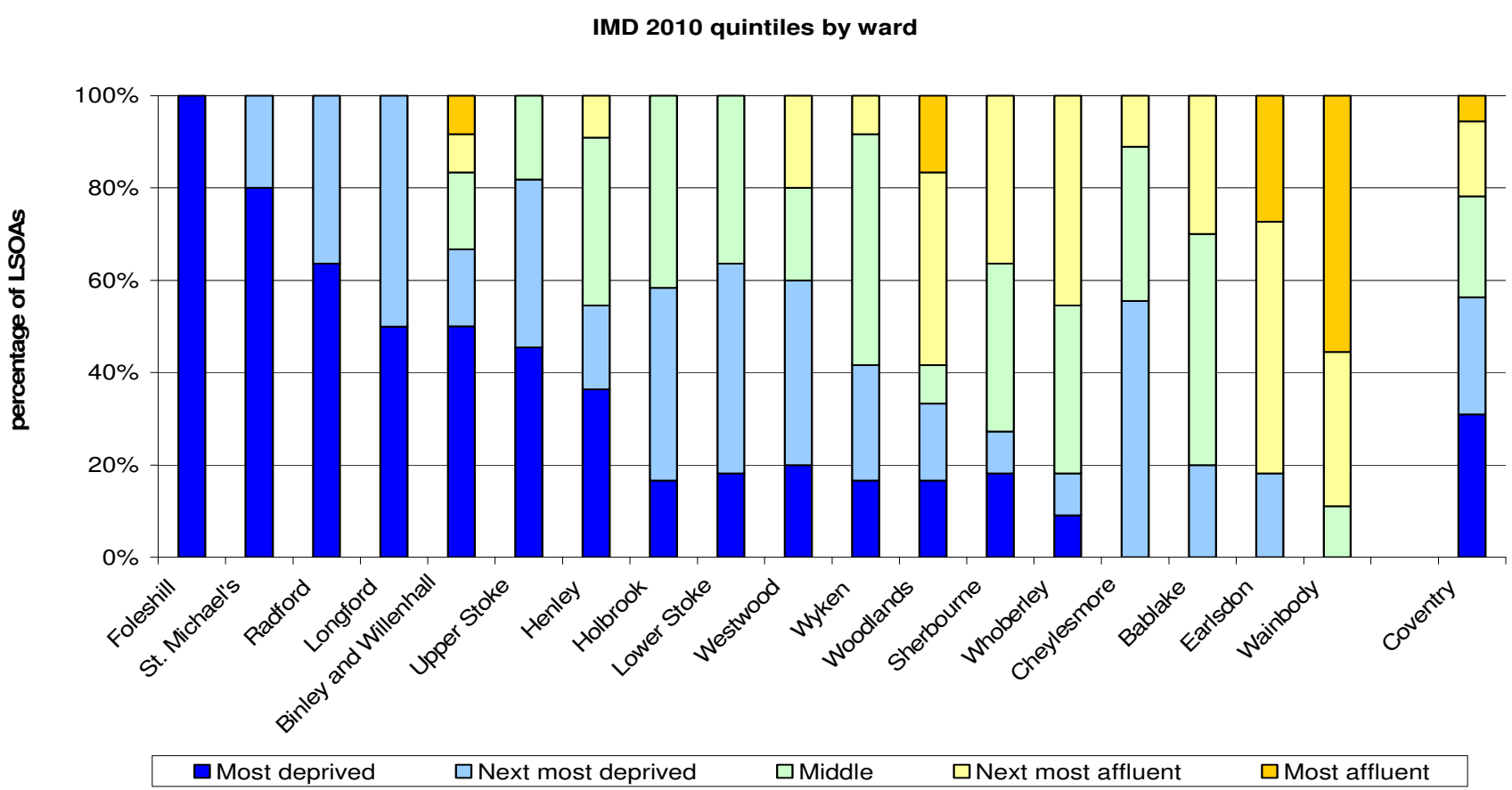
Source: IMD2010, Communities and Government

The levels of deprivation in Coventry are a challenge for primary care, first because health tends to be generally poorer amongst more deprived groups, and second because research has shown that socially deprived individuals have less contact with their GPs. This may be caused by a number of factors, including different perceptions of risk and the effectiveness of treatment, and a tendency to consult family and friends for healthcare advice.[35]

Although overall Coventry is a deprived Local Authority, there is also considerable variation within Coventry. Figure 7 demonstrates the variation in deprivation between different wards within the city.

[35] McAlister FA, Murphy NF, Simpson CR, *et al.* Influence of socioeconomic deprivation on the primary care burden and treatment of patients with a diagnosis of heart failure in general practice in Scotland: Population based study. *BMJ* 2004;328:1110.

Figure 7: Ward distribution of IMD 2010 quintiles



This figure shows variation in deprivation between different wards in the city.

Source: IMD2010, Communities and Government

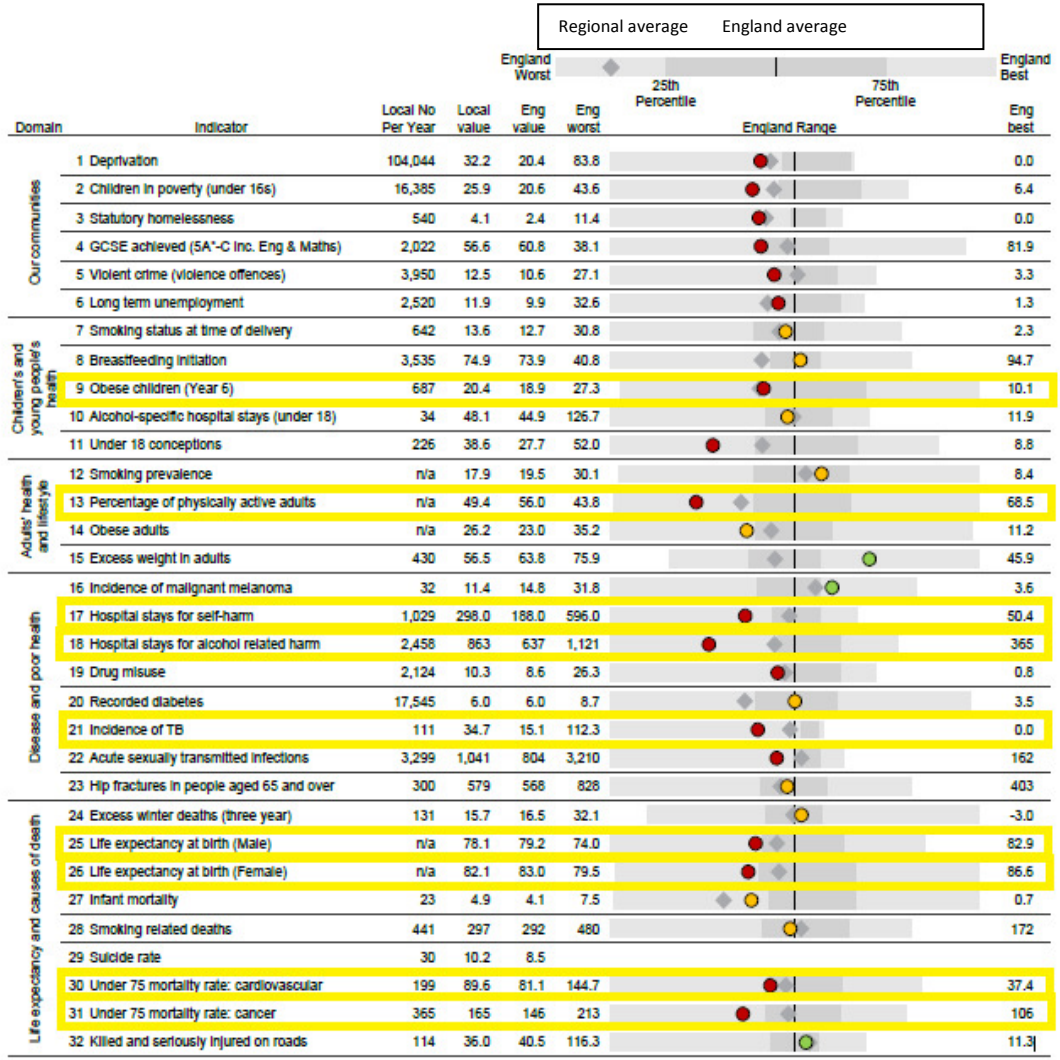
Health Outcomes

The Public Health Outcomes framework (Figure 8) demonstrates the position of Coventry as a whole in relation to life expectancy and healthy lifestyle in comparison to the regional and national average.

The Public Health Outcomes Framework shows that life expectancy for both men and women is significantly lower than for England, and Coventry residents have significantly higher death rates from all causes of mortality, including cancer, chronic obstructive pulmonary disease (COPD), liver disease, diabetes and infections and parasitic disease.

Patients should be encouraged and enabled to live healthier lifestyles, since the number of obese children, the number of alcohol related hospital admissions and the number of self-harm related hospital admissions is significantly higher than the national and regional average, and the number of physically active adults is significantly lower than the regional and national average. While GPs can and should promote healthy lifestyles, public health and patients also

Figure 8: Position of Coventry health outcomes compared to England average



Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	104,044	32.2	20.4	83.8	0.0
	2	Children in poverty (under 16s)	16,385	25.9	20.6	43.6	6.4
	3	Statutory homelessness	540	4.1	2.4	11.4	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	2,022	56.6	60.8	38.1	81.9
	5	Violent crime (violence offences)	3,950	12.5	10.6	27.1	3.3
	6	Long term unemployment	2,520	11.9	9.9	32.6	1.3
Children's and young people's health	7	Smoking status at time of delivery	642	13.6	12.7	30.8	2.3
	8	Breastfeeding initiation	3,535	74.9	73.9	40.8	94.7
	9	Obese children (Year 6)	687	20.4	18.9	27.3	10.1
	10	Alcohol-specific hospital stays (under 18)	34	48.1	44.9	126.7	11.9
	11	Under 18 conceptions	226	38.6	27.7	52.0	8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	17.9	19.5	30.1	8.4
	13	Percentage of physically active adults	n/a	49.4	56.0	43.8	68.5
	14	Obese adults	n/a	26.2	23.0	35.2	11.2
	15	Excess weight in adults	430	56.5	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma	32	11.4	14.8	31.8	3.6
	17	Hospital stays for self-harm	1,029	298.0	188.0	596.0	50.4
	18	Hospital stays for alcohol related harm	2,458	863	637	1,121	365
	19	Drug misuse	2,124	10.3	8.6	26.3	0.8
	20	Recorded diabetes	17,545	6.0	6.0	8.7	3.5
	21	Incidence of TB	111	34.7	15.1	112.3	0.0
	22	Acute sexually transmitted infections	3,299	1,041	804	3,210	162
	23	Hip fractures in people aged 65 and over	300	579	568	828	403
Life expectancy and causes of death	24	Excess winter deaths (three year)	131	15.7	16.5	32.1	-3.0
	25	Life expectancy at birth (Male)	n/a	78.1	79.2	74.0	82.9
	26	Life expectancy at birth (Female)	n/a	82.1	83.0	79.5	86.6
	27	Infant mortality	23	4.9	4.1	7.5	0.7
	28	Smoking related deaths	441	297	292	480	172
	29	Suicide rate	30	10.2	8.5		
	30	Under 75 mortality rate: cardiovascular	199	89.6	81.1	144.7	37.4
	31	Under 75 mortality rate: cancer	365	165	146	213	106
	32	Killed and seriously injured on roads	114	36.0	40.5	116.3	11.3

Source: Public Health Outcomes Framework, 2014

need to work to ensure that people live healthy lives for as long as possible.

Currently the rates for TB incidence, cardiovascular mortality under 75 and cancer mortality under 75 are significantly higher than the regional and national average. By providing good clinical care to patients and enabling patients to manage their long term conditions, primary care services have an opportunity to influence these outcomes. Improvements in the management of conditions such as diabetes and stroke are considered later in the report.

The demographics and deprivation within Coventry create a number of challenges for general practice, as variation in deprivation and ethnic background lead to variations in health outcomes, and a higher prevalence of deprivation, children in poverty, homelessness, violent crime, long term unemployment and different cultural attitudes to health and lifestyles lead to poorer overall health.

In order to reduce health inequalities in Coventry, the people living in the most deprived areas with the most need ought to receive the best possible care.

Chapter 3: Recent Improvements

There have been improvements in several aspects of primary care in Coventry in recent years. An increase in the proportion of eligible women screened for cervical cancer, an increase in the number of health checks completed, an increase in the percentage of children immunised against infectious diseases and a reduction in the prevalence of smoking in Coventry are all improvements which will have a positive impact on health inequalities in the city. In addition, work to improve the quality of prescribing has led to notable improvements against national indicators in a short period of time. There has also been a substantial increase in the number of Quality and Outcomes Framework points awarded to GP practices in Coventry, which is based on management of chronic diseases, organisation of practices, how patients view their experience and the extra services offered by the practice.

Promoting health and preventing ill health

As the most accessed part of the English health system, GPs are uniquely placed to promote health and wellbeing amongst patients. Every consultation is an opportunity to detect early warning signs that could

Sue Price, Director of Commissioning, NHS England Area Team

"The quality of primary care in Coventry has improved over the last year and continues to improve with support of NHS England, the CCG and the GPs themselves. We are very pleased with the progress although there is more to be done. The important role GPs play in managing the increased demand and the more technical services in the community requires a very different approach. The work that continues in Coventry will help the GPs to work with other staff to deliver this new model of care."

Dr Francis Campbell, Medical Director, NHS England Area Team

"Much work has been done within Coventry to support and help practices and individual GPs in delivering good quality health care. This has been supported and complemented by work within local practices, the CCG and also the Local Medical Committee. There is evidence that this is improving the overall quality of clinical services within the city."

New ways of working: cervical screening

Coventry and Rugby CCG introduced a number of measures to improve the cervical screening rate in Coventry.

Foleshill Women's Training Centre were commissioned to undertake work with ethnic minority groups to dispel myths around cervical screening. The Foleshill Women's Training Centre also attended sessions at the places of worship along the Foleshill corridor.

In addition, an incentive scheme was introduced to support practices in encouraging women who were due to attend for a smear test. GPs and practice nurses rang patients whose smear was outstanding, practice nurses saw patients opportunistically to try and improve uptake, practices involved patient participation groups to ask why some women do not attend appointments, and in addition the Locality Nurse Forums highlight practices with high levels of uptake and asked them to share the reasons for this with other practices.

prevent illness and disease, and the Royal College of General Practitioners states that GPs should proactively carry out health promotion activities and interventions.

The role of general practice in health promotion will be explored through focusing on five key areas: cervical screening, health checks, smoking, healthy living pharmacies and childhood immunisations.

Cervical Screening

About 3,000 cases of cervical cancer are diagnosed each year in the UK, which amounts to 2% of all cancers diagnosed in women.

The aim of the NHS Cervical Screening Programme is to reduce the number of women who develop cervical cancer and the number of women that die from the condition. All women aged between 25 and 64 are invited for cervical screening. Women aged between 25 and 49 are invited for testing every three years, and women aged between 50 and 64 are invited every five years.

