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Wessex Strategic Clinical Networks and Clinical Senate

WESSEX Primary Care Project

Health Education Wessex

Centre for Implementation Science

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University of Southampton

Alleviating unprecedented pressures faced by the General Practice workforce: a conceptual framework based on the extent to which Wessex GPs think that patients presenting with one condition could have been seen and appropriately managed by another healthcare professional [HCP]

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Funded by NHS Senate Strategic Clinical Network and Health Education Wessex the Wessex Primary Care Project is hosted and overseen by the Wessex Academic Health Science Network with input from the Centre for Implementation Science/University of Southampton.

For the purposes of this project, Wessex is defined as Hampshire and the Isle of Wight and Dorset. Although South Wiltshire is included within the HEW remit, as a significant number of the organisations we need to liaise with (such as CCGs and the Wessex Area Team) are defined by this smaller geo-political boundary we have maintained the smaller geography.

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ABSTRACT

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The number of patients who are finding it difficult to make a GP appointment has increased due to a lack of sufficient resourcing for general practice (*i.e.* shortage in workforce: GPs and nurses, decreased funding and increased costs) in a context of rapidly growing demand, brought about by the rising demographics, especially, but not exclusively, ageing population with long-term and complex conditions (RCGP 2015; Goodwin et al, 2011; Rosen and Parker, 2013; Deloitte, 2014; Baird et al, 2016).

2. Assessment of problem and analysis of its cause/ literature review

Various solutions have been proposed to decrease the GP workload while also increasing the accessibility of primary care: promoting NHS Choice website (Nelson et al, 2010); improving health and self-management (Goodwin et al, 2011); collaboration between GP practices (Naylor et al, 2013); multi-specialty or multi-disciplinary new integrated models of care (Smith et al, 2013; NHS England 2015; Snow-Miller, 2015; Roland et al, 2015; Matheson, 2016b, 2016c); telephone consultations (Longman, 2012); emails (Atherton et al, 2012) and e-consultations (Adamson and Bachman, 2010; Madan 2014; Longman and Diggines, 2014).

NHS Choice website was deemed in need of more marketing (Nelson et al, 2010). Multi-specialty or multi-disciplinary new integrated models of care have proven to be successful (Langridge, 2015; NHS England 2015; Liles, 2016a, 2016b; Matheson, 2016b, 2016c). Improving health initiatives (Goodwin et al, 2011; HSIC, 2015) and *collaboration* between GP practices (Naylor et al, 2013) have been slower to show progress.

Although deemed convenient and useful, physicians have been slow to adopt secure patient messaging (Wallwiener et al, 2009). Limited evidence, variable results and shortcomings in data in relation to email has been such that it could not be adequately assessed (Atherton et al, 2012). Telephone-based consultation have shown conflicting evidence: from popular and successful (NHS England, 2015, p38) to ineffective and leading to increased workload (Campbell et al, 2014). Despite various claims (Adamson and Bachman 2010; Madan et al 2014; Longman and Diggines, 2015) of increased access for patient and decreased GP workload, evidence for online consultations has demonstrated a lack of significant benefit and low uptake (NHS England, 2015; Matheson, 2016d).

3. Strategy for change/aims and objectives

To try and identify ways of closing this gap between demand and supply by investigating, from the perspective of GPs, the extent to which HCPs could replace GPs re face-to-face consultations with patients who presented with one condition.

4. Measurement of improvement/methods/outcome measures

A survey questionnaire one side of A4 would be sent via a Wessex LMCs mailing to be completed discretely by hand by GPs 'live' during a consultation using 5-bar gate tallies to count the number patients presenting with one condition who could have been seen and

appropriately managed by another Healthcare Professional [HCP] and to indicate which HCP (out of a choice of 4) could best do this with free text too for choice of HCP.

5. Effects of changes/results

A total of 212 questionnaires were received from a total of 23 practices spanning 9 Wessex CCGs that recorded 4,303 patient visits with 35% assessed as could have been seen and appropriately managed by another HCP: 18.5% could have been seen by an advanced nurse practitioner; 5.4% by an extended scope physiotherapist; 3.6% by a practice nurse; 3.1% by a MH nurse; 2.6% by a clinical pharmacist; and 1.7% by other HCPs or elsewhere. Of the 35% of consultations that could have been undertaken by an HCP: just over half (52.5%) could have been managed by advanced nurse practitioners; 15.5% by extended scope physiotherapists, 10.4% by practice nurses, 8.9% by MH nurses; 7.4% by clinical pharmacists and 5% by others/elsewhere.

6. Lessons learnt/discussion/strengths and limitations

6.1. Strengths

- First time that GPs have actually been asked to audit their practice 'live' to determine how many patients could have been seen and managed by another HCP and to identify which HCP could actually have done this
- The sample represented 13.7% of GP practices in West Hampshire and 15% of GP practices in North Hampshire.
- The survey enabled a dashboard to be built based on the results of the survey that can be populated by individual GP practices so visualise expanding the role of HCPs

6.2. Limitations

- No respondents from Portsmouth CCG and Isle of Wight CCG.
- The results entirely based on the conceptualisation by GPs of the ability of other HCPs to see patients presenting with one problem and to manage them appropriately for one
- Does not take into account patients presenting with more than one problem
- A very brief snapshot lacking in depth and does not take into account the interplay of complex factors.

