

# Reclaiming a population health perspective

Future challenges for primary care

*Research report*  
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In partnership with



national association of primary care

## Acknowledgements

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# Contents

List of figures and tables	2
Foreword	3
Executive summary	4
1. Introduction	6
Purpose of this report	6
What do we mean by a population health focus within general practice?	7
2. Why general practice?	8
Why now?	9
3. Understanding need and utilisation at general practice level	11
Understanding the scope of population health management at practice level	13
4. What is needed to enable population health management?	14
Building a vision for population health in general practice	14
Identifying the patients at risk	15
Workforce and capacity	17
Interacting with the wider system	18
5. Conclusion	20
References	22
About the author	24

# List of figures and tables

Figure 2.1: Proportion of people in age and sex groups with at least one inpatient admission linked to a chronic condition between 2004/05 and 2009/10	10
Figure 3.1: Age distribution for an average practice with a population of 10,000, by number of GP visits in one year	11
Figure 3.2: Percentage of secondary care users with no prior visits to GP practice in 2009/10	12
Table 3.1 Most costly single emergency events overall by tariff	13

# Foreword

*This feels like the last throw of the dice for primary care. We need to make things more proactive or we face a future dominated by a salaried service, foundation trusts or corporate players. (GP leader)*

The late, great Barbara Starfield, a lifelong advocate of primary care, commented on the contribution that primary care can make to improving health, noting that systems with a strong generalist construction can demonstrate value through improving access, offering quality and promoting equity of care (Starfield, 1994). These perspectives have helped to reinforce the primacy of care organised around high-quality general practice within the National Health Service (NHS).

The contribution that general practice can make to improve the health of a population is nothing new. The celebrated story of Dr John Snow, a general practitioner (GP) in 19th-century London, who took a public health perspective to arrest the cholera outbreak in Soho, demonstrates the close link that general practice can have with the health and wellbeing of a local community.

Yet, notwithstanding this rich heritage, general practice in the United Kingdom has reached a crossroads. In this current climate of austerity the focus has undeniably shifted to demand-led, reactive health care provision. The 'value' currency is now one of performance, measurement and contracts. What is being lost is the 'value' currency of population health care, wellbeing and empowerment.

The National Association of Primary Care (NAPC) has established its innovation arm, which seeks to reconnect general practice with its local community, through the 'art' of demonstrating innovative approaches that modern general practice can take to improve the health and wellbeing of its registered population. This lies at the heart of this welcome research report produced by the Nuffield Trust. The report sets out the rationale for a population health approach driven through general practice, as well as describing some early examples of the initiatives that are being developed by the newly-formed NAPC Practice Innovation Network. This is a collaboration between the NAPC and NHS Improving Quality to support 'waves' of primary care innovation orchestrated through GP practices in their role as providers of population health care.

These are early days for this network but through a combination of hard work, focusing on the right values and willingness to change, the practices hope to spread innovation through local, regional and national networks. In this way, we hope that general practice can discharge its duty to its community and reaffirm its rich legacy to provide high-value population health care in the 21st century and beyond.

*Dr Charles Alessi, Chair, NAPC and Dr Nav Chana, Vice Chair, NAPC*

# Executive summary

Over the next decade, the NHS will need to respond to the needs of a society with increasing levels of chronic ill health, on budgets which are unlikely to grow substantially. This Nuffield Trust research report explores the role general practices can play in meeting this challenge through analysis of routine data from a notional general practice of 10,000 patients. It also recounts some of the perspectives of GPs and practice managers involved in the NAPC's Practice Innovation Network, who have either already innovated in this area or would like to do so.

## Key Points

- Hypertension, tobacco, alcohol misuse, high body mass index and low physical activity are the leading risk factors for illness and disability in Western Europe. Many of these risk factors are amenable to intervention by a range of actors at national and local levels, including health services.
- General practice, with its registered list of patients, has untapped potential to engage in a more proactive approach to improving the health and wellbeing of the local population. Such a focus is essential if the NHS is to meet the challenges of responding to rising rates of chronic illness at all ages of the population, during a time of financial austerity.
- There are already examples of GP-led practices engaging in work to improve access, outreach and management of both their chronically ill patients and those who are still healthy. Interviews with GPs, practice managers and other staff for this research reveal both an appetite for further change and a multitude of ideas about how such visions might be realised.
- The recent reforms to the English NHS present opportunities for a more proactive approach to prevention and population health, and there is much that individual general practices can do on their own. But sustained progress will depend on alliances with other practices, local communities, clinical commissioning groups, local authorities, local academic groups and the full range of community partners and providers.
- It will be important for the Department of Health to review the implementation of the new public health architecture. This will enable it to assess whether public health professionals are working closely with GP communities and clinical commissioning groups, building relationships and adding capacity and expertise so that general practices are able to access and use data and evidence.