Being screened regularly means that any abnormal changes in the cells of the cervix can be identified at an early stage and, if necessary, treated to

stop cancer developing. It is estimated that early detection and treatment can prevent up to 75% of cervical cancers.[36]

The effectiveness of the programme can be judged by coverage (the percentage of women in the target age group who have been screened in the last five years). If overall coverage of 80% can be achieved, the evidence suggests that a reduction in death rates of around 95% is possible in the long term. In Coventry, the cervical screening rate is slightly below the national target of 78% but has risen from 71.5% in 2012/13 to 76.6% in 2013/2014.

Health Checks

NHS Health Checks is a public health programme in England for people aged 40-74, which aims to prevent or delay the onset of diabetes, heart disease, kidney disease and strokes, and to keep people healthy for longer.

The health check consists of both a risk assessment and risk management and reduction actions, which can include a referral, lifestyle advice, or clinical interventions.

The number of people who received a health check in Coventry this year has increased by more than 100 per cent compared to 2012/2013. In 2013/2014, 15,271 people were invited to attend a health check, and of these, 9,374 people completed a health check. As a consequence, 3% of those who completed health checks were identified as having a long-term condition and placed on a disease risk register with their GP.

GPs in Coventry have significantly increased the number of health checks completed by adopting a more flexible approach to appointment times and setting up extra clinics at the weekend. The health check programme is supported by a GP champion who proactively addresses some of the barriers faced by GPs in delivering health checks, raises the profile of NHS Health Checks, supports peers with practical issues and hosts workshops to encourage other GPs to deliver health checks.

Community outreach health specialists from Coventry and Warwickshire Partnership NHS Trust have also been successful in completing the checks in neighbourhoods across Coventry. NHS Health Check Screeners conduct

[36]NHS Cervical Screening Programme, England: 2010-2011: http://www.cancerscreening.nhs.uk/cervical/

What is the evidence for the effectiveness of health checks?

Recent media coverage has called into question the effectiveness of health checks. The Cochrane Collaboration found that health checks did not reduce morbidity or mortality, although the number of new diagnoses increased.

In response to this review, Public Health England released a statement that set out the establishment of an Expert Clinical and Scientific Advisory Panel to review emerging evidence and research needs. Results from the national evaluation of the health check programme are expected in the coming months.

Given that death rates are higher in Coventry from all causes of mortality, including cancer, COPD, liver disease and diabetes, increasing the uptake of health checks is a sensible approach to enable GPs to encourage patients to alter their lifestyle to prevent long term conditions developing, or to identify conditions and to help manage them at an earlier stage.

health checks within outreach clinics based at various locations across Coventry for those members of the community who do not attend a GP, as well as those with mental health issues or learning difficulties. Over 65% of health checks have been delivered in GP practices which are based in the most deprived areas of the city.

The Health Check programme in Coventry was originally set up in early 2012. In September 2013, the programme launched a large scale marketing and communications plan to increase population awareness, as well as a mobile unit in public venues.

Health checks are regularly monitored to ensure they are meeting quality standards and will be adapted where evidence suggests improvements can be made. Over the coming months, research findings will be used to further improve access to health checks for people with mental health issues or learning difficulties.

Healthy Living Pharmacies

Since July 2011, representatives from a wide range of important stakeholders including public health and pharmacy organisations, the NHS, local government and community pharmacy have been working to develop pharmacy's contribution to public health.

Alongside their more traditional role, community pharmacies are increasingly delivering a wide range of public health services, including:

- Stopping smoking
- Sexual health (e.g. chlamydia screening and emergency hormonal contraception)
- Healthy diet and weight
- Physical activity
- Alcohol interventions
- Needle exchange schemes
- Flu immunisations

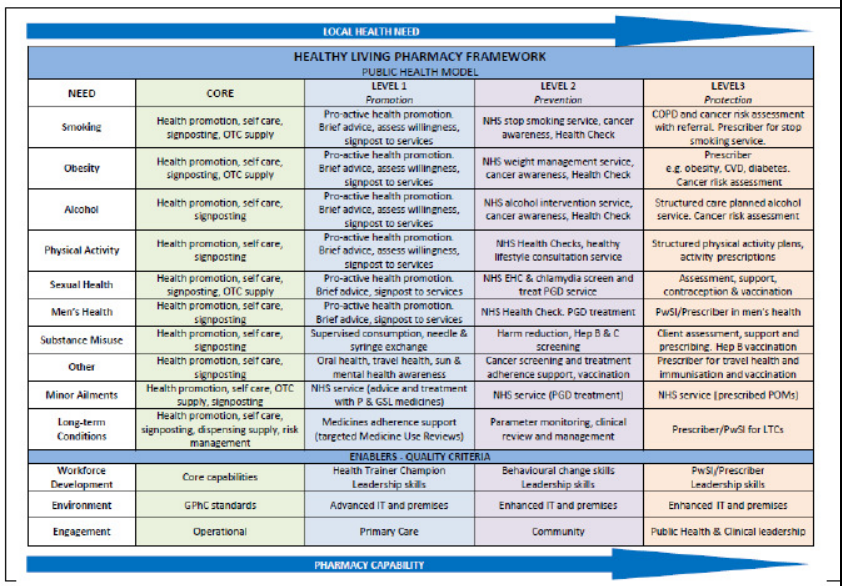
Healthy Living Pharmacies (HLPs) aim to improve the health and well-being of the local community and help to reduce health inequalities by delivering, through community pharmacies, a broad range of high quality public health services. As of April 2014, there were 34 HLPs in Coventry. The HLP concept works through a structured, tiered national commissioning framework (shown in Figure 9) based on public health need and underpinned by quality criteria, with three enablers in place including:

- workforce development, with staff trained and skilled to proactively engage with the public to deliver healthy lifestyle messages
- premises that are fit for purpose for pro-actively promoting health and well-being messages, with a dedicated health promotion zone
- local stakeholder engagement, helping to improve the health of the population locally

Healthy Living Pharmacies have a trained Health Champion who engages proactively with the community they serve, using every interaction as an opportunity for a health-promoting intervention, making 'every contact count' to improve people's health, reduce mortality and help to reduce health inequalities. To become Health Champions, pharmacy staff are required to undergo the Understanding Health Improvement Level 2 award accredited by the Royal Society for Public Health. People visiting an HLP will receive health and well-being advice from informed members of

the pharmacy team and either access or be signposted to public health services as appropriate.

Figure 9: Healthy Living Pharmacy Framework



LOCAL HEALTH NEED

HEALTHY LIVING PHARMACY FRAMEWORK
PUBLIC HEALTH MODEL

NEED	CORE	LEVEL 1 *Promotion*	LEVEL 2 *Prevention*	LEVEL3 *Protection*
Smoking	Health promotion, self care, signposting, OTC supply	Pro-active health promotion. Brief advice, assess willingness, signpost to services	NHS stop smoking service, cancer awareness, Health Check	COPD and cancer risk assessment with referral. Prescriber for stop smoking service.
Obesity	Health promotion, self care, signposting, OTC supply	Pro-active health promotion. Brief advice, assess willingness, signpost to services	NHS weight management service, cancer awareness, Health Check	Prescriber e.g. obesity, CVD, diabetes. Cancer risk assessment
Alcohol	Health promotion, self care, signposting	Pro-active health promotion. Brief advice, assess willingness, signpost to services	NHS alcohol intervention service, cancer awareness, Health Check	Structured care planned alcohol service. Cancer risk assessment
Physical Activity	Health promotion, self care, signposting	Pro-active health promotion. Brief advice, assess willingness, signpost to services	NHS Health Checks, healthy lifestyle consultation service	Structured physical activity plans, activity prescriptions
Sexual Health	Health promotion, self care, signposting, OTC supply	Pro-active health promotion. Brief advice, signpost to services	NHS EHC & chlamydia screen and treat PGD service	Assessment, support, contraception & vaccination
Men's Health	Health promotion, self care, signposting	Pro-active health promotion. Brief advice, signpost to services	NHS Health Check. PGD treatment	PwSI/Prescriber in men's health
Substance Misuse	Health promotion, self care, signposting	Supervised consumption, needle & syringe exchange	Harm reduction, Hep B & C screening	Client assessment, support and prescribing. Hep B vaccination
Other	Health promotion, self care, signposting	Oral health, travel health, sun & mental health awareness	Cancer screening and treatment adherence support, vaccination	Prescriber for travel health and immunisation and vaccination
Minor Ailments	Health promotion, self care, OTC supply, signposting	NHS service (advice and treatment with P & GSL medicines)	NHS service (PGD treatment)	NHS service (prescribed POMs)
Long-term Conditions	Health promotion, self care, signposting, dispensing supply, risk management	Medicines adherence support (targeted Medicine Use Reviews)	Parameter monitoring, clinical review and management	Prescriber/PwSI for LTCs
ENABLERS - QUALITY CRITERIA				
Workforce Development	Core capabilities	Health Trainer Champion Leadership skills	Behavioural change skills Leadership skills	PwSI/Prescriber Leadership skills
Environment	GPhC standards	Advanced IT and premises	Enhanced IT and premises	Enhanced IT and premises
Engagement	Operational	Primary Care	Community	Public Health & Clinical leadership

PHARMACY CAPABILITY

Source: PHE, Developing Pharmacy's contribution to public health, 2014

Childhood immunisation

Vaccinations can provide lifelong protection against diseases and if enough people in a community are vaccinated it is harder for diseases to pass through people who have not been vaccinated. Vaccination is also extremely cost effective, for example, each unplanned hospital admission due to flu costs between £347 and £774 per person.[37]

In 2008/2009 Coventry Primary Care Trust was one of the poorest performing PCTs for the uptake of childhood immunisations outside of London. A shared vision was embedded with NHS Coventry's Primary Care Strategy to improve immunisation uptake rates. A number of initiatives were undertaken in partnership with key stakeholders, including:

- commissioning a data cleansing exercise with GP practices and the Child Health Information System,
- workshops for practice nurses highlighting best practice
- the development of a 'Top Tips' sheet for all practices with information on what works in improving immunisation uptake

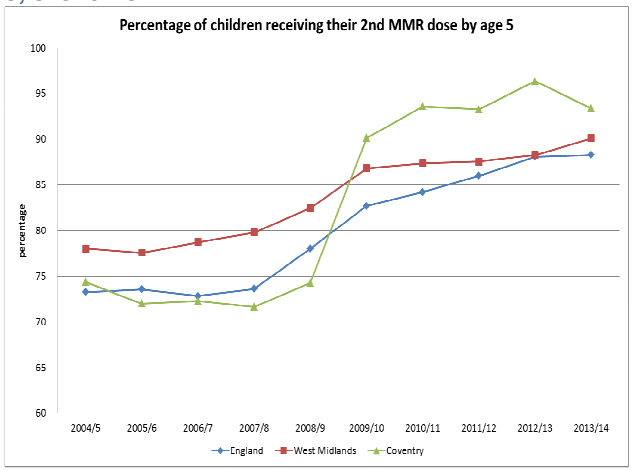
[37] Local Government Association. *Immunisation and* Screening, 2013: http://www.local.gov.uk/c/document_library/get_file?uuid=dc1fd8db-4eaf-4ef4-bc73-dc336d9bacb0&groupId=10180

- a review of the needs of the workforce in relation to capacity, roles, responsibility and training
- the development of a database system

Coventry GPs are now amongst the best performing in the country for immunisation uptake. The immunisation rates have continued to improve since December 2009 and should be sustainable given the development work that has been undertaken and embedded.

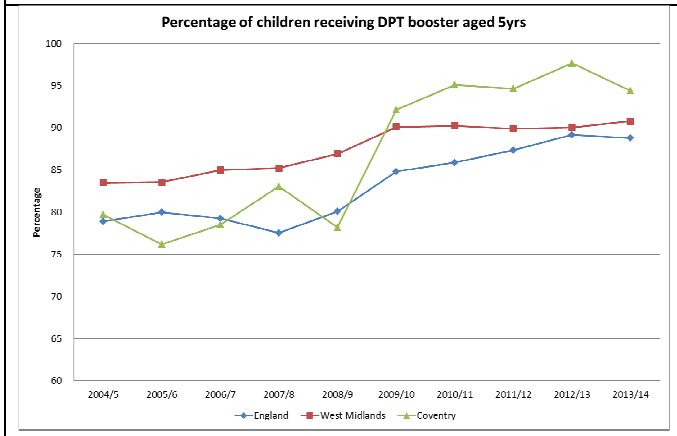
Figure 10 shows the percentage of children receiving the 2nd dose of MMR by aged 5 for the period 2004/5 to 2013/14. Figure 11 shows percentage of children aged 5 receiving the DPT booster for the period 2004/5 to 2013/14.

Figure 10: Percentage of children receiving 2nd dose of MMR booster by age 5, over time



Source: COVER

Figure 11: Percentage of children receiving DPT boosters aged 5 years, over time



Source: COVER

Stop smoking advice

Tobacco use kills more than 5 million people worldwide each year, and is responsible for 10% of all adult deaths. It is the single most preventable cause of death, responsible for the death of 80,000 people in England each year. UK hospitals also see around 9,500 admissions of children with illnesses caused by secondhand smoke. In Coventry, smoking prevalence has fallen from 29% in 2007 to 22% in 2013, although the proportion of people who smoke is still greater than the England average of 19.5%.[38]

There is a strong link between cigarette smoking and socio-economic group. Smoking has been identified as the biggest single cause of inequality in mortality rates between rich and poor in the UK, as death rates from tobacco are two to three times higher among disadvantaged groups than among more affluent groups.

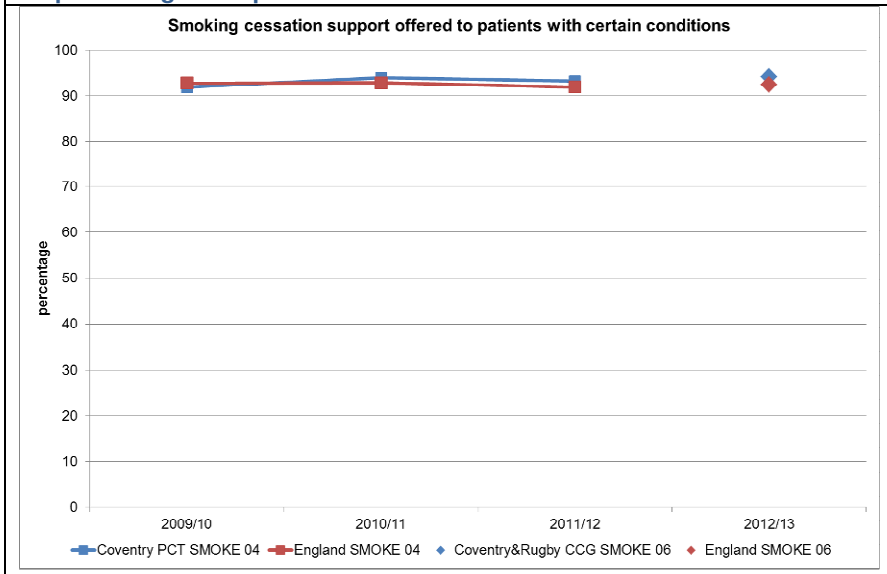
Figure 12 shows that the percentage of patients with selected conditions from Coventry General Practices who were offered stop smoking support was similar to the national average.