7. Message for others/recommendations

- The project could be replicated on a larger scale and supplemented by focus group with GPs or an additional electronic survey.
- Involve patients and other HCPs in the design of interventions.

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1. Outline of the problem/context

1.1. Background

The number of patients who are finding it difficult to make a GP appointment has increased due to a lack of sufficient resourcing for general practice (i.e. unprecedented pressures resulting in an increasing proportion of GPs and nurses working part-time and/or decreasing their hours, many GPs and nurses approaching retirement age or retiring early, not being matched by recruitment of trainee GPs and nurses, decreased funding and increased costs) in a context of rapidly growing demand, brought about by rising demographics, especially, but not exclusively, ageing population with increased burden of disease especially long-term and complex conditions requiring treatment (Rosen et al, 2011; Goodwin et al, 2011; Rosen and Parker, 2013; Deloitte, 2014; RCGP, 2015; Clay and Stern, 2015; Watson and King 2015; Baird et al, 2016).

1.2. The Wessex Primary Care Project

Despite the number of publications discussing the unprecedented pressure and crisis situation (Abbt and Alderson, 2014; Locke et al, 2015) and a number of reviews (Centre for Workforce Intelligence, 2014; Dayan, et al 2014; and Appleby, 2014), including some work at national level about future models of general practice (Smith, et al 2013; RCGP, 2013; NHS, 2014), a lack of nationally available, real-time data has ensured that the primary care crisis has remained, until recently, largely invisible to commissioners and policy-makers (Baird et al 2016).

In this context, Wessex Clinical Senate and Health Education Wessex (HEW) have jointly funded a Wessex Primary Care Project, with management provided by the Wessex Academic Health Science Network (AHSN) in order to define the problem, examine what has been done to remedy the problem, suggest possible solutions and assess their feasibility and effectiveness, before making recommendations.

1.3. Delineation of the problem

1.3.1. Rising population and burden of disease

Over the past decade, due to rising birth rate, immigration and improved longevity, the UK population, including Wessex, has significantly increased (Morse, 2015; ONS, 2016). Chronic conditions (maintenance and acute exacerbations) increase with age (NHS England, 2014; Barnett et al, 2012) leading to the average number of prescription items per person per year rising from 13.7 to 19.6 or 43% uplift between 2004 and 2014 (HSCIC, 2015a).

1.3.2. Demand

<u>Shortcomings in data collection and analysis</u>

Since 2008 there has been no systematic national data collection about the number or nature of consultations and who undertakes them (i.e. Hippisley-Cox and Vinogradova,

2009). Change in volume and trends of activity in general practice years cannot be precisely asserted and remains unclear (Curry, 2015).

Reliable studies estimating these figures and making predictions for the future are scarce (Baird et al, 2016, p5). Patient records do not usually differentiate systematically and accurately, if at all, between type and outcome of primary care consultations *i.e.* between face to face and telephone consultations or between consultations with GPs or nursing staff. Outcomes are usually inferred from recorded test results and/or correspondence from secondary care). E-consultations, emails and quick phone calls may not even be recorded and if recorded, they are likely not differentiated. Estimates are calculated by extrapolating activity based on trends in a sample of practices over the previous decade and assume no change the way in which GP practices deliver services (Curry, 2015; Baird et al, 2016).

Increasing number of consultations

General practice accounts for 90% of all NHS patient contacts. In 2013 the number of consultations climbed to 340 m, a rise of 13 per cent since 2008 (Curry, 2015) and had reached 370 million patients per year in 2015*, i.e.* 150,000 more GP consultations per day than even 5 years ago (RCGP, 2015). A number of recent publications have estimated that the annual average number of face to face and telephone consultations (GP and nurse) in England will continue to steadily increase in the period 2014 to 2020 (See table 1).

Table 1: Comparison of estimates for GP and nurse consultations England and Wessex 2014-2020

Publication	Average consultations per person per year	England estimate of annual % increase	England estimate of total numbers		Wessex estimate of total numbers	
			2014-2015	2019-2020	2014-2015	2019-2020
Morse 2015	n/a	3.1% -3.5%	372m	433.3m- 442m	18.6m	21.7m-22.1m
Hobbs et al 2016	4.67 in 2007-08 5.16 in 2013-14	1.25%	n/a	396m*	n/a	19.8m
Baird et al 2016	4.29 in 2010-11 4.91 in 2014-15	3.1%	n/a	433.3m*	n/a	21.7m
HSCIC/NHS England 2014	n/a	3%	371.5m	430.7m	18.6m	21.5m

* Morse (2015) estimate of 372m multiplied by the relevant estimate of annual percentage increase
** The final two columns show the estimate for Wessex (based on the calculation that the permanent population of Wessex is approximately 5% that of England[1]).

[1] In 2014, England's population was 54.3m, Hampshire's was 1.8m, Dorset's 760,000 and the Isle of Wight's permanent population was 139,000.

Taking the lowest annual increase estimate (1.25%) (Hobbs et al, 2016) and the highest 3.5% (Morse, 2015) and applying these to the estimated 372m consultations in 2014-2015 gives an projected number of consultations ranging between 396m and 442m for the period 2019-2020. The projected numbers for Wessex are between 19.8m and 22.1m consultations, an increase of between 1.2 and 3.5 million over 5 years (See table 1).