- Successful projects also depend on imaginative approaches to deploying staff, and better use of existing data in order to fully leverage the unique knowledge that staff in general practices have of their individual patients, their families and their local communities.
- Good-quality data and risk stratification tools will be essential to support this task. Routine data on smoking, body mass index and other lifestyle indicators for patients who do not normally come into contact with their GPs represent the biggest challenge. Policy-makers will need to enable investment in data collection, alongside innovative approaches to payment systems and contracts, which will enable practices to work with others to be more proactive.

# 1. Introduction

*The profession has a minority of doctors who seek to conserve health in populations rather than restore it in sick individuals; but they are at the periphery, and have never been encouraged to combine the functions of prevention and cure.*  
(Tudor Hart, 1981, p.871 )

The call for general practices to engage with the wellbeing of their local populations as well as the care of their individual patients is not a new one. Since Tudor Hart's eloquent appeal made over 30 years ago, there has been considerable progress in moving the activities of general practice beyond the purely curative and reactive. In 1990, following the publication of the White Paper *Promoting Better Health* (DHSS, 1987), a programme of financial incentives was introduced, which aimed to broaden the focus of GP activity to include more preventative care. Limited financial incentives were introduced for childhood immunisations and screening programmes via the new GP contract in 1990. These were gradually expanded and in 2004 the Quality and Outcomes Framework was implemented, to incentivise practices to manage chronic disease and better identify those at risk of worsening chronic ill health (Roland and others, 2012). Locally Enhanced Services payments have also been used by commissioners to incentivise practices in some areas to deliver smoking cessation and other health promotion activities (Peckham and others, 2011).

But there is still a powerful sense that general practice could and should do more to improve the health and wellbeing of its local population. A major review of the quality of general practice conducted by The King's Fund in 2011 concluded that:

*General practice is regarded as uniquely well placed not just to provide medical care, but also to promote the health and well-being of the practice population and to address health inequalities. However, there has been little success in drawing GPs 'beyond the surgery door', and GPs still concentrate on what are essentially clinical activities. Generally, GPs focus their prevention-related actions on patients at high risk rather than taking a whole population approach or maximising opportunities for health promotion advice to all patients who might benefit.* (Goodwin and others, 2011, p.129.)

## Purpose of this report

This research report has been commissioned by the NAPC. It explores the arguments for encouraging and enabling general practices to take a much more proactive role in improving the health and wellbeing of their local populations as well as their individual patients. This report does not set out to systematically review the evidence of what might work at general practice level. Instead, it looks at the potential for action, through analysis of routine data from a notional general practice of 10,000 patients.

It also draws on a series of interviews conducted with GPs and practice managers who are participating in the NAPC's newly-established Practice Innovation Network. The

Practice Innovation Network is bringing together a group of practices to develop and test out new approaches to population health management and work with each other to spread best practice, at local and national level.<sup>1</sup>

### What do we mean by a population health focus within general practice?

The most recent study of global mortality and morbidity published in *The Lancet* has underlined how chronic ill health has replaced infectious disease in nearly all parts of the globe, and represents the greatest challenge to health systems worldwide (Murray and others, 2012). Hypertension, tobacco, alcohol misuse, high body mass index and low levels of physical activity are the leading risk factors for illness and disability in Western Europe, a pattern now being replicated in many other regions (Lim and others, 2012).

In most countries, these risks are not evenly distributed across the population: in England, the gap between the health of the poorest and the rest of the population shows no sign of narrowing (Gregory and others, 2012).

Many of these risk factors are amenable to intervention by a range of actors at national and local levels, including health services. The past few decades have seen an increasing international focus on the importance of primary health care as the most efficient way to respond to both the prevention and management of chronic illness, through low-cost, preventative and curative community-based services organised around family physicians and multidisciplinary teams (Starfield and others, 2005; WHO, 2008).