Stop Smoking Services seek to reduce the number of smokers by providing evidence based treatment and behavioural support. Evidence demonstrates that people who use an NHS approved Stop Smoking Service are four times more likely to succeed than those who attempt to quit in other ways.

During 2013/14 5,632 people engaged with Coventry stop smoking services resulting in a 53% quit rate. Smoking prevalence has fallen from 29% in 2007 to 22% in 2013. The number of people who have received stop smoking advice or referral in the last 15 months has remained stable, with Coventry and Rugby CCG performing better than the average for England.

[38]Coventry Partnership. *Coventry Household Survey*, 2013: http://www.coventrypartnership.com/research/householdsurvey

Figure 12: QOF percentage of patients with selected diseases[39] supported to stop smoking in the previous 15 months



Source: QOF

The line is not continuous because change between the indicators from 2011/12 and 2012/13.

[39]SMOKE06: The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the preceding 15 months.

SMOK04: The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, asthma, CKD, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the preceding 15 months.

Prescribing

Patients depend on medicines to help maintain health, prevent illness, manage chronic conditions and treat disease. Prescribing is a marker for clinical effectiveness, as good quality prescribing can improve outcomes for patients. Good quality prescribing can also be a cost effective use of primary care resources and can reduce the need for further GP consultations. Similarly, poor quality prescribing can affect the patient's health and wellbeing through an inappropriate or failed intervention, but can also lead to additional care or avoidable hospital admissions, worse clinical outcomes and increased economic costs.[40]

Over the years, much work has been done to ensure the use of medicine is evidence based and cost effective. However, relatively little research has focused on patient adherence to what is prescribed. Current evidence suggests that the use of medicine is sub-optimal. Medicine optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. The goal is to help patients to take their medicines

[40]Naylor C, Imison C, Addicott R, *et al. Transforming our health care system: Ten priorities for commissioners.* London: The King's Fund, 2013.

correctly, to avoid prescription of unnecessary medicines, to reduce wastage of medicines, and to improve medicines' safety[41].

Prescribing is an area where evidence-based indicators of quality and safety may diverge from patient preferences. Patient satisfaction may be influenced negatively by not receiving a prescription when they expect to do so.[42] [43] Moreover, clinicians may overestimate these expectations and over-prescribe medications that they perceive to be harmless to avoid damaging the doctor-patient relationship.[42]

However, it is sometimes necessary to reduce prescription volume to ensure better, safer and more cost-effective care. A recent report by the King's Fund identified good medicines management as one of the key priorities for health service commissioners.[44] As well as reducing the likelihood of medication errors and therefore patient harm, effective medicines management can help patients with self-care and increase compliance with treatment. Communication can facilitate good medicines management by managing patient expectations and increasing shared decision-making.[45] [46]

Patient experience

"My GPs are both willing to listen when asked questions about medication and will listen and make suggestions to reduce side effects. However, when I decided that I wanted to try to minimise the amount of medication I was on, they listened to my reasons and suggestions and, between us, we agreed a plan that enabled me to reduce the amount of medication I am taking. This gave me more control over my condition and reduced the amount of drugs I take as well as saving the cost of the medication."

The National Institute for Health and Clinical Excellence (NICE) summarises the evidence base for key therapeutic areas in medicines management.[47] The medicines management team for Coventry and Rugby CCG have produced a dashboard to show progress against national

[41]NHS England. *Medicine Optimisation Dashboard*, 2014: http://www.england.nhs.uk/ourwork/pe/mo-dash/

[42]Coenen S, Francis N, Kelly M, *et al.* Are patient views about antibiotics related to clinician perceptions, management and outcome? A multi-country study in outpatients with acute cough. *Plos One 2013;8:*e76691.

[43]Zgierska A, Miller M, Rabago D. Patient satisfaction, prescription drug abuse, and unintended consequences. *JAMA 2012;307:*1377-8.

[44]Naylor C, Imison C, Addicott R, *et al. Transforming our health care system: Ten priorities for commissioners.* London: The King's Fund, 2013.

[45]Chewning B, Sleath B. Medication decision-making and management: A client-centered model. *Soc Sci Med 1996;42:*389–98.

[46]Zolnierek KB, Dimatteo MR. Physician communication and adherence to treatment: A meta-analysis. *Med Care 2009;47:*826-34.

[47]National Institute for Health and Clinical Excellence. *Key therapeutic topics. Medicines management options for local implementation.* NICE, 2013.

targets listed by the Medicines and Prescribing Centre at NICE[48], including antibacterials, hypnotics, angiotensin-receptor blockers, ezetimibe and statins, and non-steroidal anti-inflammatory drugs. Figure 13 compares prescribing in Coventry practices in March 2013 and March 2014, demonstrating a notable improvement in a short period of time.

Medicines optimisation is a central concept in medicines management, and describes maximising health gains from medication. Polypharmacy, or the concurrent use of multiple medication items by an individual, is a major concern in medicines optimisation. This may describe appropriate polypharmacy, in which the necessary quantities and combinations of medicines are used to manage complex patient needs, or problematic polypharmacy, where efficacy, safety or cost-effectiveness may be compromised.[49] Polypharmacy is becoming increasingly common as a result of more patients living with long-term conditions and comorbidities, and most of these patients will be managed in primary care. Involving patients in decisions about prescribing can help to ensure appropriate polypharmacy by overcoming barriers to adherence such as side effects and inconvenience.[49]

Current evidence demonstrates that:

- up to 50% of medicines are not taken as intended by the prescriber
- between 5 to 8% of all unplanned hospital admissions are due to medication issues (this figure rises to 17% in the over 65s)
- medicines waste is a significant issue (reported as £300 million in primary care alone, about half of which is avoidable)
- the health gains that are lost because of incorrect or inadequate medicines in five therapeutic contexts are financially equivalent to in excess of £500 million per annum
- medication safety data indicates that there should be better reporting and preventing of avoidable harm from medicines
- resistance to antimicrobial treatments presents a very real and significant threat to modern healthcare.[50]

[48] NICE. Key therapeutic Topics. Medicines management options for local implementation. 31 January 2013: http://publications.nice.org.uk/pmg7

[49] Duerden M, Avery T, Payne R. Polypharmacy and medicines optimisation: Making it safe and sound. London: The King's Fund, 2013.

[50] York Health Economics Consortium & School of Pharmacy, University of London: *Evaluation of the scale, causes and costs of waste medicines*, November 2010: http://discovery.ucl.ac.uk/1350234/1/Evaluation_of_NHS_Medicines_Waste__web_publication_version.pdf

Figure 13: Prescribing Dashboards for March 2013 and March 2014, Coventry practices only

Ezetimibe [≤2.4%]	Hypnotics [≤0.24]	Antibacterials volume [≤1.14]	Quins/Cephs Volume [≤3%]	NSAIDS Volume [≤1.32]	ARBs [95%] Includes first and second choice	Statins (excluding Ezetimibe) [95%] Includes first choice only	Blacklist [≤ 2.8 items/1,000]

2013

Ezetimibe [≤2.4%]	Hypnotics [≤0.24]	Antibacterials volume [≤1.14]	Quins/Cephs Volume [≤3%]	NSAIDS Volume [≤1.32]	ARBs [95%]	Statins [95%]	Blacklist [≤ 2.8 items/1,000]
1%	0.32	0.59	1%	0.551	91%	75%	0.71
3%	0.30	1.01	3%	0.441	87%	74%	0.35
2%	0.73	0.84	4%	0.642	90%	77%	1.14
4%	0.90	0.94	3%	0.540	86%	73%	0.76
0%	0.94	1.83	2%	1.000	94%	90%	1.84
2%	0.76	0.98	2%	0.698	84%	64%	1.00
3%	0.76	0.96	2%	0.529	96%	63%	0.35
2%	0.83	1.14	2%	1.076	97%	83%	0.48
3%	0.79	1.07	2%	0.842	83%	76%	2.05
6%	0.66	0.94	3%	0.717	90%	74%	1.91
1%	1.08	1.11	3%	0.613	95%	82%	0.25
4%	0.71	0.98	2%	0.803	90%	71%	1.32
5%	0.92	1.09	0%	1.117	85%	61%	0.74
4%	0.61	1.11	2%	1.458	82%	84%	0.95
5%	0.85	0.64	3%	0.605	79%	68%	0.97
5%	0.93	1.07	2%	0.448	89%	61%	2.55
8%	0.96	0.84	1%	0.808	94%	61%	0.79
3%	1.10	1.28	2%	0.972	85%	68%	0.58
1%	1.17	1.32	2%	0.882	69%	77%	0.98
6%	0.58	1.33	2%	0.611	69%	72%	0.96
6%	0.49	0.94	3%	0.781	79%	71%	3.34
1%	1.20	1.71	1%	1.226	82%	83%	1.38
3%	0.17	0.90	5%	1.017	84%	70%	0.51
5%	0.09	0.49	4%	0.911	68%	70%	2.57
5%	0.67	0.76	4%	0.959	70%	73%	3.45
3%	0.75	1.08	3%	0.893	81%	51%	1.75
5%	1.06	1.23	3%	0.848	85%	74%	2.28
4%	1.01	1.02	2%	1.101	81%	69%	0.67
5%	1.06	0.95	4%	0.440	66%	61%	1.66
6%	1.03	0.95	3%	0.884	83%	69%	2.47
5%	1.14	1.25	2%	1.108	79%	67%	1.29
3%	1.77	1.34	2%	1.126	78%	71%	0.47
7%	1.28	1.56	0%	0.921	93%	72%	2.04
2%	1.50	1.70	2%	1.136	81%	68%	1.73
0%	8.31	0.70	1%	2.653	38%	73%	6.63
4%	1.26	1.32	2%	1.081	78%	73%	1.09
2%	1.13	1.38	2%	1.499	72%	78%	1.76
3%	1.59	0.99	5%	1.031	79%	79%	2.05
3%	0.76	1.04	6%	1.117	74%	73%	2.57
2%	1.46	1.35	3%	1.424	86%	74%	1.00
2%	1.51	1.76	2%	1.270	89%	77%	1.77
4%	2.03	1.05	3%	0.880	55%	68%	3.05
2%	1.58	1.21	3%	0.798	82%	67%	1.26
1%	1.42	1.31	5%	1.012	78%	82%	3.18
2%	2.03	1.88	5%	0.879	85%	67%	1.35
3%	1.00	1.29	3%	1.190	69%	75%	2.94
6%	1.15	1.21	3%	0.885	80%	67%	2.30
6%	1.08	1.44	5%	1.551	96%	83%	1.48
7%	1.65	1.20	3%	0.787	79%	65%	2.27
1%	2.21	1.87	7%	1.325	88%	79%	2.58
9%	1.79	0.96	3%	0.614	89%	71%	3.76
3%	1.31	1.64	2%	1.574	81%	68%	2.03
4%	1.67	1.42	2%	1.024	78%	73%	1.45
6%	0.97	1.26	4%	1.138	75%	72%	1.79
1%	1.52	1.43	4%	1.270	73%	73%	1.81
6%	1.65	1.51	4%	1.031	71%	76%	2.73
5%	1.14	0.96	6%	1.244	55%	68%	2.93
12%	0.80	1.00	4%	0.683	69%	66%	3.47
5%	1.01	1.33	4%	1.297	71%	70%	3.46
5%	1.66	1.39	4%	1.001	74%	73%	2.10
4%	2.12	1.18	5%	1.264	77%	74%	2.01
1%	1.66	1.45	4%	2.311	54%	92%	3.49
6%	1.37	1.13	3%	1.589	67%	64%	2.66
4%	2.40	1.38	3%	1.355	69%	59%	1.50
6%	1.84	1.34	8%	1.349	65%	73%	2.50
4%	1.18	1.22	3%	0.984	79%	71%	1.88
4%	1.35	1.10	3%	1.102	79%	73%	1.81
4%	1.26	1.18	3%	1.048	77%	70%	1.94

2014

Ezetimibe [≤2.4%]	Hypnotics [≤0.24]	Antibacterials volume [≤1.14]	Quins/Cephs Volume [≤3%]	NSAIDS Volume [≤1.32]	ARBs [95%] Includes first and second choice	Statins [excluding Ezetimibe] [95%] Includes first choice	Blacklist [≤ 2.8 items/1,000]
2.5%	0.11	0.90	0.5%	0.81	91%	100%	0.51
2.0%	0.09	0.89	0.5%	1.03	97%	96%	0.19
0.0%	0.04	0.46	2.8%	1.00	91%	99%	0.81
1.3%	0.21	0.84	3.0%	0.86	94%	98%	1.22
1.8%	0.15	0.88	2.3%	0.85	94%	98%	3.20
0.4%	0.22	1.57	2.2%	1.21	95%	98%	2.29
0.3%	0.19	1.07	0.5%	1.42	89%	99%	0.75
0.0%	0.27	1.02	2.3%	1.19	96%	97%	0.10
1.8%	0.17	0.91	1.5%	1.26	94%	98%	1.64
1.1%	0.22	1.08	2.5%	1.45	98%	98%	1.30
2.3%	0.22	1.03	1.5%	1.01	95%	98%	0.54
2.4%	0.24	0.75	1.3%	0.71	90%	97%	3.57
0.4%	0.08	1.35	0.4%	1.52	91%	97%	1.33
2.2%	0.12	0.77	3.3%	0.84	90%	93%	0.96
1.2%	0.25	0.92	0.8%	0.96	94%	97%	2.29
1.4%	0.21	0.95	1.6%	1.38	92%	95%	1.33
1.3%	0.25	0.66	2.5%	1.00	89%	95%	2.46
4.6%	0.24	0.81	1.6%	0.90	98%	96%	0.68
2.3%	0.17	0.80	0.9%	0.66	89%	96%	3.30
5.3%	0.25	1.22	0.5%	1.03	94%	100%	2.77
2.4%	0.27	1.03	2.3%	1.09	91%	97%	1.32
5.3%	0.13	0.91	2.0%	1.23	92%	97%	2.32
0.3%	0.35	1.21	2.8%	1.57	96%	98%	1.39
2.3%	0.33	1.09	2.1%	1.02	87%	98%	2.92
3.9%	0.17	0.94	2.7%	1.24	91%	97%	0.67
1.1%	0.27	0.99	1.5%	1.50	88%	97%	3.81
2.7%	0.28	0.92	1.8%	1.63	88%	98%	0.43
2.1%	0.20	1.44	1.5%	1.41	84%	98%	1.69
0.5%	0.45	1.11	1.9%	1.27	93%	98%	3.25
1.2%	0.47	1.34	3.1%	1.20	94%	98%	2.31
0.6%	0.34	1.63	2.0%	1.62	95%	97%	1.37
2.8%	0.29	1.13	2.7%	1.20	97%	92%	2.04
1.0%	0.35	1.48	1.9%	1.29	94%	94%	1.25
1.7%	0.34	1.18	2.3%	0.99	96%	99%	5.61
6.0%	0.18	0.87	4.2%	1.10	86%	96%	3.04
4.6%	0.18	1.01	3.9%	1.00	82%	94%	1.38
1.5%	0.35	1.08	2.6%	1.44	86%	98%	2.85
2.2%	0.38	1.35	2.0%	2.30	98%	99%	1.01
2.6%	0.22	1.03	5.8%	1.22	92%	97%	2.99
6.1%	0.31	0.88	2.8%	1.03	90%	99%	2.00
0.4%	0.45	1.04	3.0%	1.63	93%	97%	2.88
3.5%	0.20	0.78	4.5%	1.40	87%	96%	2.10
3.3%	0.31	0.77	3.4%	1.07	81%	100%	4.65
4.1%	0.36	0.87	2.7%	1.19	91%	96%	2.86
1.9%	0.47	0.87	2.9%	1.69	87%	98%	2.39
6.8%	0.41	0.84	2.6%	1.00	94%	98%	2.92
2.8%	0.41	1.20	1.9%	2.09	91%	97%	2.34
2.0%	0.54	1.12	2.8%	1.65	83%	98%	1.16
3.0%	0.22	0.89	4.2%	1.80	93%	95%	3.91
2.5%	0.39	1.20	3.6%	1.32	92%	96%	2.00
0.8%	0.39	1.22	2.2%	1.24	82%	97%	1.46
2.9%	0.26	1.36	3.9%	2.18	98%	97%	1.72
0.6%	0.41	1.33	2.3%	1.36	82%	98%	4.47
1.6%	0.59	1.75	3.2%	1.99	98%	98%	5.41
3.9%	0.14	1.19	3.9%	1.39	92%	98%	4.51
1.8%	0.43	1.13	3.9%	3.26	89%	98%	3.84
2.9%	0.32	1.41	1.7%	2.26	87%	96%	2.90
3.6%	0.59	0.82	3.0%	1.33	80%	94%	3.35
0.0%	2.25	1.19	1.2%	4.05	74%	99%	10.35
4.9%	0.35	0.84	5.4%	1.71	65%	96%	3.85
1.2%	0.30	1.15	2.3%	1.78	86%	94%	4.50
3.1%	0.33	1.24	3.6%	1.70	80%	97%	4.91
4.1%	0.60	1.20	1.9%	1.78	79%	95%	2.69
5.4%	0.62	1.45	5.5%	2.76	79%	99%	5.19
4.9%	0.50	1.19	3.1%	1.99	76%	97%	4.51
2.7%	0.30	1.11	2.5%	1.40	89%	97%	2.82
2.0%	0.37	1.01	2.7%	1.48	89%	97%	2.27
2.7%	0.34	1.07	3.0%	1.48	89%	96%	2.71