Telephone consultations

Telephone consultations have increased significantly more than face-to-face consultations, although face-to-face still make up the vast majority (~90%) of general practice consultations (HSCIC/NHS England 2014; RCGP, 2015 ; Morse, 2015; Baird et al, 2016, Hobbs et al, 2016). From 2010 to 2015 the number of telephone consultations has increased by 62% while face to face consultations only increased by 12% (Baird et al, 2016). Face-to-face consultations with GPs are getting longer, from 8.65mins to 9.22mins (6.7% increase between 2007 and 2014) (Hobbs et al, 2016).[2]

Unmet demand

The unmet demand (i.e. those who fail to book an appointment as they cannot get one that they can attend or cannot get through to actually make an appointment or do not even try to make an appointment but need one) cannot be easily measured. Using GP patient survey and predictive statistics, the occasions when patients will have to wait a week or more were set to rise from 62.4m in 2014 to more than 66.4m in 2015, making it the fourth successive year with a significant increase (RCGP 2015). Approximately 11% of patients failed to get an appointment in 2014-2015 against 9% in 2011-2012 (Curry, 2015).

1.3.3. Workforce

Current shortages in GPs and nursing staff

The numbers of full-time equivalent (FTE) GPs rose by 4.9% between 2010 and 2014 (Baird et al, 2016), but the number of GPs per 100,000 population in England declined by 2.6% between 2009 and 2013 (from 69.6m to 67.8m) (Lind, 2014). New partners and salaried doctors are hard to recruit; and increasing numbers of GPs are either retiring or reducing their hours. At the same time, the majority of practice nurses are over 45 or even 50 with until recently no career pathway; many work part-time; many are retiring early; and new nurses are hard to recruit (RCGP, 2015; Wall and Kennedy, 2015; Watson and King, 2015; Matheson 2016a).

Numbers leaving are not being matched by recruitment into the specialty and in Wessex especially in the Isle of Wight, Gosport and Southampton East some GP practices have been closed or risk closure (Watson and King, 2015). It is becoming difficult for this traditional workforce of GP plus Practice Nurse to meet current demands and unlikely it will be able to meet ongoing demands (Rosen and Parker 2013; Moberley 2014; RCGP 2015; Watson and King, 2015; Clay and Stern, 2015; Roland 2015; NHS England and RCGP 2016).

[2] Retrospective analysis of GP and nurse consultations of non-temporary patients registered at 398 English general practices between April, 2007, and March, 2014. Data from electronic health records routinely entered in the Clinical Practice Research Datalink, and linked CPRD data to national datasets were used. Trends in age-standardised and sex-standardised consultation rates were modelled with joinpoint regression analysis.

Projected GP shortages for 2020

Projected GP shortages across England show that, to meet the growth of the population and make up for existing current shortages, some CCGs will need substantial increases in the number of GPs by 2020.[3] Overall, England will need 8,000 new full time equivalent GPs by 2020. In Wessex, West Hampshire will need 109 additional FTD GPs (an uplift of 37%) and Dorset will need 105 additional full time equivalent GPs (an uplift of 23%) totalling a shortage of 214 Wessex GPs by 2020 (RCGPs, 2015).

Reduced job satisfaction

The Eighth National GP Work Life Survey showed that overall job satisfaction is at its lowest level since 2001. Satisfaction about remuneration, hours of work and amount of responsibility is now lower than before 2004 when the new GP contract was introduced. For the first time since 2004 average satisfaction with hours of work fell below the mid-point of the scale (neutral) (Gibson et al, 2015).

In May 2014 the Local Medical Committees (LMCs) for Wessex[4] found that more than 20% of GPs intended to retire earlier than planned, nearly 30% wanted to reduce the number of sessions to cope with the workload and nearly 40% of GP practices were currently short of GP sessions. Only 15% of newly qualified GPs wanted to look for a partnership and 77% were opting for locum or salaried work as their initial preference (Watson and King, 2015).

Recruitment of GP trainees

Despite concerted efforts to increase the national numbers of GP trainees, not enough trainees are recruited to General Practice. In 2015, applications were 6.2% lower than in 2014, when, despite an unprecedented third round, 12.4% of the posts remained unfilled (HEEoE 2015) in a context in which more trainees decide not to enter specialty training straight after the Foundation Programme (Rimmer, 2013, 2014a, 2014b) and an increasing number of trainees are choosing post-Foundation Programme NOT to become GPs (Zarkali et el, 2015). In 2015, Wessex had an unprecedented low fill rate of only 90 places out of the advertised 142 vacancies after Round One of national recruitment. (Watson and King, 2015).

Unmanageable pressures

Inevitably this reduction in the GP and nurse workforce will create further pressure on those staff left potentially leading to the GP practice closing down and handing its contract back to the Commissioner. In less severe, but increasingly frequent, cases this pressure can lead to practice mergers and reduction in practice boundaries, all of which is likely to bring about reduced patient choice and convenience.

1.3.4. Funding

Spending on general practice fell in real terms in 2011-12 and 2012-13. Despite 90% of contacts taking place, in primary care (RCGPs, 2015), in 2014-15 the Department of Health

[3] The RCGP analysis of GP shortages is based on assessment of population growth and current GP numbers in each Clinical Commissioning Group (CCG) area in England. The analysis looks at population growth alone, but there are numerous other factors that need to be taken into account when estimating the number of GPs an area needs, such as age of population, recruitment rates, and deprivation.