Based on a review of the literature and interviews for this research, a population health approach could be defined as including the following characteristics:

- an interest in the health and wellbeing of local populations or communities
- in addition to (but not instead of) a focus on individuals and family care by GP practices
- includes proactive, preventative care for healthy and chronically ill people
- includes a focus on the distribution of health within populations
- it means proactive care for people attending regularly who are at risk of deteriorating health
- it means thinking about the health of people who are registered but not attending regularly.

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1. See [www.napc.co.uk/index.php/7-news/1379-napc-practice-innovation-network](http://www.napc.co.uk/index.php/7-news/1379-napc-practice-innovation-network)

## 2. Why general practice?

General practice is the cornerstone of primary health care in the NHS, with population health described as one of its key pillars (Toon, 1994). Improving the health and wellbeing of local populations has a very wide scope and many of the determinants of health are, of course, not under the direct control of general practices. As the government's White Paper on public health acknowledges (HM Government, 2010), good health depends on a range of contextual factors, including employment status, income level, housing, the environment, education and family relationships. These both determine and interact with people's individual characteristics, including behaviour, culture and attitudes towards their own health.

Nevertheless, there are numerous examples of attempts to include a population health approach in primary care, including the activities of the Peckham Pioneer Health Centre in the 1930s and Tudor Hart's pioneering work as a GP in a Welsh mining community, both of which focused on keeping people and communities engaged in their health and illness (Gillam, 2002). More recent examples include the Community-Oriented Primary Care experiment promoted by The King's Fund in the 1990s (Gillam, 2002); and modern variants such as the Community-Oriented Health and Wellbeing Service in Cumbria (Ashton, 2011) and the Bromley-by-Bow Centre in East London, which is co-located with a range of services designed to improve people's access to employment, benefits and housing (Bromley-by-Bow Centre, 2012).

Some of these recent examples include a very explicit focus on general practice as the impetus for change, such as the GPs at the Deep End project in Glasgow, which supports practices to work with many different health and non-health agencies to provide services to patients in very deprived areas (Watt, 2011).

The case for general practice taking a more proactive role in improving population health rests on three main arguments. The first is that it is the most accessed part of the NHS. According to the most recent data, there were over 300 million consultations with general practices in 2008, equating to about 5.5 consultations per person (Hippisley-Cox and Vinograda, 2009).

Allied to this is the second key feature of primary care in the NHS: the registered GP list, described as the 'basic tool' for a population health approach (Ashton, 2011). This offers GPs a relatively stable cohort of patients, who reside within a broadly defined geographical area. In some parts of the country – particularly rural areas – the overlap between a GP catchment area and the underlying geographical area is very tight, so patients will have a strong connection with their immediate locality. In more urban and suburban areas, patients often reside in overlapping catchment areas, implying a more collaborative approach between practices if geographical areas are to be targeted effectively (Sofianopoulou and others, 2012; Watt, 2011). It should be noted that the registered list does not offer a complete picture. A minority of people are unregistered, including homeless people and asylum seekers. There is an absence of systematic data on unregistered populations (Pollock and Majeed, 1995) and yet their health needs are often significant: a recent study found that unregistered patients accounted for nearly 100,000 patient episodes in one year (Davies and others, 2012).

Finally, and perhaps most importantly, population health can be seen as a logical extension from the strong generalist tradition of general practice in the NHS, which sees individual patients in their wider context. Generalism is defined as care of the whole person, based on a full understanding of the person's social context (RCGP, 2012). While a generalist approach is not confined to primary care, clinicians who work in general practice are uniquely well placed to build up and capitalise on their knowledge of their patients and their local contexts, which is gained from repeated contacts over extended periods of time. The Royal College of General Practitioners (RCGP) has defined generalism as 'demonstrating concern not only for the needs of the presenting patient, but also for the wider group of patients or population' (RCGP, 2012, p.7).

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 Clinicians who work in general practice are uniquely placed to capitalise on their knowledge of their patients

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Population health can, therefore, be seen as the unique product of the multiple personal contacts between generalists and their registered local patients, a crucial tool in the fight to improve health for all as well as reducing inequalities in health outcomes locally.

### Why now?

The NHS is facing a decade of austerity, in which demand will have to be balanced with financial constraint (Roberts and others, 2012).