Source: Medicines Management Team, C&RCCG

A practice is given a red score if it is more than 20% below target and a green score if it is 20% above the national average. The dashboard shows the practices in a league table in order of score, but it also shows the top three most improved practices.

NHS England is developing principles to support medicines optimisation, in collaboration with the Royal Pharmaceutical Society, patients, the medical and nursing professions and the pharmaceutical industry. It is developing a Medicines Optimisation Dashboard which brings currently available prescribing data together in one place. It is not designed for performance monitoring and therefore there are no targets.

In Coventry efforts are currently directed to target prescribing in care homes and the frail elderly population with poly pharmacy. The aim is to optimise prescribing with a target to reduce items by 10-20%.

Over-medicalization

Polypharmacy and over-prescribing are part of the wider issue of over-medicalisation, which is an increasing concern in primary care and the focus of the BMJ's 'Too much medicine' campaign.[51] While there are undoubted benefits to medicine, there are also limitations to treatment and risks from over-treatment. As well as posing a threat to health, overdiagnosing and overtreating conditions such as prostate and thyroid cancers, asthma, and chronic kidney disease wastes NHS resources on unnecessary care.[52]

New ways of working: Prescribing in care homes

Care homes have been supported to use 'on line' ordering systems. This will increase patient safety as transcription errors will be reduced, duplicate ordering will be reduced, and unnecessary contact with surgeries to chase scripts will be reduced. It will also be possible to provide an audit trail and ordering will work more efficiently for both care home and surgery staff.

In addition, bulk prescribing for continence, dressings, thickeners and sip feeds has been set up in all Coventry nursing homes as appropriate, enabling nursing homes to respond to patient needs in a timelier manner and reduce the potential for unplanned hospital admissions. Using this supply route has also been shown to reduce waste of thickeners and sip feeds when patients' needs have changed, and care staff should see a reduction in workload relating to the medication supply cycle, enabling them to spend more time caring for people.

[51] BMJ. Too much medicine: http://www.bmj.com/too-much-medicine

[52] Glasziou P, Moynihan R, Richards T, *et al.* Too much medicine; too little care. *BMJ* 2013;347:f4247.

New ways of working: reducing polypharmacy

Coventry and Rugby CCG are developing a protocol to assist prescribers in medication reviews with patients over 80 years old in order to reduce the number of medications taken which are no longer of benefit to the patient. This will ensure that the benefits from prescribed medication are maximised, while the risks of harm are minimised.

In the UK, 45% of prescriptions are dispensed to patients aged 65 years or over, even though this age group only makes up 17% of the total population. Older people generally have a higher prevalence of multiple co-morbidities and are therefore likely to be prescribed many different medications to treat these conditions. The number of different drugs and their potential interactions increase the risk of adverse drug reactions in the elderly populations.

One of the strategies recommended to reduce the risk of adverse drug reactions are regular medication reviews in primary care. Ideally this should be done every 6 months. Drugs identified during a medication review as conferring little or no benefit and/or causing harm could be considered for discontinuation in a process known as de-prescribing. Evidence for drug discontinuation, or de-prescribing, is continuously evolving. In one study of 70 community-based older patients prescribed on average 7.7 drugs, 58% were discontinued, with an 81% success rate with no long term adverse consequences and with an almost 90% improvement in health.[50]

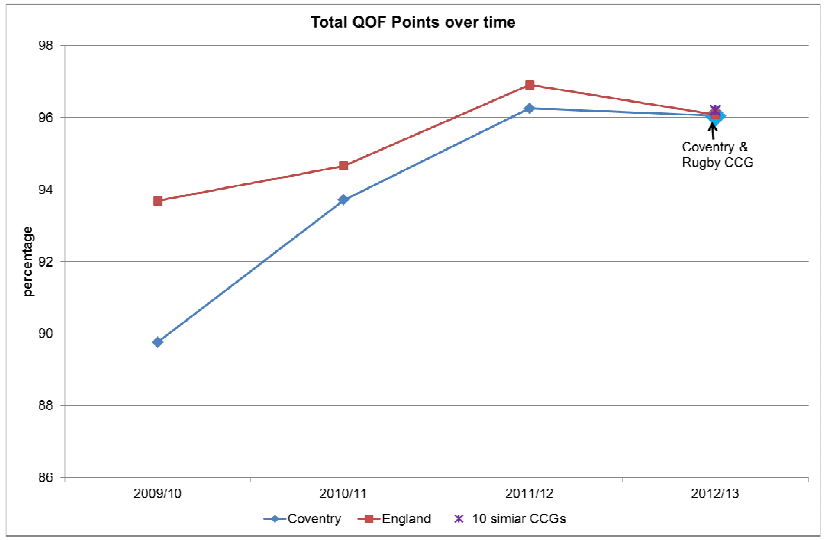
This protocol was used at a number of GP practices across Coventry. At some practices these reviews were undertaken by GPs alone and at some practices they were done by a GP and pharmacist together. A random sample of each of these showed that when this was done by a GP with a pharmacist there was an 18% reduction in medication opposed to only a 9% reduction if this was done by a GP alone.

[53]Garfinkel D, Mangin D. Feasibility study of a systematic approach for discontinuation of multiple medications in older adults. *Arch Intern Med* 2010;170(18):1648-54.

Quality Outcomes Framework

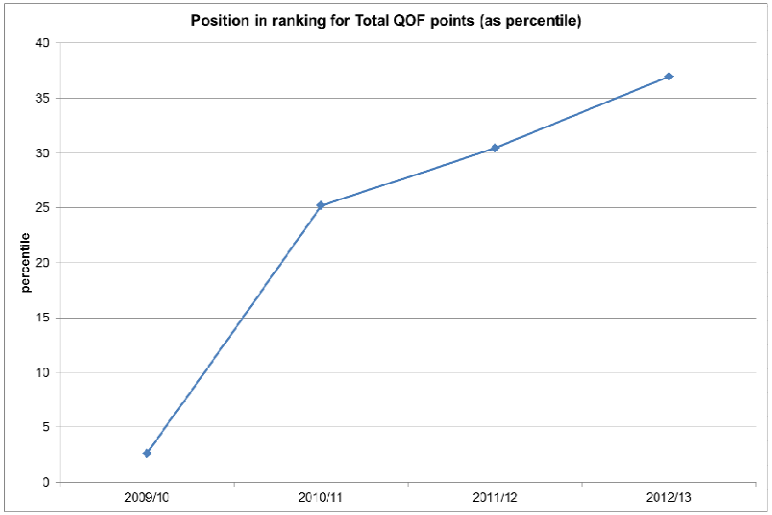
Over the last few years there have been significant improvements in the number of Quality and Outcomes Framework points awarded to GP practices in Coventry. In 2009/2010, Coventry PCT was ranked 149th out of 152 PCTs for the total QOF points received by all GP practices, while in 2012/13, Coventry and Rugby CCG was ranked 134th out of 211 CCGs. The improvement in the number of QOF points awarded to Coventry GP practices over time is demonstrated in Figures 14 and 15. This shows that there have been improvements in the number of QOF points awarded to primary care in Coventry, and Coventry's performance is now in line with the average number of QOF points awarded in England.

Figure 14: Percentage of total QOF points scored over time



Source: QOF

Figure 15 : Ranking for total QOF points over time as a percentile



Source: QOF

Chapter 4: Persisting Challenges

While there have been a number of recent improvements, there remain challenges across the primary care system. Patient demand and patient expectations are rising, there is variation in patients' reports of their experience of general practice and how easy they find accessing their GP, and there is also variation in the structure of GP practices in Coventry, with a larger proportion of practices with single contract holders than the rest of England. In order to improve health outcomes and reduce health inequalities in Coventry, public health, patients, practices and the wider health and social care systems should ensure patients live a healthy lifestyle, are able to self-care where possible, access the most appropriate services for their needs and have an improved experience when visiting their GP, while practices should work together in larger groupings to share learning and access the benefits of working at scale.

Demands and expectations

Of the many challenges which face general practice, the ageing population is expected to have the greatest impact.[54] For many people, extra years of life may be undermined by long term conditions or chronic diseases for which there is currently no cure, and which are managed with drugs and other treatment. About 15 million people in England have a long-term condition. About 50% of all GP appointments are concerned with people with long-term conditions, and treatment and care for people with long-term conditions is estimated to account for 70% of total health and social care expenditure. In addition the number of people with multiple long-term conditions is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018.[55]

Long-term conditions and multi-morbidity are more prevalent and more severe in people from lower socio-economic groups. People from the most deprived groups have a 60% higher prevalence of long-term conditions than those in the most affluent groups.[56] On average, people living in deprived areas will have multiple health problems 10-15 years earlier than people in affluent areas.[57] This section considers management of diabetes, stroke, heart disease, and avoidable admissions. While practices have a responsibility to provide good clinical

[54]Goodwin N, Dixon A, Poole T, et al. Improving the Quality of Care in English General Practice. Report of an independent inquiry commissioned by The King's Fund. London: The King's Fund, 2011.

[55]The Kings Fund. *Long Term Conditions and Multi Morbidity,* 2013: http://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/long-term-conditions-multi-morbidity

[56]Department of Health. *Long-term conditions compendium of information*, 3rd edition. 2012.

[57]Barnett K, Mercer SW, Norbury M, et al. Epidemiology of multimorbidity and implications for health care, research and medical education: A cross sectional study. *Lancet* 2012;380(9836):37-43.

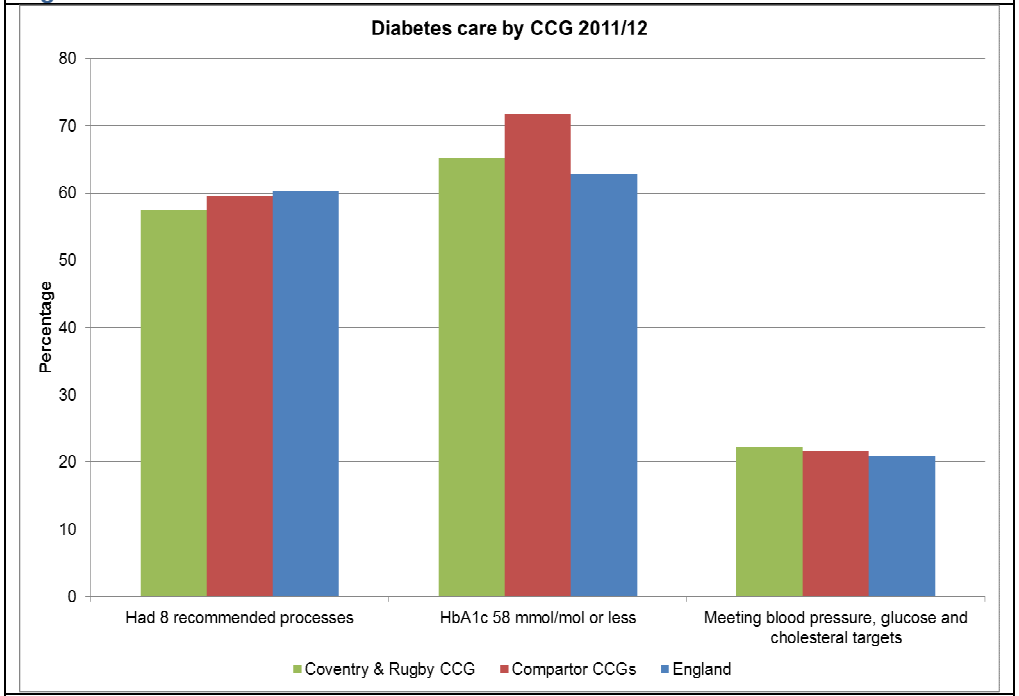
care to patients and to enable patients to manage their long term conditions, patients should also be supported to live a healthy lifestyle, manage their conditions at home, self-care where possible, and to access the most appropriate service for their needs.

Diabetes

Diabetes mellitus is an endocrine disease in which the level of glucose in the blood is raised because of lack of, or resistance to insulin (Type I and Type II Diabetes respectively). A person with diabetes has a higher risk of heart attack, angina, heart failure, stroke, amputation and renal disease[58]. The majority of care for diabetic patients takes place in primary care.

Figure 16 shows the overall performance for 8 recommended health care processes (including: BMI, blood pressure, smoking, glucose levels (HbA1c), cholesterol, urine microalbumin, creatinine, and foot nerve and circulation examination) as recommended by NICE. It also shows blood glucose control (at HbA1c 58mmol/mol or less) and the performance for optimal blood pressure, blood glucose and cholesterol. In 2011/12 Coventry & Rugby CCG had a lower percentage of patients receiving the 8 recommended care processes, but a higher percentage than England had good blood glucose control and a higher percentage than both England and the 10 comparator CCGs met the targets for blood pressure, blood glucose and cholesterol.