[4] https://www.wessexlmcs.com/retentionandrecruitmentsurveyresults

gave NHS England £97.4 billion, of which £7.7 billion was spent on general practice (~8%) (Morse, 2015). Not only has gross income fallen but expenses have increased so that, in real terms, resourcing for general practice has failed to keep up with service delivery costs (Deloitte, 2014; Baird et al, 2016). The recently published *General Practice Forward View* (April 2016) endeavours to address this problem with a proposed increase in funding for primary care of £2.4bn by 2021 (NHS England, 2014).

2. Assessment and analysis of the problem/literature review

2.1. Solutions already tried

Various solutions approaches have been proposed and tried to decrease the GP workload while also increasing the accessibility of primary care to patients: from promoting NHS Choice website, (Nelson et al, 2010); improving health and self-management (Goodwin et al, 2011); collaboration between GP practices (Naylor et al, 2013); multi-specialty or multi-disciplinary new integrated models of care (Smith et al, 2013; Snow-Miller, 2015; Roland et al, 2015; Matheson, 2016b, 2016c); telephone consultations (Longman, 2012); emails (Atherton et al, 2012) and e-consultations (Adamson and Bachman, 2010; Madan et al 2014; Longman and Diggines, 2014).

2.2. Review of solutions already tried

2.2.1. NHS Choices website

NHS Choices website was deemed in need of more marketing. Whereas 37% of patients said that the NHS Choice website decreased their use of GP services, and 70% said they browsed internet sources for medical and health related purposes, only 6% indicated that they had actually used NHS Choices (Nelson *et al*, 2010).

2.2.2. Health initiatives, collaboration between GPs and multi-disciplinary new integrated models of care

Progress in relation to improving health initiatives has been slow (Goodwin et al, 2011). Effective interventions take more time and thus more appointments (NICE, 2013) mostly with nurses i.e. the number of smokers aged 16 and over in the UK has reduced by a fifth from 26% in 2003 to 19% in 2013 (HSIC, 2015b). Collaboration between GP practices encouraged by clinical commissioning groups (CCGs) has been slow with widely varying levels of involvement (Naylor et al, 2013). Multi-specialty or multi-disciplinary new integrated models of care have proven to be successful (Langridge, 2015; NHS England 2015; Liles, 2016a, 2016b; Matheson, 2016b, 2016c).

2.2.3. Secure patient messaging and emails

In reviews of the literature, Wallwiener et al (2009) found that secure patient messaging is convenient and useful, but physicians have been slow to adopt the technique into their

practice and Atherton et al (2012) concluded that the evidence base for emails was limited due to variable results and missing data (in the 9 clinical trials reviewed), and could not be adequately assessed to the extent that recommendations for clinical practice could not be made. Roland (2015) pointed out that email had been used in some European countries for a considerable amount of time and found to be very useful by both patients and clinicians, but that it should be carefully evaluated in the English context before being introduced.

2.2.4. Telephone consultations

Telephone consultations are increasingly used to try and manage workload in general practice with the aim of cutting down on unnecessary consultations (Campbell et al 2014; Baird et al, 2016; Hobbs et al, 2015). NHS England (2015, p38) confirmed that to date telephone-based GP consultation models have proved popular and successful. However, Campbell et al, 2014) found that over-the-phone medical consultations did not reduce GP workload, whether delivered by a GP or a nurse, due to an increase in the number of primary care contacts in the 28 days after a patient's request for a same-day GP consultation, but after 28 days costs were similar to those of usual care.

2.2.5. Online consultations

Online consultations have been promoted has having the potential to reduce for face-to-face appointments with GPs. Research and evaluation of various pilots show that: only 40% required a face to face appointment with a GP (Adamson and Bachman 2010; Madan 2014); only 23% required a face to face appointment with a GP (Matheson, 2016d); 45% of all consultations were now online (Longman and Diggines, 2015) against 0.71% for Madan et al (2014) and 0.83% for Matheson (2016d). However, an evaluation by NHS England of the *Prime Minister's Challenge Fund: Improving Access to General Practice* confirms that, unlike telephone consultations, e-consultations have yet to prove any significant benefits and have had low patient take-up (NHS England, 2015).

2.2.6. Difficulty in making robust evaluations

While 75% of those who make appointments go online for health information, just 6% of patients book appointments online while 10% order prescriptions online. (Nelson et al, 2010). Although 29% per cent of respondents said online booking would be their preferred way, only 3% were actually doing this at the time (The Pulse, 2012). While 34% of patients said they would like to book appointments online, the vast majority (86%) said they do not use any online services. Half of patients who ordered online repeat prescriptions rated their surgery as "very good", compared to only 41% of patients who said they could not access online services (MDDUS, 2015). There is a considerable gap between what patients say they prefer and what they actually do.

Historical and more especially current lack of accurate and systematic data collection and reporting of trends in activity and performance (data about number, type and outcome of consultations) made even more unlikely because of unprecedented pressures that have

resulted in lack of time and resources for pilot interventions to be meaningfully and robustly evaluated make it (Baird et al, 2016).

3. Strategy for change/aims and objectives

To investigate, from the perspective of GPs, the extent to which HCPs could replace GPs re face to face consultations with patients presenting with one single problem.