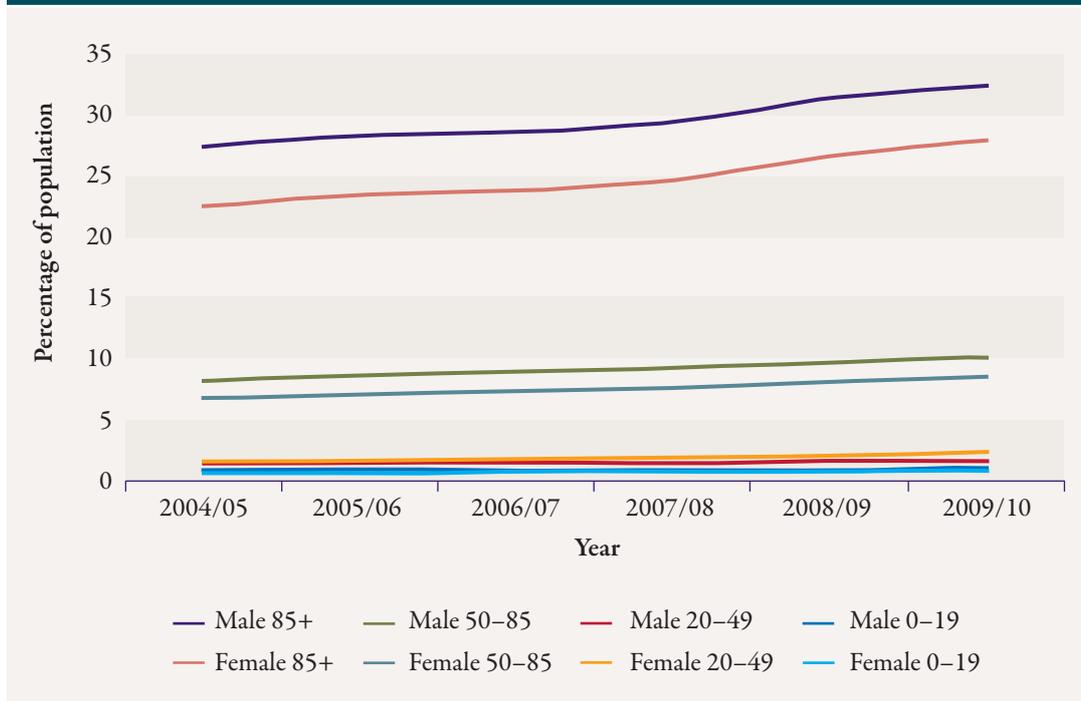
The 'gap' between the minimal funding growth allocated to the NHS in 2010 and projected demand was valued at £20 billion between 2010 and 2014. After 2014 however, it is unlikely that economic growth will recover quickly enough for the Government to allow NHS funding growth rates to return to anything close to the long-term average of four per cent. The Nuffield Trust (Roberts and others, 2012) estimates that if health service spending in England continues to be held flat in real terms for a decade (from 2011/12) and demand continues to rise in line with recent trends, there could still be a funding gap of £28 billion by 2021/22.

This expected growth in demand is not just a function of an ageing population, but a combination of the effects of longevity (itself a product of better health care) and rising costs of treating chronic illness at all ages. The Nuffield Trust's recent report on the future demand for health services noted that the probability of ill health is rising within all age bands and concluded: 'If this trend continues, the impact on the NHS due to chronic conditions will amplify the effect of population growth alone' (Roberts and others, 2012; see Figure 2.1).

It will be imperative, therefore, for the NHS to take every possible action to reduce the prevalence and severity of chronic disease at all ages.

The recent reforms to the English NHS present both opportunities for, and threats to, a more proactive approach to prevention and population health and threats. On the health care purchasing side, as budgets transfer from primary care trusts to clinical commissioning groups, there is an opportunity for primary care-led commissioners to engage general practices much more actively in decisions about how local health care resources are spent, using peer review, data feedback and clinical leadership to improve the quality and effectiveness of primary and other care. But it is still not clear

Figure 2.1: Proportion of people in age and sex groups with at least one inpatient admission linked to a chronic condition between 2004/05 and 2009/10



Source: Roberts and others (2012)

how closely GPs will be willing and able to work with clinical commissioning groups when their contracts are still managed centrally by NHS England.