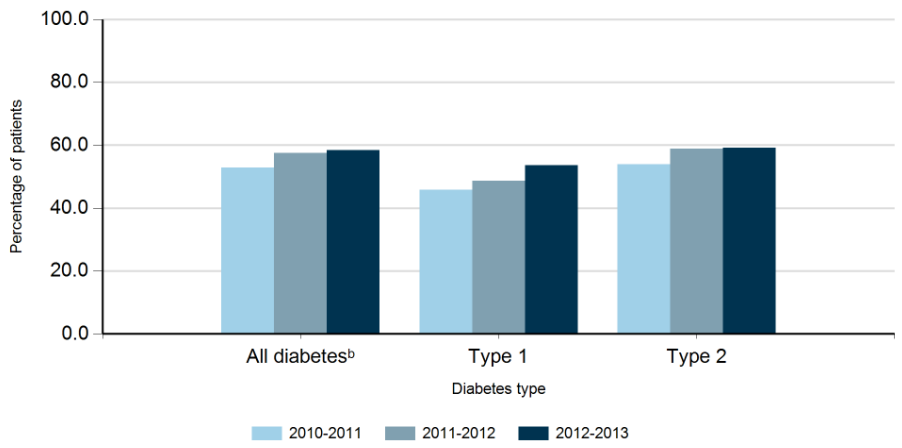
Figure 16: Diabetes care in 2011/12



The National Cardiovascular Intelligence Network (NCVIN)

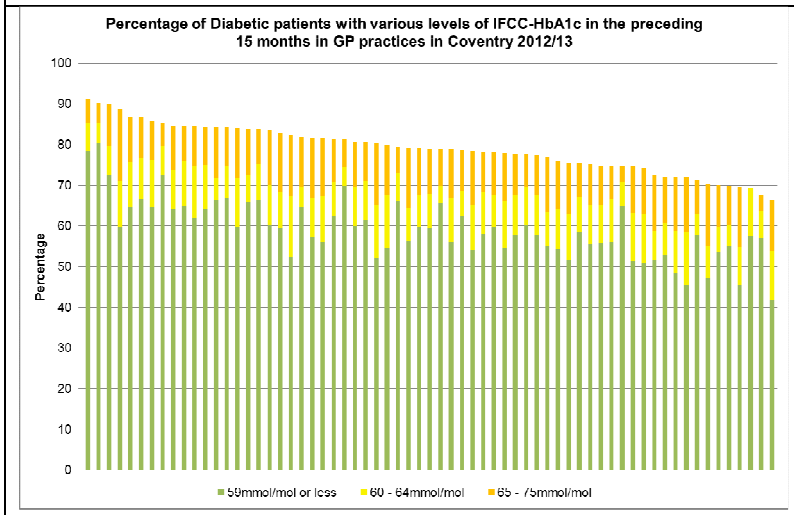
[58]Public Health England. 2014. Cardiovascular Disease Profiles – Diabetes

Figure: 17 Percentage of all patients in NHS Coventry and Rugby CCG receiving the eight NICE recommended care processes by audit year and diabetes type



Source: National Diabetes Report 2012-2013

Figure 18: Blood glucose control in diabetic patients in Coventry GP practices 2012/13



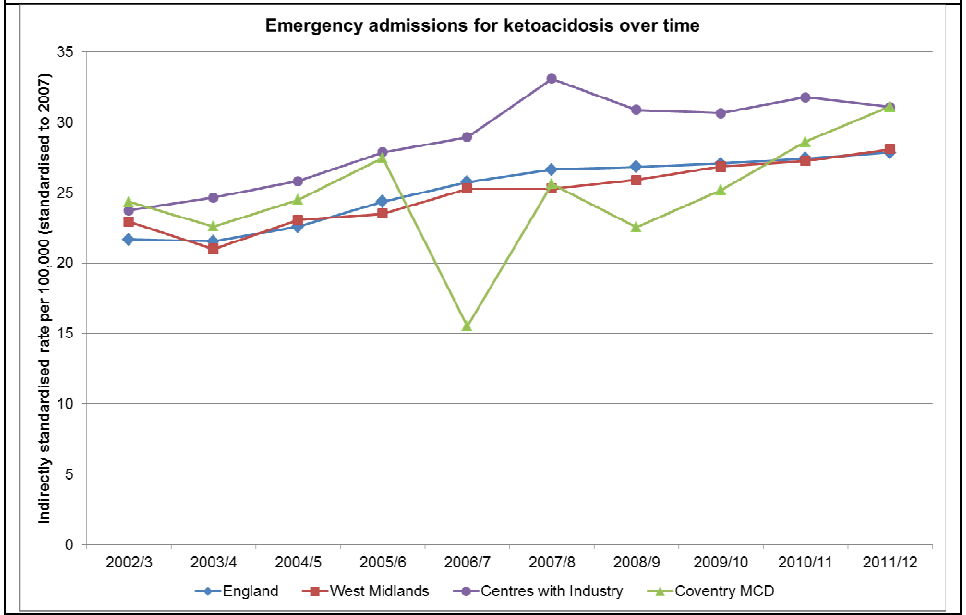
Source: QOF

Figure 17 shows that the percentage of patients receiving the eight NICE recommended processes in Coventry has increased over time.

Figure 18 shows the distribution of blood glucose levels by practices in Coventry GP practices. The percentage of those with an IFCC-HbA1c of 75 mmol/mol or less in the last 15 months varied from 66% to 91%.

People with poorly controlled diabetes may develop ketoacidosis which is a medical emergency. Figure 19 shows the rate of emergency admissions for ketoacidosis in Coventry compared with England, the West Midlands region and similar local authorities over time. Over the period 2002/3 to 2011/12, the rate for Coventry was not significantly different from England except for the 2006/7 rate when it was significantly lower.

Figure 19: Emergency admissions for Ketoacidosis between 2002/3 and 2011/12



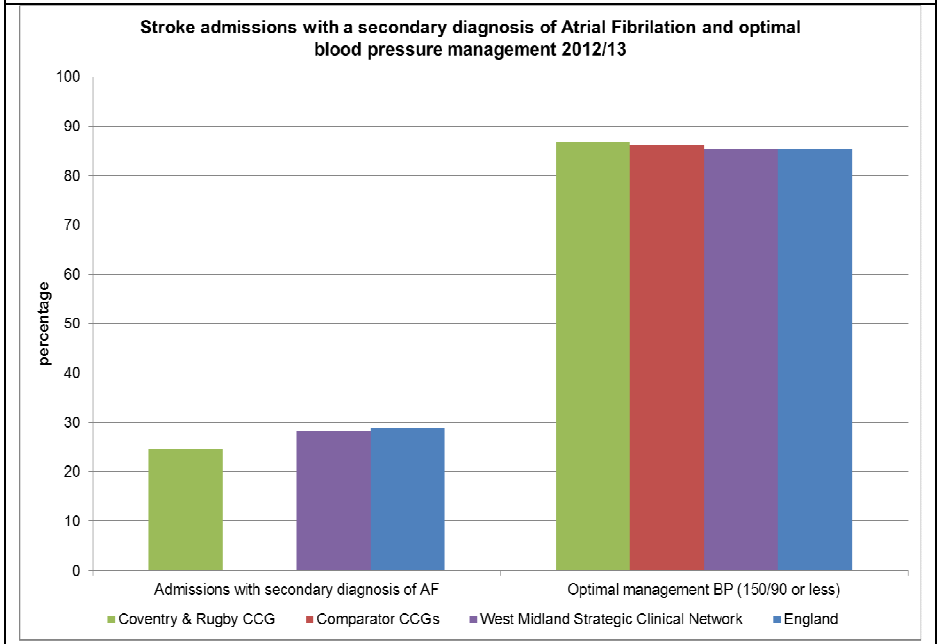
Source: HSCIC

Stroke

A stroke occurs when the blood supply to a part of the brain is suddenly cut off either due to a clot or a bleed. The cells in the affected area of brain become damaged, or die. Depending on the severity of the stroke, it can result in death or mild to severe disability. Transient Ischaemic Attacks (TIAs) are like mini strokes and are due to a temporary lack of blood supply to a part of the brain, with symptoms lasting for less than 24 hours.

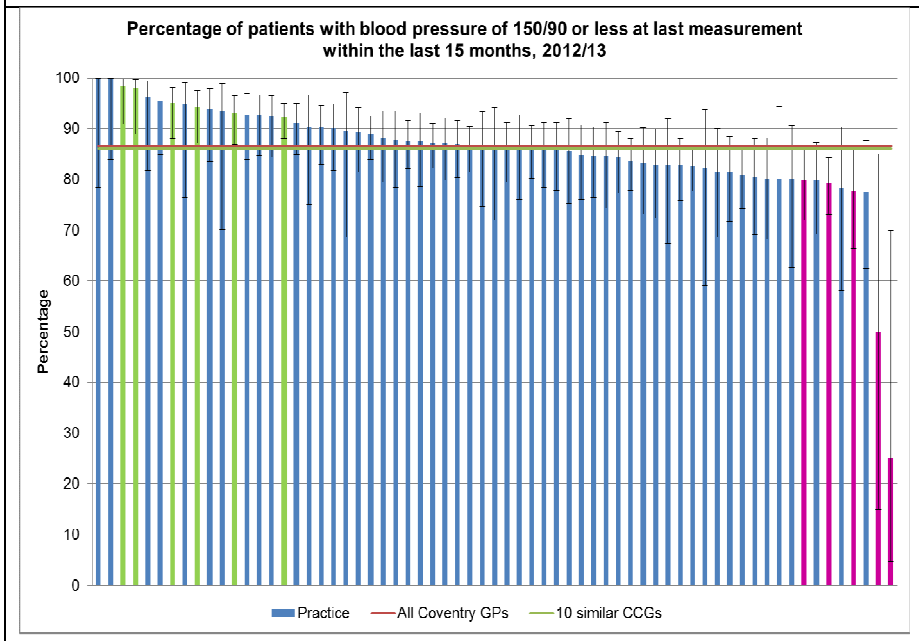
Atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and high blood pressure are known risk factors for stroke but not all cases are detected before a stroke occurs. Figure 20 shows that 24.5% of patients in Coventry & Rugby CCG were diagnosed with Atrial fibrillation following admission for stroke, which is better than the English average rate. Figure 20 also shows the percentage of stroke or TIA patients whose blood pressure was optimal (150/90 mmhg or less in the previous 12 months) again showing that Coventry & Rugby CCG has a better rate than England and the 10 similar CCGs.

Figure 20: Stroke admissions with a secondary diagnosis of atrial fibrillation and optimal blood pressure management 2012/13



Source: The National Cardiovascular Intelligence Network (NCVIN)

Figure 21: The percentage of patients with optimal blood pressure management at Coventry GP practices, 2012,13



Source: QOF

Figure 21 shows the variation in the percentage of stroke patients with optimal blood pressure in Coventry GP practices. The majority are not significantly different to the rate for the 10 similar CCGs but 6 practices have significantly higher percentages of stroke patients with controlled blood pressure, while 5 have a significantly lower percentage.

Heart Disease

Coronary heart disease is the leading cause of death, both in the UK and worldwide, responsible for 74,000 deaths in the UK each year. According to NHS Choices, about 1 in 5 men and 1 in 8 women die from coronary heart disease. In the UK, there are an estimated 2.7m people living with

the condition. The main symptoms of coronary heart disease are angina (chest pain), heart attacks and heart failure.[59]

In Coventry, it is estimated that around 21,350 people (4.5% of the population aged 16 and over) are currently living with coronary heart disease.[60] The prevalence of coronary heart disease is lower than the average for England.

The burden of heart disease is not shared equally across the city, with those from more deprived areas more likely to develop and die from the disease. Although coronary heart disease cannot be cured, treatment, such as lifestyle changes, medication and surgery can help to manage the symptoms.

In 2012/13, the emergency admission rate for coronary heart disease in Coventry was 349 for every 100,000 people in the population (1,205 admissions). This is significantly lower than the average for England (575 per 100,000), suggesting heart disease is currently being better managed in the community in Coventry than elsewhere in the country.[61]

Referrals – two week wait

Approximately one in 20 GP consultations results in a referral being made to another service. Referrals may be made to establish diagnosis, for treatment or an operation, for a specific test which cannot be ordered by the GP, for advice on management of a condition, for a second opinion or to seek reassurance for the patient, family or GP.[62]

The NHS Constitution states that patients have the right to access certain services within maximum waiting times. National Institute for Health and Care Excellence (NICE) guidelines state that patients suspected of cancer have the right to be seen by a specialist within a maximum of two weeks from seeing their GP.[63]

Variation in referral rates is influenced by a range of factors, some of which general practice cannot influence directly, such as patient characteristics, while others such as practice size, the availability of different services and GP attitudes to risk can be attributed to practice characteristics.

Overall, the rate of two week wait referrals in Coventry is 20% higher, at 2,283 per 100,000 of the population, than the rate for England on average

[59]Public Health England, *Cardiovascular Disease Profile: Coventry and Rugby CCG*, August 2014: http://www.nhs.uk/conditions/Coronary-heart-disease/Pages/Introduction.aspx
[60]Ibid.
[61]Ibid.

[62]Bowling A, Redfern J. The process of outpatient referral and care: the experiences and views of patients, their general practitioners, and specialists'. *Br J Gen Pract* 2000;50:116–20.
[63]National Institute of Clinical Healthcare Excellence. Referral guidelines for suspected cancer: CG27. NICE, 2005.

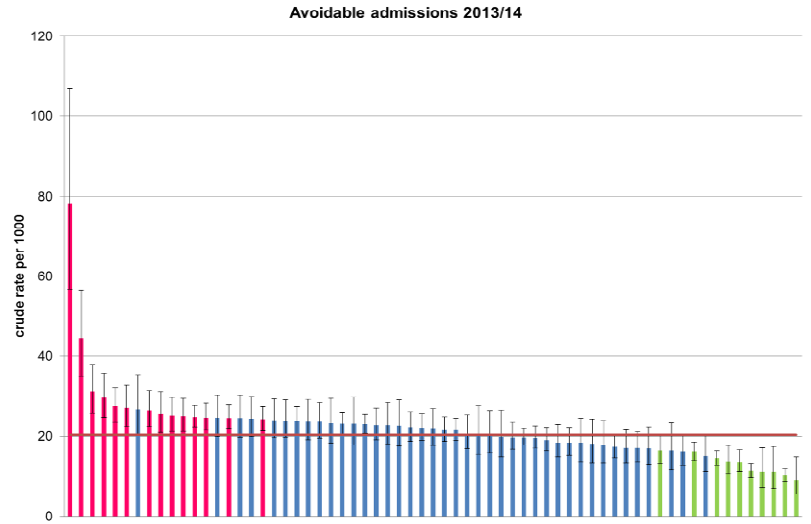
(1,900 per 100,000 of the population). According to the National Cancer Intelligence Network (NCIN), there are no "right" or "wrong" levels of referral,[64] as a decrease in the number of "unnecessary" referrals would also lead to a decrease in the number of "necessary" referrals.