4. Methods (design, scope, sample, methodology and outcome measures)

4.1. Design, scope and data collection instrument

In January 2016 a data collection instrument was drafted by GP clinical lead and project manager and reviewed at the monthly Wessex AHSN Primary Care Project [PCP] Advisory Board, by the 10 members of the Advisory Board, which includes another GP and a GP trainer and one HCP. The questionnaire was then forwarded to 2 GPs for comments.

The questionnaire sought to investigate, from the perspective of GPs, the extent to which HCPs could replace GPs re face to face consultations with patients. As there is a shortage of GPs and they are under pressure with rising demand and hence very busy, the questionnaire had to be one side of A4 and would be downloaded and printed by the GP who would complete the questionnaire 'live' but discretely during a face to face consultation. For at least two weeks GPs that agreed to take part would place the A4 questionnaire beside or in front of them during face to face consultations with patients and, using 5-bar gate tallies (four vertical lines crossed by an horizontal line), count the number of patients with one condition that could be managed appropriately by an HCP and indicate which HCP could best do this.

The survey asked GPs to count the number patients presenting with one condition who could have been seen and appropriately managed by another Healthcare Professional [HCP]. The choices of responses were either 'yes' or 'no (only GP)'. If the answer was yes, GPs had to select from a list of HCPs the one that could have seen face to face that very patient on their own instead of the GP (extended scope physiotherapist, advanced nurse practitioner, clinical pharmacist, practice nurse, psychiatric nurse. There were also options for 'elsewhere i.e. midwife, health visitor, outpatient, dentist, optometrist' and for 'other'. The boxes were big enough to also include comments and, if required, further comments could be written on the back of the questionnaire. [See Appendix 1 for a copy of the questionnaire].

4.2. Sample size and methodology

The survey was piloted with 3 GP practices in February 2016 where GPs were employed who were known professionally to the clinical lead for the Wessex Primary Care Project (two of

whom had also commented on the draft questionnaire). A total of 23 questionnaires from 3 GP practices spanning 2 CCGs Dorset and West Hampshire were returned, indicating 479 patients seen. As the questionnaire was not redrafted following the pilot, the results were included in the final figures. [See next section 'results' for more details on the pilot.]

After trying it out, the Chair of Wessex Local Medical Committees [LMCs] endorsed the survey questionnaire and circulated it in early April 2016 as part of a Wessex LMC general mailing to all 315 general practices that were part of Wessex LMCs *i.e.* practice manager or lead GP or both or to whoever was/were the contact person/s, who then cascaded the survey questionnaire to individual GPs in their practice.

Self-addressed envelopes were sent to 26 GP practices who had indicated that they were interested in participating and would be collecting data sets. A total of 20 GP practices had returned SAEs team by the end of June 2016. The data sets were then entered into Excel spreadsheets at the beginning of July 2016 before numerical analysis was undertaken.

All the 23 GP practices that returned data sets were sent summary results by email at the beginning of July 2016.

4.3. Outcome measures

The outcome measures were: whether patients presenting with one condition could have been seen and appropriately managed by another Healthcare Professional [HCP]; number of such patients; the type of HCP that could have seen and appropriately managed these patients (extended scope physiotherapist, advanced nurse practitioner, clinical pharmacist, practice nurse, MH nurse); and which other HCPs could have done this, if not included among the four to be selected from.

5. Results

A total of 20 GP practices returned 189 data sets that were collected in May and June 2016. A total of 3 GP practices returned 23 data sets collected in February 2016, giving 212 data sets from 23 GP practices. These practices were spread across nine CCGs in the Wessex LMC area, including BaNES and Wiltshire. Seven Wessex CCGs were represented (See table 1). The practices variously served urban, suburban, semi-rural and rural communities. Wessex CCGs not represented were Portsmouth and Isle of Wight.

5.1. Pilot study only

A total of 23 questionnaires from 3 GP practices spanning 2 CCGs (Dorset and West Hampshire) were returned in the pilot study, indicating 479 patients seen. Of those 479, 32% (n=154) were assessed as could have been seen and appropriately managed by another healthcare professional. In ranking order, the 32% was split as follows (See table 2):

Table 2: Results of pilot re patients that could have been seen and appropriately managed by another HCP

HCPs	32.1% of responses [n=154]	% of total px seen [n=479]	% of px that could have been seen by HCP [n=154]
1. Advanced Nurse Practitioner	94	19.6	61.0
2. Practice Nurse	19	3.9	12.3
3. Extended Scope Physiotherapist	14	2.9	9.6
4. Clinical Pharmacist	13	2.7	8.4
5. Elsewhere (e.g. Midwife, Outpatients, Health Visitor, Dentist)	6	1.2	3.8
6. Mental Health Nurse	5	1.0	3.2
7. Other (e.g. Admin, Letter required, no appointment needed)	3	0.6	1.9

The results of the pilot survey are broadly similar to those of the overall survey in both rankings and representation of the various HCPs. However, a main difference is a greater representation of Advanced Nurse Practitioners who could have seen and managed 61% of patients instead of 52.9% in the overall survey as well as a greater proportion of Practice Nurse, ranked second in the pilot who could have seen and managed 12.3% of patients instead of 10.4% in the overall survey, but third in the overall survey.