On the public health side, uncertainty surrounds the impact of moving public health departments from primary care trusts to local government (Gillam, 2011). In some cases, it may increase the distance between the commissioners and prevention activities, as public health and analytical support is no longer automatically available. The intense financial pressure on commissioners to find savings in the immediate future may also undermine efforts to invest in upstream prevention, particularly if the benefits of prevention are only realised over the longer term.

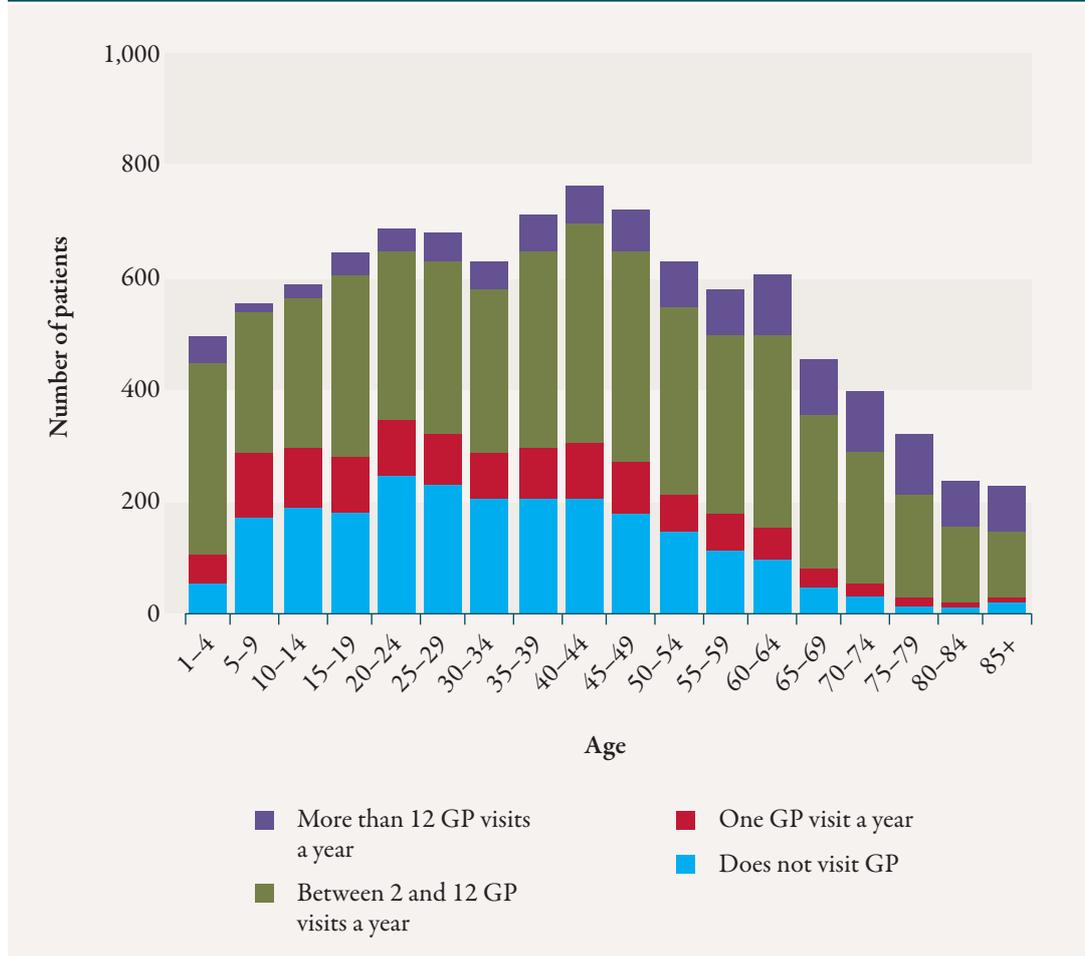
### 3. Understanding need and utilisation at general practice level

What does the challenge of population health at general practice level look like, in terms of numbers of people and patterns of use? The Nuffield Trust analysed a range of national data sources to generate a ‘typical’ general practice, including data from a sample of nearly 300 practices spanning urban and rural areas, and hospital data.

In an average GP practice of 10,000 people, one quarter of patients will be under 20 years of age and 16 per cent will be 65 or over. Over the course of a year, one quarter of registered patients will not visit the practice, and a further 12 per cent will visit just once. Nearly half (4,675) will use secondary care at some point during the year, although only one sixth of the total will use it as inpatients.