7.3% of two week wait referrals result in a cancer diagnosis in Coventry, compared with 8.8% nationally.

Avoidable admissions

Acute illness sometimes necessitates hospital admission, however wherever possible patients are managed at home. The CCG dashboard shown in figure 23 includes an indicator for "avoidable admissions"[65] and the results for the Coventry practices are shown in figure 22. The rate ranged from 9 to 78 per 1000 patients in 2013/14 with the average for Coventry practices being 20 per 1000. 14 practices had significantly higher rates than this and 10 had significantly lower rates. Overall, Coventry practices showed higher rates for avoidable admissions to hospital than England.

Figure 22: Avoidable hospital admissions



Source: CCG

Patients who do not feel supported by health services or confident in managing their own conditions are likely to deteriorate more quickly, more likely to be admitted to hospital and are more likely to die at an earlier age, resulting in health inequalities between patients who are more knowledgeable, more confident, or who have access to better quality care and those that do not.[66]

[64] National Cancer Intelligence Network, *Urgent GP referral rates for suspected cancer,* 2011: http://www.ncin.org.uk/publications/data_briefings/gp_referral_rates

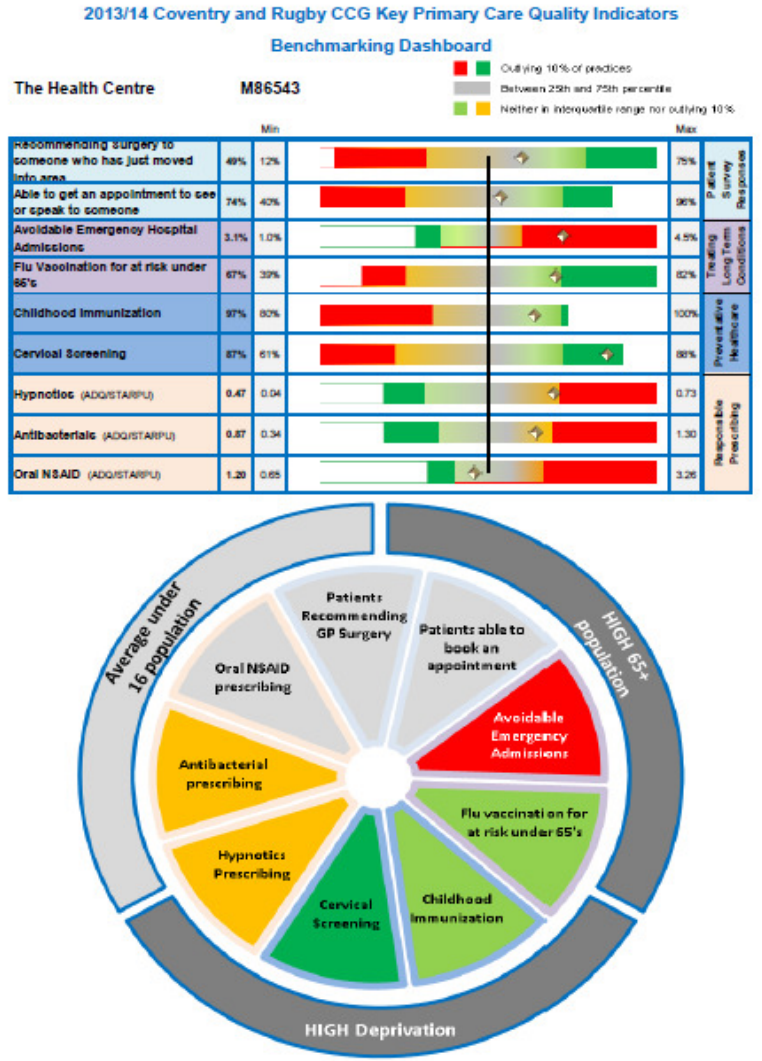
[65] Admissions which could be prevented by interventions in primary care

[66] Blunt I. Identifying the members of the A&E frequent flyers club. *HSJ* 2014: http://www.hsj.co.uk/5066856.article#.Us0qMPRdWVM

Coventry and Rugby CCG Dashboard

Coventry and Rugby CCG have developed a dashboard (Figure 23) to show where practices sit on a range of indicators relative to others. This will be available for both practices and the public to view, to enable patients to make informed choices about the practice they belong to and to encourage improvement in practices.

Figure 23: Coventry and Rugby CCG Primary Care Dashboard



Patient Experience

Lord Darzi's report *High quality care for all* (2008) highlighted the importance of patient experience within the NHS, ensuring that people are treated with compassion, dignity and respect within a clean, safe and well-managed environment.[67]

Patients who feel that they are able to access primary care services in a suitable way and in a timely manner, patients who have confidence and trust in their GP, are able to see their preferred GP or at least have an experience of continuous care, and patients who feel involved in decisions about their care are more likely to visit their GP at an earlier stage, more likely to take advice, more likely to adhere to treatment and therefore more likely to have better health outcomes.[68]

Friends and family test

From December 2014 all practices will have to undertake the friends and family test and report on the results. The friends and family test consists of one standard question which is "How likely are you to recommend our practice to friends and family if they needed similar care or treatment?" Further guidance is being developed to provide further details and information on data collection. This will allow patients to see how well a practice is doing in terms of recommendations from service users.

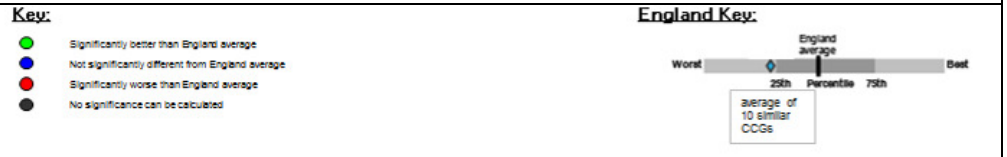
The GP patient survey

The NHS GP Patient Survey (GPPS) measures patient satisfaction and experiences in relation to access and continuity of care. The King's Fund have recommended that GPs, practice nurses, reception and other practice staff should routinely monitor their GPPS results, benchmark themselves against their peers, and make improvements where needed. The response rate to the survey is low, with only 35% of patients responding nationally. In Coventry, the response rate varies by practice from 10% to 47%.

[67] Darzi A. High Quality Care for All: NHS Next Stage Review (Final Report). London: Department of Health, 2008.

[68] NHS England. *NHS Outcomes Framework:* http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-4/

Figure 24: Selected questions from the National GP patient survey showing Coventry & Rugby CCG's score in relation to other CCGs, and with the 10 most similar CCGs as a comparison, based on July 2014 release[69]



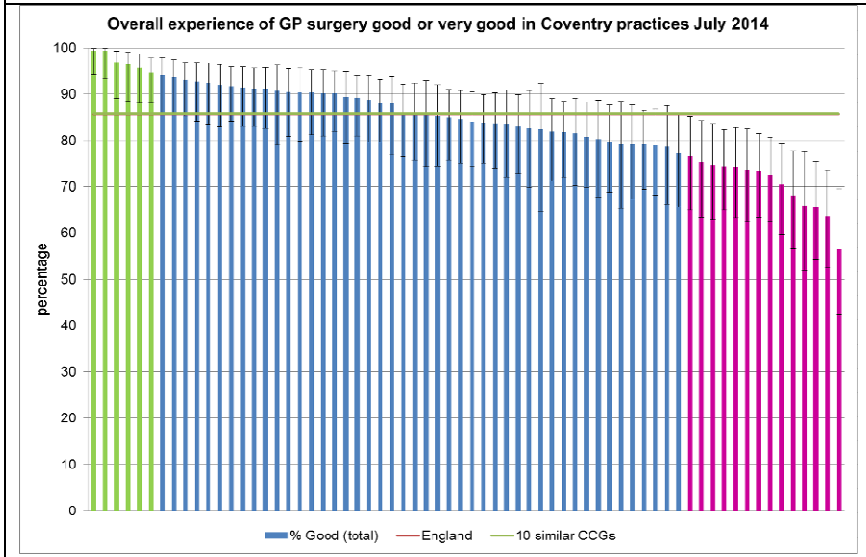
	Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
1	Easy to get through to someone at GP surgery on the p	n/a	73.4	72.9	47.0		88.5
2	Waiting more than 15 mins	n/a	32.9	26.7	44.4		15.7
3	Helpful receptionist	n/a	86.7	87.3	76.4		94.7
4	GP give enough time	n/a	84.5	85.8	77.0		91.3
5	GP good at listening	n/a	86.2	87.5	78.8		93.0
6	GP shows care and concern	n/a	81.2	83.0	72.8		89.5
7	Involves patient in decisions about care	n/a	74.9	75.2	64.6		83.9
8	Patien has confidence and trust in GP	n/a	91.5	92.5	85.8		96.9
9	Don't know how to contact OOH Service	n/a	48.8	44.2	62.3		30.0
10	Can see preferred GP	n/a	57.0	60.6	39.2		74.1

Source: Spine Template by WMPHO (Now PHE) and data from National GP Patient Survey

Responses from the GP Patient Survey in Coventry did not differ significantly from previous years. Figure 24 provides a comparison between the responses from respondents from Coventry practices to the GP Patient Survey, average responses in England and average responses from the 10 most similar CCGs. Overall, the responses from Coventry residents are worse than the average responses for England, with select questions such as 'Do you know how to contact your out of hours service?', 'Do you have confidence and trust in your GP?', and 'Do you have to wait more than 15 minutes for an appointment' highlighting particularly challenging areas.

When asked about their overall experience of their GP surgery, the average proportion of patients in Coventry who provided a rating of 'good' or 'very good' was 84%, varying from 54% to 97% between practices (compared to the national average of 86%).

Figure 25: Overall experience of GP surgery



Source: GP Patient Survey, July 2014

[69] 10 most similar CCGs from the 'Commissioning for Value Insight Pack': NHS Wakefield CCG, NHS Bristol CCG, NHS Greater Huddersfield CCG, NHS Sheffield CCG, NHS Southern Derbyshire CCG, NHS Stoke on Trent CCG, NHS Hillingdon CCG, NHS Bolton CCG, NHS Hull CCG, NHS Greater Preston CCG

NHS Choices

The NHS choices website allows patients to comment on their experience of their GP practice either positively or negatively. This allows other patients to review different GP practices in their area as well as allowing the GP practice to respond to these comments. The use of this system in variable. The majority of practices have a very small amount of feedback on this website, usually less than 30 individual comments, and in Coventry the response rate is even lower than average.

Healthwatch Survey

Healthwatch Coventry undertook a paper and electronic survey between July and the end of September 2014 to gather views on what makes good quality GP care. The survey was made available through the Healthwatch website, community outreach by Healthwatch and Coventry and Rugby CCG; through libraries; some GP practices and other community settings. It was also distributed to the Healthwatch membership and through voluntary sector networks. The majority of the surveys were completed by post or online and others were completed through one to one interviews undertaken by Healthwatch volunteers or staff.

Four practices had significantly better results, and 11 practices had significantly worse results, as shown in Figure 25. Nationally, 5% of respondents rated their experience as 'poor' or 'very poor', while in Coventry this varied from 0% to 26% (with an average of 6%).

A survey undertaken by Healthwatch Coventry of 156 people using GP services suggests that 93.6% of respondents felt the receptionist was very important to their experience of their GP practice. Reception staff were seen as important as the first point of contact and in setting the tone for the practice and some respondents saw reception staff as having an important information and link role. Attitude, manner and approach were seen as very important to patients and Healthwatch has recommended support and training for reception staff to meet the list of personal and skills listed by respondents, with a particular focus on customer service.[70]

[70]Healthwatch Coventry, Interim findings regarding the importance of receptionists to people using GP services, October 2014.

John Mason, Chair, Healthwatch Coventry

"Healthwatch Coventry is the independent consumer champion for health and social care in Coventry. We work to give people a voice in their services and argue for the interests of those who are unable to access services. Queries about GP services are the most frequent questions received by the Healthwatch Coventry Public Information Line and people regularly raise views and experiences of using GP services with us. This reflects the pivotal role the GP services play in managing people's health and in accessing other health services.. It can be difficult for people to know what level of service they should be getting from their GP. This is why we are carrying out our surveys and focus groups to help define what good service looks like and how this can be supported locally."

New ways of working: Training reception staff

One of the practices based in the Foleshill corridor area of the city serves a diverse community. Patients from many different countries of origin, covering 20 different languages, attend the surgery. The receptionists are the first point of contact for the majority of patients and therefore being able to communicate effectively with them is key to their job role. For this reason the Medical Centre prioritises recruitment of receptionists who can speak at least five different local languages and then look to train them in further key receptionist skills.

This was identified as key by the patient participation group who are made up of members from different ethnicities. They felt that one of the key priorities for patient engagement was that their elderly population were able to speak to someone at the GP surgery who could speak their own language. This has been positive in improving the relationship between the GP surgery and the local community.

Access

Overall, according to the GP Patient Survey, patients in Coventry are accessing their GPs at a similar rate to the national average: 73% of registered patients in England and 74% in Coventry saw their GP in the last six months, and in Coventry the proportion varied from 60% to 92% between practices. Responses to the GP Patient Survey also indicated that while most people book by phone (both nationally and in Coventry) and are happy to do so, a large proportion of patients would prefer to book online.

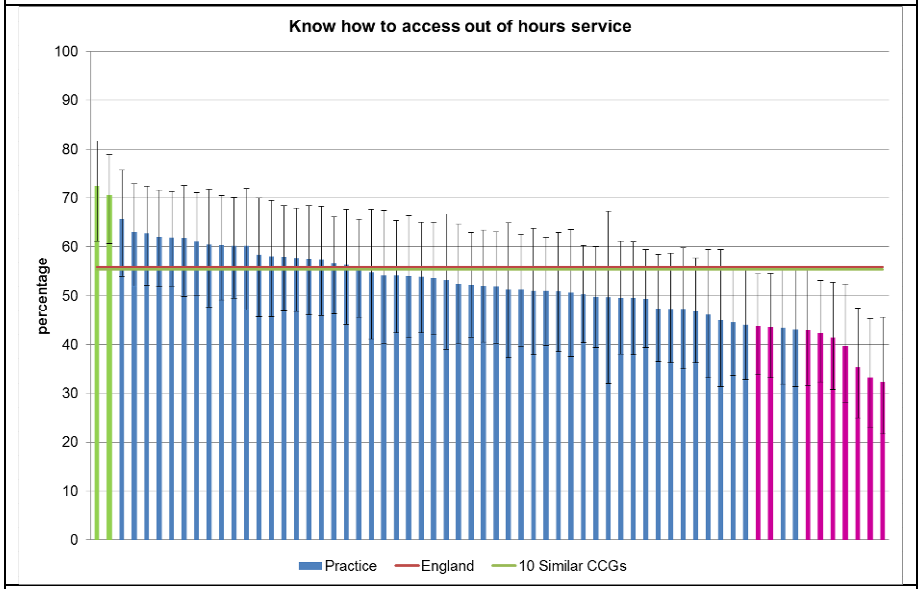
There is variation in how easy patients find it to contact their practice in Coventry. Nationally, 73% of patients report that contacting their practice by phone is 'easy' while in Coventry this ranges between 43% to 98%, with an average of 74%.