Another difference was a lesser representation of Extended Scope Physiotherapists, ranked second in the overall survey (15.5%), but ranked third in the pilot survey (9.6%). The category 'elsewhere' is also represented to more prominently in the pilot survey with 3.8% of patients that could have been seen and managed instead of 3.1% in the overall survey. (See table 2 and table 3).

5.2. Overview of the overall survey, including the pilot survey

A total 4,303 patient visits were recorded across the 23 practices (including the 3 pilot GP practices). Of these 4,303 patients, 35% were assessed as could have been seen and appropriately managed by another HCP (n=1,507) and in 65% as could NOT have been seen and appropriately managed by another HCP (n=2,796).

Of these 4,303 patients, 35% were assessed as could have been seen and appropriately managed by another healthcare professional. In ranking order, the 35% was split as follows (See table 2):

Table 3: Patients that could have been seen and appropriately managed by another HCP

HCPs	35.0% of responses [n=1,507]	% of total px seen [n=4,303]	% of px that could have been seen by HCP [n= 1,507]
1. Advanced Nurse Practitioner	797	18.5	52.9
2. Extended Scope Physiotherapist	233	5.4	15.5
3. Practice Nurse	157	3.6	10.4
4. Mental Health Nurse	134	3.1	8.9
5. Clinical Pharmacist	112	2.6	7.4
6. Elsewhere (e.g. Midwife, Outpatients, Health Visitor, Dentist)	47	1.1	3.1
7. Other (e.g. administrative, letter required, no appointment needed)	27	0.6	1.8

By far the greatest number of patients could have been seen and appropriately managed by Advanced Nurse Practitioners, 18.5% (n=797) of the total number of patient encounters (n=4,303) and 52.5% of the number of patient encounters suitable for HCPs (n=1,507). In second place were extended scope physiotherapists with 5.4% (n=233) of total number of patient encounters and 15.5% of patient encounters suitable for HCPs (See table 3). [See Appendix 1 for an overview of the results exclusive of the pilot.]

When the categories ‘elsewhere’ and ‘other’ are analysed according to individual items, 12 categories emerge: 11 HCPs as well as ‘outpatient in hospital’. The latter was ranked second and was mentioned eight times (See table 4)

Table 4: Breakdown of the 'elsewhere' category in ranking order

Category	Number
Midwife	9
Hospital (outpatients)	8
Health Visitor	6
Community Alcohol Drug Advisory Service	6
Specialist nurse	5
Dentist	3
Podiatry	3
Community Matron	3
Optician	1
Phlebotomy	1
Occupational Therapist	1
Unspecified	1
	47

Ranked first in the categories 'elsewhere' and 'other' were 'midwife' mentioned 9 times. Ranked third was 'health visitor' mentioned 6 times. 'Specialist nurse' was mentioned 5 times. All other categories of HCP were mentioned less than 4 times. (See table 4)

Ranked first and mentioned 11 times in the 'other' category is 'administrator', followed by telephone consultations. These two items make up 59% of the responses.

Table 5: Breakdown of the 'other' category in ranking order

Category	Number
Administrator	11
Telephone consultation	5
Letter required	3
Counsellor/MH support worker	3
No appointment needed	2
High street chemist	1
BPAS	1
Acupuncturist/Physio	1
	27

In view of rising demand and shortages of GPs and increasing pressures in primary care, it is astonishing that GPs could say that the patient could have been seen and appropriately managed by an administrator in no less than 11 instances. (See table 5)

5.3. Results by CCG

The sample of respondents spanned 9 CCGs. Six CCGs had one or two participating GP practices. Three of them had 3 or more participating GP practices. The top 2 CCGs were West Hampshire and Dorset with 7 and 5 participating GP practices respectively. The percentage of those who said that patient could have been seen and appropriately managed by another HCP ranged from 13% to 55%. (See table 5)

West Hampshire was the CCG with the greatest number of participating GP practices (n=7 or 30.4%), the greatest number of questionnaires completed (n=71 or 33.4%) and by far the greatest number of patients seen (n=1,430 or 33.2%).

Dorset and North Hampshire were the other two CCGs among the top 3. North Hampshire had fewer participating GP practices (n=3 instead of n=5), but more questionnaires completed (n=46 or 21.6% against n=37 or 17.4%) and more patients seen: 20.1% against 19.5%.

North Hampshire had a higher percentage of GPs who said that patients could have been seen and appropriately managed by another HCP: 39% against 36% for West Hampshire and 35% for Dorset. (See table 6)

Table 6: Participating GP practices by CCG

CCG	GPs** in CCG	Participating GP practices n [%]	Qs^ Completed n [%]	Px seen n [%]	Yes* n [%]
1. West Hampshire	51	7 [30.4%]	71 [33.4%]	1,430 [33.2%]	509 [36%]
2. Dorset	100	5 [21.75]	37 [17.4%]	843 [19.5%]	294 [35%]
3. North Hampshire	20	3 [13.0%]	46 [21.6%]	865 [20.1%]	334 [39%]
4. Southampton	33	2 [8.6%]	12 [5.6%]	287 [6.6%]	99 [34%]
5. Fareham & Gosport	21	1 [4.3%]	4 [18.1%]	82 [1.9%]	11 [13%]
6. North East Hampshire & Farnham	24	1 [4.3%]	5 [2.3%]	147 [3.4%]	32 [22%]
7. South East Hampshire	25	1 [4.3%]	4 [18.1%]	72 [1.6%]	19 [26%]
8. Wiltshire	tbc	2 [8.6%]	32 [15.0%]	489 [11.3%]	161 [33%]
9. BaNES	tbc	1 [4.3%]	5 [2.3%]	88 [2.0%]	48 [55%]
10. Total	tbc	23	212	4,303	1,507 [35%]

**GP practices

*Yes, this patient could have been seen and appropriately managed by another HCP
^Questionnaires

In all CCGs, except Fareham and Gosport, Advanced Nurse Practitioners were the top HCP with percentages ranging from 36.6% to 68.4% (See table 6) and an average of 52.9% (See table 3).