Figure 3.1 shows the age distribution for patients aged one year and older, broken down into four broad categories of service use (no visits, one visit, between two and 12 visits, and many visits). It is noteworthy that a substantial minority of people registered with

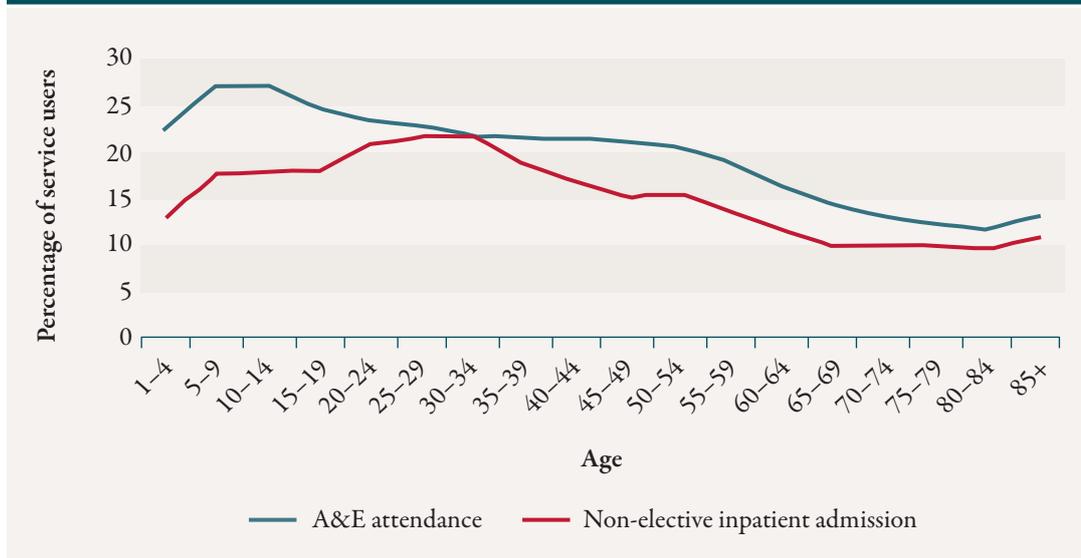
**Figure 3.1: Age distribution for an average practice with a population of 10,000, by number of GP visits in one year**



the GP does not visit within an average year (2,500 people), even among older age groups. From a population health perspective, this means that a majority does visit regularly enough for the practice to gather data and deliver preventative care. But it also means that practices will need to devise ways to reach out to those registered but not regularly attending, in order to understand their lifestyle risks.

While many of those not attending may be healthy, low-risk individuals, some will almost certainly benefit in the future if they were to receive more proactive care or health advice. Nearly 300 of the 1,390 patients (from our average practice of 10,000) who use an Accident & Emergency (A&E) department in one year will not have visited their GP, nor will 100 of the 671 patients using non-elective inpatient services. Figure 3.2 shows the percentage by age bands. As might be expected, this proportion declines with age, but there are still 10 per cent of people aged 65 or over having non-elective admissions who had no contact with general practice in the previous year – equivalent to 25 patients a year.

Figure 3.2: Percentage of secondary care users with no prior visits to GP practice in 2009/10



# 1 in 5

approx. average  
proportion of patients  
using A&E who have not  
visited their GP in the  
previous year

The total secondary care cost of a typical GP practice with 10,000 people is around £5.5 million a year, including A&E, inpatient and outpatient services (but excluding mental health). Table 3.1 (p.13) shows the top five conditions underlying emergency admissions, ranked by cost, based on the current tariff system. Admissions from stroke and cardiovascular disease dominate the list. While some of these admissions may be entirely appropriate, others may have been avoidable through better preventative care.