Out-of-hours GPs provide urgent primary care when GP surgeries are typically closed. They form part of the urgent care system, along with other services including NHS 111 and A&E departments.

Most patients are positive about their experience of out-of-hours GP services. The GP Patient Survey reported that 66% of people nationally rated their overall experience as very good or fairly good, although within Coventry this was lower at 53%. There was also variation, ranging from 21% to 88%, with one practice having a significantly lower proportion than England. The responses also indicated a perception that services are generally responsive, with 59% nationally stating that the time it took was about right, while in Coventry this was also lower at 37% and variable (between 7% and 66%, with two practices having significantly lower proportions than England).

The GP Patient Survey also found that 44% of people nationally and 49% of people in Coventry did not know how to contact the Out of Hours Service (ranging from 27% to 68% within Coventry). A survey commissioned by the National Audit Office found that around a quarter of people nationally had not heard of out-of-hours GP services, and that awareness among certain groups, including young people and people

Figure 26: Percentage of patients who know how to contact their out of hours service



Source: GP Patient Survey, July 2014

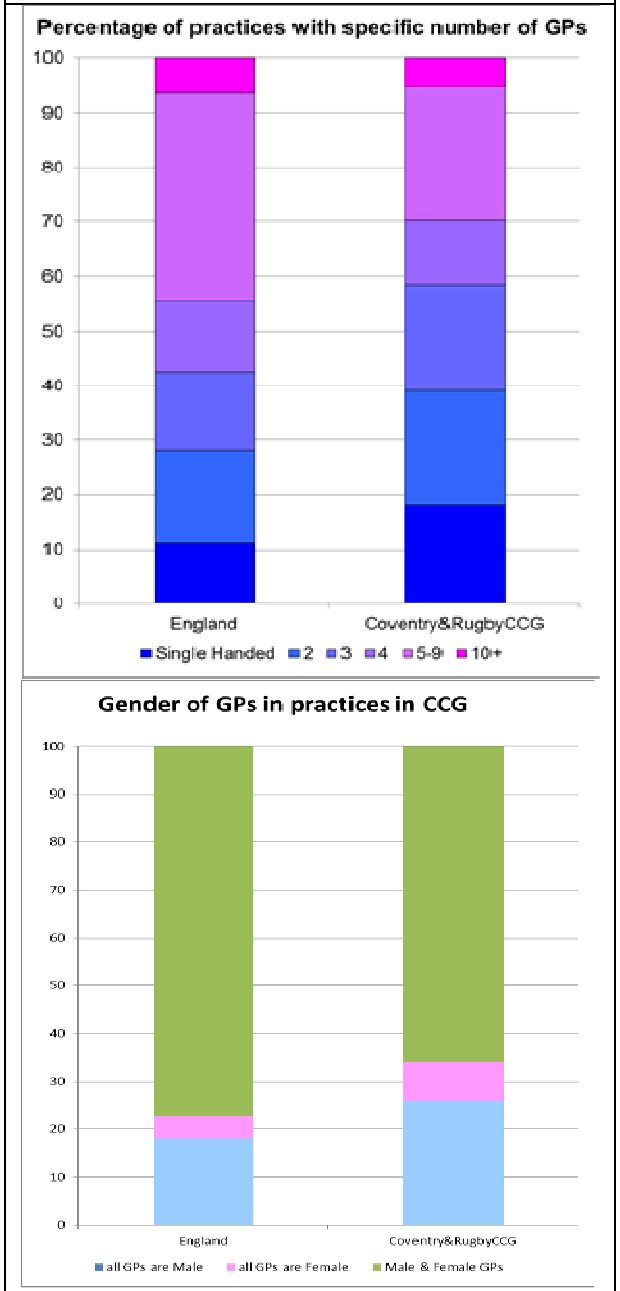
from black and minority ethnic communities was lower than among others. People who could not access their GP, or who have not heard of out-of-hours GP services or do not know how to contact them were more likely to go to A&E departments or call 999 if they or their family felt unwell during the night or at the weekend.

List size, staffing levels and premises

The list size (numbers of registered patients) at practices in Coventry ranges from approximately 18,500 to less than 500. On average, the number of staff in Coventry practices is lower than the average for England. A number of the small practices are specialised and deliver care to specific groups, for example the homeless and refugee populations of Coventry.

There is variation in the number of GPs per practice in Coventry and Rugby CCG. Figure 27 shows data from the HSCIC indicating that in 2013 there were more single GP contract holders (18%) than is average for England (11%), and a higher proportion of practices with single sexed contract holders (26% all male, 8% all female, compared to 18% all male and 5% all female in England). Note that where a GP practice has a single

Figure 27: Number of GPs by practice and gender of GPs by practice in Coventry and Rugby CCG, 2013



Source: HSCIC

contract holder, this does not necessarily mean there is only one GP working in that practice; there may be a number of salaried GPs, long term locums, and other practice staff.

Primary care premises are recognised as being an important contributor to the quality of care delivered. There is conflict between 'traditional' general practice, which is based on a model of small, independently contracted businesses, and the move towards general practice operating within larger organisations or networks. Despite investment in new GP-led health centres, there are still practices throughout the country that are operating within premises not fit for purpose.[71] However, the King's Fund independent inquiry report recommends that further investment should only be made when existing premises and infrastructures are being fully utilised.[72] It is also acknowledged that there are aspects of small practices that are valued by patients. Rather than replacing them altogether, the emphasis should be on bringing smaller, more isolated practices into more collaborative structures.[73]

There is conflicting evidence on the ability of small practices to deliver high quality care. While practices with smaller list sizes have been found to have greater perceived physician availability and longer consultation times, which can improve patient satisfaction and compliance, being a single-handed practitioner can be isolating. The range of services smaller practices can offer may also be constrained.[74]

KPMG International's Report, *The Primary Care Paradox, New Designs and Models* states that new models of primary care organization are emerging in countries which are seeking better coordination between services for people with long term conditions and stronger links between primary and specialist care. KPMG suggests there is a growing trend towards larger scale practices – working through networks, federations, alliances, polyclinics; extended physician partnership or integrated systems. The strength of these models lies in their scale which allows:

- an extended range of services with access to specialist advice
- a focus on population health management,
- development of tailored care for people with multi-morbidity,
- peer review and clinical governance,
- professional humans resource, financial and leadership capacity,
- career development and support for professional and other staff.[75]

[71]Goodwin N, Dixon A, Poole T, et al. Improving the Quality of Care in English General Practice. Report of an independent inquiry commissioned by The King's Fund. London: The King's Fund, 2011.
[72]Ibid.
[73]Ibid, 132.

[74]Edwards N, Smith J, Rosen R, et al. The Primary care paradox, new designs and models, *KPMG* 2014
[75]Ibid, 13

In a comparative study of single-handed and group practices in The Netherlands, group practices were found to score better on nearly all aspects of infrastructure except those rated by patients,[76] and Ashworth et al identified a cohort of 2.7% of practices which remained in the lowest decile for total QOF scores in the four years following its introduction.[77] These practices were almost 14 times more likely to be single-handed, non-training practices, and located in deprived areas. GPs in these practices were more likely to be aged 65 years or more, male, UK qualified and with small list sizes.

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New ways of working: Coventry GP Alliance

General practices are typically small organisations working in relative isolation from one another. Coventry is no different to most cities.

The population of the UK is ageing and an increasing number of people have multiple long term conditions driving demand on practices.

A group of Coventry GPs intend to work together as a federation to provide high quality, comprehensive, local primary health care and to remove inequalities in access and service through protecting and supporting general practice, improving general practice skills, working better with others and being more efficient and effective.

[76] van den Hombergh P, Engels Y, van den Hoogen H, *et al.* Saying 'goodbye' to single-handed practices; what do patients and staff lose or gain*? Family Practice* 2005;22:20-7.
[77] Ashworth M, Schofield P, Seed P, *et al.* Identifying poorly performing general practices in England: A longitudinal study using data from the quality and outcomes framework', *J Health Serv Res Policy* 2011;16:21-7.

Chapter 5: Looking to the future

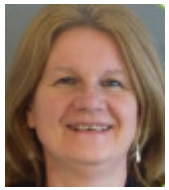
There has been considerable progress in general practice in Coventry in recent years. There has been an increase year-on-year in the number of QOF points awarded to GP practices in Coventry, improvements in prescribing, and improvements in a range of health promotion measures which encourage prevention and early intervention.

The population of Coventry is diverse, with high levels of deprivation and a high birth rate. While the population of Coventry is younger, on average, than other parts of the country, the number of people living with multiple health conditions is rising, and an increased need for health services is compounded by a tighter financial context, changes in the allocation of resources and pressure on public budgets. In order to rise to the challenges of today and of the future and to contribute to a reduction of health inequalities in Coventry, the scale and pace of improvements made must accelerate.

Innovative practice in Coventry

General practice cannot exist in isolation; it should form part of broader social structure with numerous influences on health. Within Coventry, a number of practices are developing innovative approaches to patient care

Dr Madeleine Wells, Medical Director, Coventry and Rugby Clinical Commissioning Group



"As Medical Director for the CCG, charged with quality and assurance, and a long standing GP in the city, I feel we should celebrate the good work being done in General Practice in the city and the improvements that have been taking place year on year despite an increasing work load in an increasingly diverse and challenging city.

I have been working with Health Education West Midlands and the Area Team to scope recruitment and retention of both GPs and practice nurses and there have been some exciting developments that should hopefully feed through to help us maintain an enthusiastic workforce for Coventry, delivering the healthcare our population deserves."

and working closely with wider health and social care systems to maximise resources and provide an integrated service for patients. Some examples of these approaches, including greater use of tele-consultations, the development of a safeguarding hub, asset based working and the piloting of an integrated 'Acting Early' model and hot house workshops are included below.

Telehealth

Telehealth is the use of digital technologies to deliver medical care, health education, and public health services by connecting multiple users in separate locations. Telehealth can be used to monitor patients with long term health conditions from home and to enable remote consultations to take place between health professionals or between health professionals and patients.

The Department of Health aims to implement telehealth within primary care services in order to provide benefits for patients with long term health conditions[78] based on a two year randomised controlled trial of telehealth which has been completed in three areas of England and demonstrated significant outcomes during the period, including:

Patient experience

I like the fact that we can, if the problem is minor, or if we're not sure if we need to actually see a GP, have a telephone appointment. Often it is the same day, or the next day when the GP will telephone us and talk us through the problem. This service is very good because sometimes a small matter can easily be dealt with over the phone. The patient can be re-assured that it is nothing to worry about, or an appointment can then be made should the GP decide that it is necessary to discuss things further. This service saves us going to the surgery – saving us time and reduces the risk of infection from other patients and it frees up surgery appointment time for other patients with greater need than ours.

- 45% reduction in mortality rates
- 20% reduction in emergency hospital admissions
- 14% reduction in elective admissions
- 14% per cent reduction in bed days
- 8% reduction in tariff costs[79]

[78] Healthcare UK. *Primary Care Working in Partnership.* UK Trade & Investment, 2011: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266789/02_PC_28.11.13.pdf

[79] Steventon A, Bardsley M, Billings J, *et al.* Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial. *BMJ*, 2012; 344:e3874.

New ways of working: telephone triage

In order to improve patient experience, Park-Leys practice introduced telephone triage of every request for a GP appointment seven years ago.

The practice aimed to reduce the number of face-to-face appointments which concentrated on minor problems that could be managed in less time without the need for patients to come to the surgery.

The system at Park-Leys practice has evolved over time. Patients are now offered the option of a telephone appointment, or can book a face-to-face appointment up to 10.30am (after which calls are triaged). Every surgery is now made up of a mix of 5 minute telephone consultations and 10 minute face-to-face consultations. Typically two out of three consultations take place over the phone.

This has improved access to GP services for patients, while ensuring that GP time is used to address the patients who most need the time and support of a face-to-face consultation.

A number of studies exploring the effectiveness of telehealth for long term health conditions such as cardiovascular disease, high blood pressure and depression found that telemonitoring can lead to improved patient outcomes and reduced health costs,[80] [81] [82] although more research is needed and the debate around telehealth continues.[83]

One of the aims of telehealth is to reduce the number of face to face GP consultations that patients require. In Coventry, one practice in particular now conducts two out of three consultations over the phone, and has found this has improved access for patients while ensuring optimal use of GP time. This is just one example of how practices are using telehealth and almost two thirds of practices are using telehealth and telephone triage in ways that suit their local population. However research by Martin Bardsley has suggested that the implementation of telehealth in primary care did not appear to be

[80] Cottrell E, Chambers R, O'Connell P. Using simple telehealth in primary care to reduce blood pressure: A service evaluation. *BMJ Open* 2012;2:e001391.
[81] Hunkeler EM, Meresman JF, Hargreaves WA, *et al.* Efficacy of nurse telehealth care and peer support in augmenting treatment of depression in primary care. *Arch Fam Med* 2000;9:700-8.
[82] Ibid.
[83] Currell R, Urquhart C, Wainwright P, *et al.* Telemedicine versus face to face patient care: Effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews* 2000, Issue 2, Art No CD002098.

associated with different levels of contact with GPs and practice nurses.[84] One problem with telehealth interventions is that they may contribute to an increase, rather than a reduction, in health inequalities. It is possible that patients belonging to certain socioeconomic groups may benefit more from telehealth services due to their age, income and educational level and level of computer and internet access.

Recently, Coventry and Rugby CCG has purchased Eclipse for all GP practices. Eclipse allows 'virtual referrals', ensuring that hospital consultants are able to access all records without the need to send the patient to the hospital. It also prepares all the information required in a referral letter for when patients do require a formal referral.

[84]Bardsley M, Steventon A, Doll H. IImpact of telehealth on general practice contacts: Findings from the whole systems demonstrator cluster randomised trial. *BMC Health Serv Res* 2013;13:395.

Safeguarding

GP practices and primary care teams provide frontline services to children, young people and their families. They have an important role in protecting children, young people and vulnerable adults from abuse or neglect. GPs are required to maintain their knowledge and skills to protect children and young people and to demonstrate Level 3 safeguarding competence.

'New ways of working: Safeguarding' outlines innovative plans in Coventry to set up a primary care safeguarding practice forum to share good practice in relation to safeguarding in primary care.

New ways of working: Safeguarding

The designated nurse for child protection has identified the need for a "primary care safeguarding practice forum". There is commitment to this from 12 primary care professionals currently from a variety of practices. It is intended that this will be facilitated by the designated nurse and the Lead GPs for safeguarding children and safeguarding adults (currently being appointed). The purpose of this forum would to be to share good practice in relation to safeguarding practice in primary care, provide a forum for addressing issues experience, developing local practice guidance, supporting lead GPs for safeguarding and to facilitate engagement with other agencies around specific issues. This group will also provide peer support and networking for primary care professionals.