Extended scope physiotherapists ranked second in 4 CCGs, with percentages ranging from 8.3% to 24.2% (See table 6) with an average of 15.5% (See table 3), but third or equal second in 5 CCGs, overtaken by either practice nurses or MH nurses.

Table 7: Patients that could have been seen and appropriately managed by another HCP by individual CCG

CCG [total px seen]	ANP	Physio	PN	MHN	Pharm	Elsewhere	Other
West Hants [n=509]	276 [53.3%]	100 [19.3%]	45 [8.7%]	41 [7.9%]	31 [5.9%]	13 [2.5%]	11 [2.1%]
Dorset[n=294]	190 [64.6%]	29 [9.8%]	20 [6.8%]	12 [4.0%]	24 [8.0%]	15 [5.1%]	4 [1.3%]
North Hants [n=334]	169 [50.5%]	35 [10.5%]	58 [17.3%]	34 [10.1%]	21 [6.2%]	14 [4.1%]	3 [0.8%]
Southampton [n=99]	47 [47.4%]	20 [20.2%]	6 [6.0%]	13 [13.1%]	7 [7.0%]	4 [4.0%]	2 [2.0%]
Wiltshire [n=161]	59 [36.6%]	39 [24.2%]	15 [9.3%]	19 [11.8%]	20 [12.4%]	3 [1.8%]	6 [3.7%]
Fareham &Gosport [n=11]	0	2 [18.1%]	4 [36.3%]	4 [36.3%]	0	1 [9.0%]	0
South East Hants [n=19]	13 [68.4%]	2 [10.5%]	2 [10.5%]	0	2 [10.5%]	0	0
North East Hants & Farnham [n=32]	19 [59.3%]	2 [6.2%]	4 [21.0%]	5 [26.3%]	2 [6.2%]	0	0
BaNES [n=48]	24 [50%]	4 [8.3%]	5 [10.4%]	9 [18.7%]	5 [10.4%]	0	1 [2.0%]
	797 [52.9%]	233 [15.5%]	157 [10.4%]	134 [8.9%]	112 [7.4%]	47 [3.1%]	27 [1.8%]

The representation of practice nurses ranged from 6.8% to 36.3% (See table 7) and an average of 10.4% (See table 3). The representation of MH nurses ranged from 4% to 36.3% (See table 7) with an average of 8.9% (See table 3). The representation of clinical pharmacists ranged from 5.9% to 12.4% with an average of 7.4% (See table 3).

6. Lessons learnt/strengths and limitations/conclusion

Whereas the representation of HCPs demonstrated both similarities and differences between CCGs as well as wide variations between CCGs, up to 30+ points which is not unexpected as the reason that patients consult GPs can vary considerably on a day to day basis, the percentage of GPs who said that patients could have been seen and appropriately managed by another HCP showed less variation in the case of 5 out of 9 CCGs ranging from 33% to 39%. For 4 of the CCGs this percentage ranged from 13% to 55%. Less than 12 questionnaires were returned and 88 or fewer patients were seen in these 4 CCGs.

6.1. Strengths

Most research and evaluation have focussed on perspectives about the crisis in primary care or in piloting various models of care. Rather than asking GPs to make retrospective assessments, this is the first time that GPs have actually been asked to audit their practice 'live' to determine how many patients could have been seen and managed by another HCP and to identify which HCP could actually have done this.

The sample of respondents spanned 23 GP practices and 9 CCGs with 212 questionnaires returned and 4,303 patients seen. The sample represented just over 5% of all Wessex GP practices but 13.7% of GP practices in West Hampshire and 15% of GP practices in North Hampshire.

The survey enabled a dashboard to be built based on the results of the survey that can be populated by individual GP practices so they can visualise the workforce implications of expanding the role of advanced nurse practitioners and practice nurses as well as that of extended scope physiotherapists and MH nurses.

6.2. Limitations

It is not known how many GPs actually received the survey as it was distributed through a cascade method.

The questionnaire depended entirely on the opinion and judgement of each GP completing it. No descriptions of the other professions, or competencies required, were provided. So the results are entirely based on the conceptualisation by GPs of the ability of other HCPs to undertake part of their work.

The survey did not take into account patients presenting with more than one problem. It is assumed that patients presenting with more than one problem were immediately scored as could not have been seen by another professional. It is unknown how many patients presented with more than one problem.

Only one data collection method was used. A very brief snapshot had been provided which is lacking in depth. Interplay of complex factors has not been considered at this point.

There were no respondents from Portsmouth CCG and Isle of Wight CCG.