It is anticipated that this will be in place by November/December 2014 and that the group will meet on a quarterly basis. It is expected that task and finish groups will undertake pieces of work and that recommendations from this group will be disseminated to member practices and that professionals from other agencies will be invited where appropriate.

New ways of working: "Hot House" urgent care transformation programme

Recognising that rate of attendance at Accident and Emergency Departments is much higher in Coventry than nationally, Coventry and Rugby CCG held a multi-stakeholder 'hot house' event to try and understand the reasons for this and develop a programme of work to reduce attendance. The event included around 70 delegates representing 40 different local stakeholder groups. Delegates were split into different teams and over a two-day period each team was challenged to come up with a solution to safely reduce hospital attendances and admissions.

Following the event, a 90 day deadline to design and implement the chosen programme of works to reduce A&E attendance was put in place. This programme included delivering a co-ordinated Primary Care Assessment function, supported by appropriate clinical and operational protocols, including GP support. It also included a comprehensive communications plan to support appropriate referrals and attendance.

The communications plan is being developed by looking at what types of people are currently using A&E and appropriateness of this use. Evidence for why people choose to attend A+E, rather than using other available services, is also being looked at. This information will be used to develop messages to 'nudge' people toward using different urgent care services, where appropriate, and to ensure that these messages are being properly targeted.

Essentially this work aims to make the right choice the easiest choice for people when they have an urgent health problem and to ensure that everyone is aware of all the services available to them.

New ways of working: asset based working

'Asset based working' is an approach which is being used across the country to enable local people to do more for themselves. Asset based working sees people as citizens and co-producers with something to offer rather than just clients and service users. It helps people take control of their lives rather than treating people as passive and 'done to'. It supports people to develop their potential rather than 'fixing people'. This is increasingly important as funding across the NHS and the whole of the public sector declines.

In 2014 a local Telephone Survey asked 1000 local people if they would like to get more involved in their local community. Two in three people agreed that local people could to do more for themselves. 1 in 3 people said that they thought local people could do more to help older or vulnerable people. This suggests that there is an appetite locally for people living in Coventry to do more for themselves.

In Coventry there have been a number of projects which aim to support patients to develop strong social networks to help reduce isolation, promote well-being and independence and stronger connections. The Integrated Neighbourhood team which provide integrated support to people aged over 75 in two pilot practices, includes a community development officer who has been able to connect isolated patients in activities in their local areas. The RIPPLE project, supported by UHCW connects patients with COPD who have had multiple hospital admissions to help improve their self-confidence and ability to manage their symptoms. Multi-agency training has been supported by the City Council to train staff, including staff from the CCG in how to use asset based approaches in their day to day work. These are small scale projects and a key challenge will be to identify ways to embed these approaches in core service delivery and train a wider cohort of staff.

Acting Early

The health and wellbeing of children in Coventry is generally worse than the England average across a number of key outcome measures, from infant mortality to a child's readiness for school. The new Acting Early model of delivery is based on integrating existing teams (midwifery, health visiting and children's centres) and services (including general practitioners' services) on a locality basis to improve outcomes for children aged 0-5 years. The new model has been piloted in Hillfields and Tile Hill since April 2014.

New ways of working: Acting Early

As part of the Acting Early project teams in Tile Hill and Hillfields have been engaging with GPs in their areas. Two GP advocates were identified to work with the teams to shape the programme and determine the communication mechanisms and the contribution of General Practice to the integrated teams.

GPs have been engaging positively with the project since May 2014 at Tile Hill. The lead Midwife, Health Visitor and Children's Centre Manager for Tile Hill have been holding meetings with GPs and Practice Managers in their areas to brief them on the Acting Early project. These meetings allow the integrated team to raise awareness of the services that are delivered from the Children's Centre building, for example welfare advice, clinic times and contact details of the integrated teams. These meetings allow better links to develop within the localised teams. Since Tile Hill has started their meetings they have had contact from two GP Practices requesting support in signposting families onto relevant services.

Examples of information being shared between the integrated teams and General Practitioners has included clarifying changes of addresses for families where a General Practitioners maybe unaware of a patient moving into the area and sharing Domestic Violence information.

The closer links with GPs brought about by the project has raised awareness of the assessment process within Social Care and use of CAF (Common Assessment Framework) as a common language/tool. The practice managers have been part of the meetings and this has provided an opportunity to build positive relationships with them. As a result of the relationship building a GP has asked for support from the integrated team with their patient's forum in order for it to be representative of their practice demographic.

New ways of working: Integrated Neighbourhood Teams

The Integrated Neighbourhood Team (INT) Pilot Project originated within a Hot House workshop that took place over three days during March 2014, in which Senior Leaders from Health and Social Care organisations took part. (UHCW; CWPT: CRCCG; CCC). The overarching aim of the Hot House was to devise a radical new way of joint working which would improve the care of the frail and elderly across Coventry and Warwickshire. For the Hot House, four teams were formed, each with representatives from across all the organisations with the objective to create a new way of working across the system that would enable the winning team to develop a plan that would deliver a prototype at pace within a 90 day period. The idea being that this would provide an opportunity to test the concept, and test the sustainability and scalability of the project for cluster wide roll out.

The winning team have developed a three tiered model of care which at its heart seeks to ensure that the frail elderly are managed at the most appropriate level of care within the community and reduce the reliance on statutory agencies. The focus of the 6 month prototype phase will be on the level 3 element of the model and the establishment of the Integrated Neighbourhood Team. The base patient cohort is patients aged 75+ from The Forum Medical Practice and Jubilee Crescent Practice. The INT consists of a core team, with a GP; Community Matron; Community Nursing; Physiotherapist / OT; Social Worker, IAPT and a Community Development Officer. The INT will carry out a fortnightly multi-disciplinary team meeting at each GP practice to accept and review patients in to Level 3 Care and monitor actions lists (care plans) for these people. The team will also consider whether actions enable people to be discharged from the INT into level 2 and back into core service.

*The project team will develop a plan during September – December 14 to scale up the INT Programme across the City. Learning from the INT will shape the next phase of the project which will be to develop a Level 1 and level 2 offer**.** The project team has embraced the opportunity to work across system boundaries and deliver step change at pace, with no additional pump priming resource. The key to the success of the prototype phase will be the ability to learn lessons, 'fail fast' and flex the model alongside developing a sustainable solution that can be delivered at scale across the City.*

Recommendations

As well as recent improvements and innovative practice, this report has highlighted local and national challenges which affect patients, practices and the wider health and social care systems, as well as variation in the quality of general practice in Coventry. The improvements and innovations seen in some general practices need to be further developed and need to be spread faster, further and more effectively than elsewhere in the country, while commissioners of primary care also need to have robust systems in place to tackle unacceptable standards of care.

The following recommendations are aimed at celebrating the progress and achievements in primary care in Coventry, but also at reducing the variation and overcoming the challenges that persist in order to improve health in the city. They are aimed at public health, patients, practices, commissioners and the wider care system and they take account of the challenging context within which primary care operates, both nationally and locally. They also consider potential future developments that will ensure general practice is able to adapt to these challenges.

The Primary Care Quality Group, directly accountable to Coventry's Health and Wellbeing Board, will provide strategic leadership to oversee the further development and implementation of these recommendations, driving forward an action plan in collaboration with wider stakeholders.

Keeping people healthy:

1) **Public health should work with GPs and communities to continue to promote healthy lifestyles to ensure people stay healthier for longer.** We need to empower communities to change and ensure that we co-design and co-produce services with local people, work with existing assets within communities, work with local champions who can act as advocates in their communities and make sure services are easy to access so that people can get the right support at the right time. GPs have a key role in helping people to make healthier choices and referring people to appropriate lifestyle services.
2) **Public health and GPs should work together to enable practices to better understand the population in their local areas.** Information on local demographics and the likely prevalence of different conditions can help planning amongst GP practices and can enable practices to take a holistic view of their locality. It is key to link this information with knowledge of community initiatives in the local area that may be able to support people's care outside of the practice setting.

Making the right choice:

3) **Patients should have a more active role in managing their health.** By living a healthy lifestyle, looking after themselves and making best use of services such as NHS Choices and NHS 111, patients can help to reduce pressure on primary care services. Visits to the GP for conditions that can be self-treated cost the NHS an estimated £2 billion every year. There are many minor conditions that can be treated at home in the first instance with self-care methods and over-the-counter medicines, saving patients time and trouble.

4) **Patients should choose the most appropriate service for their needs.** Patients should have the necessary information to make an informed choice about the most appropriate service to access, and should ensure that they use that service in the first instance. In the event that a condition cannot be treated at home with self-care or over-the-counter medicines, your GP is generally the first medical professional to contact when you feel unwell (rather than a walk-in centre or A&E).

5) **Patients should be involved in co-designing services.** Patients should engage with patient participation forums and Healthwatch, making sure that their views are represented and they are involved in the co-design and co-production of services. In addition, patients should ensure that they are proactive in exercising their choice to change GP practice if they are not satisfied.

Collaborative and innovative primary care:

6) **General practice should be open and accessible.** Additional training for receptionists should be provided, as the skills and qualities of receptionists are vital to ensuring that patients feel able to access care when they need to. Practices should also utilise the Coventry and Rugby Clinical Commissioning Group dashboard as a tool to highlight where they are doing well and where they could improve.

7) **Practices should collaborate and share learning.** Smaller practices should be encouraged to work together in larger groupings to improve collaboration and sharing of innovative practice between different GP practices. Working together through networks facilitates an extended range of services, a greater focus on population health management and increased investment in IT and other technologies.

A health and social care system that supports good primary care:

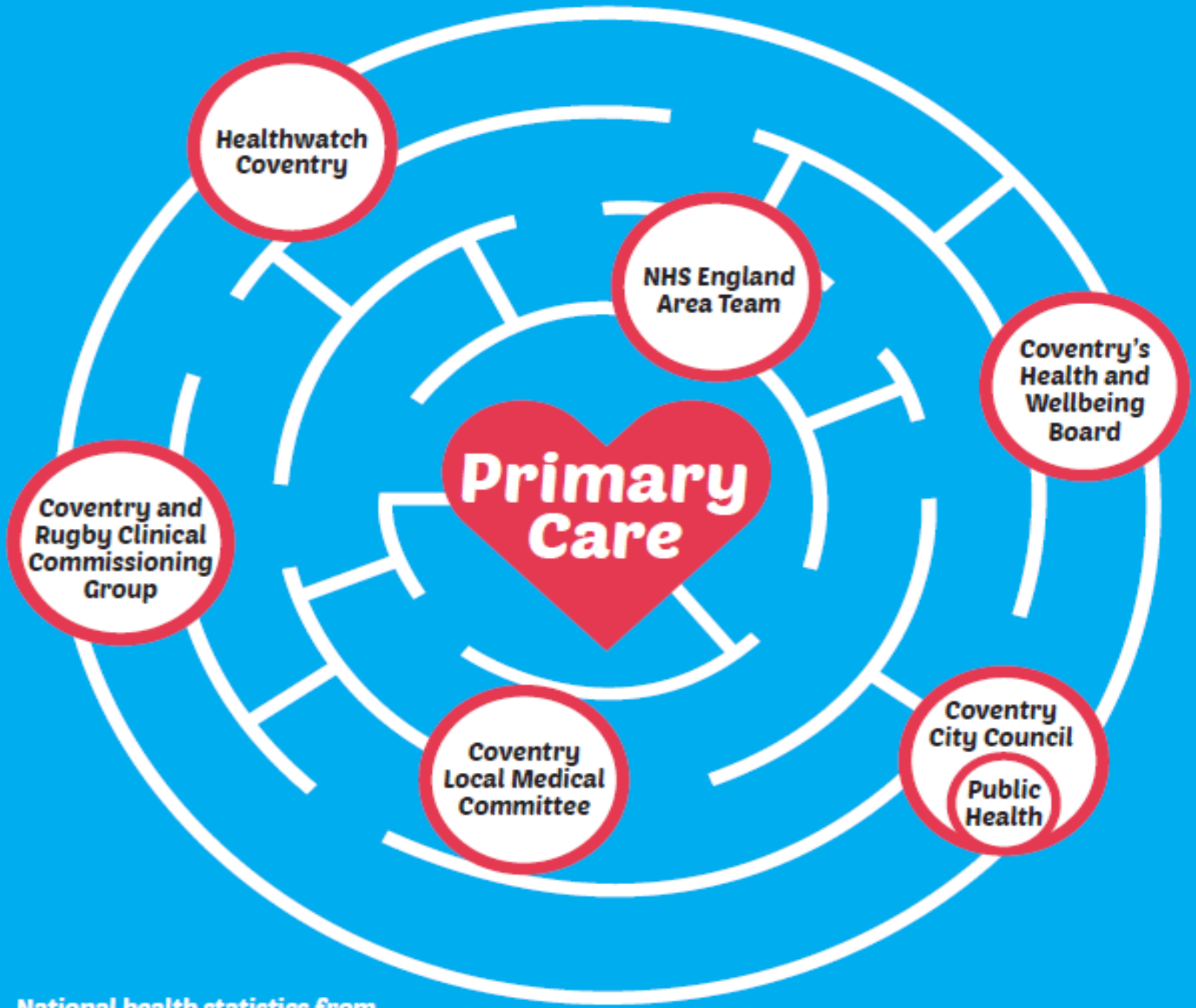
8) **A workshop should be organised to consider the future configuration of general practice in the city to ensure that services are fit for purpose in the future.** This should include discussion of ways to improve recruitment and retention of GPs in the city. Coventry should be given a voice in regional and national discussions around the changing role of primary care to influence the future direction of travel.

9) **Mechanisms to celebrate and share success should be continued.** This will ensure that good performance and innovative approaches are rewarded and encouraged and will ensure that these approaches and their results and benefits are shared throughout Coventry. In previous years a GP award evening has been held by the Inspires Locality, with awards given for improvements or innovative practice in a number of key areas, including healthy lifestyles. This year a proposal for a further Coventry-wide GP award evening is being developed.

10) **Communication materials should be developed to engage with and inform the public.** The materials should focus on:

- Clarifying the role and responsibility of the GP, and what patients should expect from their GP – when accessing GP services is appropriate, the ways GPs can help, when the practice is open, whether they can expect to see the same GP on a continual basis, how to book an appointment and how long they can expect to wait.
- What a patients' GP can expect from them – to turn up for appointments, to take medication as prescribed and to live a healthy lifestyle to minimise the need for GP intervention.
- How a patient can change GP practice – clearly communicate that patients have a choice in which practice they are registered with, and set out the process for changing practices if the patient is not satisfied with the care they are receiving.

11) **Commissioners should continue to provide feedback and support to practices that are the most challenged.** Performance of GP practices in Coventry should continue to be monitored and managed. The NHS Area Team are further developing mechanisms to identify practices that are not performing as expected against a range of different indicators. Where this is the case, the NHS Area Team should work with practices to understand the underlying issues and support practices to improve.



National health statistics from 'Primary Care: Today and Tomorrow - Improving general practice by working differently', May 2012, used with kind permission from Deloitte Centre for Health Solutions.

A full copy of this report can be found at www.coventry.gov.uk