No designated patient representatives were involved in the design of the study. However, all 10 members of the Wessex Primary Care Advisory Board were involved in the design of the study. All are also patients, three are GPs and one member is an HCP was involved in the design of the study.

7. Message for others/recommendations

The project could be replicated on a larger scale. It could be supplemented by focus group with GPs or an additional larger scale electronic survey. It could also be enhanced by investigating how GPs perceive the skills and abilities of other HCPs and by involving GPs, patients and other HCPs in the design of interventions. Should a pilot be implemented based on the findings of the survey, type of primary care consultations *i.e.* face to face, telephone, email and e-consultations and by whom i.e. GP, nurse, other HCP as well as outcomes need to be explicitly recorded rather than inferred from recorded test results and/or correspondence from secondary care.

The project raised awareness of the fact that the change in volume and trends of activity in general practice remains unclear and underlined that shortcomings in data collection and intelligence need to be addressed, not only to make the issues more visible to commissioners, policy-makers and the public, but also to ensure new models of care can be meaningfully evaluated.

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APPENDICES

Appendix 1

Table A1: Overall results minus pilot* re *patients that could have been seen and appropriately managed by another HCP

There were some differences between the results of the pilot and the survey

HCPs	35.2% of responses [n=1,353]	% of total px seen [n=3,824]	% of px that could have been seen by HCP [n=1,353]
11. Advanced Nurse Practitioner	703	18.3	51.9
12. Extended Scope Physiotherapist	219	5.7	16.1
13. Practice Nurse	138	3.6	10.1
14. Mental Health Nurse	129	3.3	9.5
15. Clinical Pharmacist	99	2.5	7.3
16. Elsewhere (eg Midwife, Outpatients, Health Visitor, Dentist)	41	1.0	3.0
17. Other (eg Admin, Letter required, no appointment needed)	24	0.6	1.7

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Appendix 2

Table A2: Results for all GP practices and CCGs

Qs	px	Yes	No	Physio	ANP	Pharm	PN	MHN	Elsewhere	Other	CCG
6	121	51	70	6	31		4	7	3		W Hants
9	207	65	142	18	27	2	9	9	0	0	W Hants
20	296	146	150	34	74	8	9	11	3	7	W Hants
13	330	89	241	22	53	3	4	6	1	0	W Hants
3	70	32	38	10	11	7	5	3	3	1	W Hants
11	235	72	163	6	55	3	4	1	2	1	W Hants
9	171	54	117	4	25	8	10	4	1	2	W Hants
71	**1430**	**509**	**921**	**100**	**276**	**31**	**45**	**41**	**13**	**11**	**W Hants**
3	57	22	35	2	13	2	0	2	1	2	Dorset
1	60	18	42	2	10	3	3	0	0	0	Dorset
14	306	160	146	10	109	17	9	9	5	1	Dorset
16	347	66	281	11	44	0	3	1	6	1	Dorset
3	73	28	45	4	14	2	5	0	3	0	Dorset
37	**843**	**294**	**549**	**29**	**190**	**24**	**20**	**12**	**15**	**4**	**Dorset**
18	318	107	211	12	47	15	18	10	5	0	N Hants
2	54	18	36	2	5	4	0	7			N Hants
26	493	209	284	21	117	2	40	17	9	3	N Hants
46	**865**	**334**	**531**	**35**	**169**	**21**	**58**	**34**	**14**	**3**	**N Hants**
7	172	53	119	10	24	4	4	10	1		Southampton
5	115	46	69	10	23	3	2	3	3	2	Southampton
12	**287**	**99**	**188**	**20**	**47**	**7**	**6**	**13**	**4**	**2**	**Southampton**
4	**82**	**11**	**71**	**2**	**0**	**0**	**4**	**4**	**1**	**0**	**F&G**
4	**72**	**19**	**53**	**2**	**13**	**2**	**2**	**0**	**0**	**0**	**SE Hants**
5	**147**	**32**	**115**	**2**	**19**	**2**	**4**	**5**	**0**	**0**	**NE Hants & F**
27	401	123	278	37	40	13	10	17	3	3	Wiltshire
5	88	38	50	2	19	7	5	2	0	3	Wiltshire
32	**489**	**161**	**328**	**39**	**59**	**20**	**15**	**19**	**3**	**6**	**Wiltshire**
5	**88**	**48**	**40**	**4**	**24**	**5**	**5**	**9**	**0**	**1**	**BaNES**

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Appendix 3

NHS Health Education Wessex	Wessex Academic Health Science Network	NHS Wessex Strategic Clinical Networks and Clinical Senate

The Wessex Primary Care Project

Alternative Professional Questionnaire

Please complete one page per day. Please return completed pages in the SAE provided.

Practice:

.....

Date:

.....

For every patient seen, please complete the questions using 5-bar gate tallies, as illustrated:

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Could this patient have been seen and appropriately managed by another healthcare professional?
Yes
No (only by GP)

If yes, by whom? (select **one** only)
Extended Scope Physiotherapist
Advanced Nurse Practitioner
Clinical Pharmacist
Practice Nurse
Psychiatric Nurse
Elsewhere (eg Outpatients Clinic, Optometrist, Dentist)
Other (please write):

For Project Use Only:

	Pts	Yes	No	Physio	ANP	Pharm	P Nurse	Psych N	Elsewh	Other
n =										