Many of the current public health interventions that aim to prevent chronic ill health and future hospital admissions, for example smoking cessation and weight management services, have often been commissioned at a scale larger than individual general practices, for example primary care trust-wide. Nevertheless, it is notable that within the 'average' general practice, the numbers of people potentially eligible for such services are not insignificant. Extrapolating from Health Survey for England data, of the 10,000

Table 3.1: Most costly single emergency events overall by tariff

Emergency event	Tariff	Number expected per 10,000	Total cost
EB01Z Non-interventional acquired cardiac conditions, 19 years and over	£836	48	£40,128
AA22Z Non-transient stroke or cerebrovascular accident, nervous system infections or encephalopathy	£4,348	6	£26,088
AA26Z Muscular, balance, cranial or peripheral nerve disorders; epilepsy; head injury	£1,571	14	£21,994
FZ35C General abdominal disorders without clinical complications	£991	22	£21,802
EB10Z Actual or suspected myocardial infarction	£3,872	5	£19,360

registered patients, 1,828 people are likely to be current smokers and 2,709 are overweight or obese, suggesting considerable scope for commissioning interventions to address such risk factors.

## Understanding the scope of population health management at practice level

The analysis presented above underlines the complexity of what faces the average general practice: a small cohort of patients with chronic conditions and a much larger group who visit infrequently, or not at all, but some of whom will (on current projections) develop ill health and disability in the future.

By slightly adapting the risk pyramid developed by Kaiser Permanente (Singh and Ham, 2006) to include the well population in addition to the chronically ill, it is possible to identify three broad categories:

- people with existing (and possibly multiple) diagnoses of chronic illness, which are being managed in primary care, or in collaboration with secondary care or specialist providers (this group is likely to be older, and smaller in number, than others)
- people who are well but at risk of chronic ill health in the near future, because of either age or lifestyle
- people who are well (and visit the GP only intermittently for minor problems) who might benefit from more proactive encouragement for maintaining wellness and health over the longer term.

Within each group, there is likely to be a spectrum of need: for example in the second and third categories, those who are currently well will include people with just one lifestyle risk factor and those with several, for example who are both obese and smoke. A recent King's Fund study found that although the proportion of respondents to the Health Survey for England with four or more risk factors (poor diet, smoking, excessive alcohol use and low levels of exercise) had declined over time (from 33 per cent of the population in 2003 to 25 per cent in 2008), the decline had been fastest among higher socioeconomic groups. This is likely to lead to widening inequalities in health outcomes over time, unless steps are taken to narrow these differences (Buck and Frosini, 2012).

## 4. What is needed to enable population health management?

This section draws on the perspectives of GPs, practice managers and others involved in the NAPC's Practice Innovation Network, launched in October 2012, together with selected examples from the literature. Several themes emerged from the initial meeting of the network and subsequent interviews. These included a focus on the importance of first changing the culture of general practice in order to articulate a vision for health improvement, followed by concrete ideas about what is needed to enable such change, including new ideas about which populations to target, new ways of using data, innovative ways of working and observations about what policy changes to the wider health and social care system might be needed.

### Building a vision for population health in general practice

The first challenge facing those eager to build a population health approach within general practice is to articulate a vision that can inspire and motivate primary care professionals. Many of those interviewed felt that many of their colleagues believe there is little scope to deliver more than reactive care or go beyond the existing demands of the disease management models enshrined in the Quality and Outcomes Framework.



General practice is the best tool to use, because we know the patients as people

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Those interviewed for this research all felt it was important to root these visions in general practice itself, particularly around the concept of 'generalism', and the high-profile status that general practice has among the public.

*General practice represents continuity in the community, unlike hospitals or other institutions. People know where GP practices are, they listen to us. (GP)*

*General practice is the best tool to use, because we know the patients as people, we know their families, their situation. PCTs [primary care trusts] or CCGs [clinical commissioning groups] can't know this. (GP)*

Building on this, interviewees felt that general practice needs to reclaim prevention and a population health perspective, to both inspire those working in general practice at a time of financial austerity and reinforce the value of generalism in the NHS as whole.

*The reality is that spending is tight. What options do we have? As GPs we can continue to run like mice in a wheel, or we can contribute to keeping people living healthier for longer. (GP)*

*The NHS is coming under fire and we are at the front line in people's minds, we can reduce disease, promote wellbeing, demonstrate value. Value is as important as quality. (GP)*

If general practice is able to articulate a strong vision of a proactive role, it might also reinforce the value of general practice to outside bodies, particularly public health professionals and their new colleagues in local government. Many public health

departments in primary care trusts have seen general practices as important partners in delivering preventative programmes, but this might need to be strengthened and expanded in the future.

*GPs are still key providers of smoking cessation for us. Sixty-five per cent of our quitters have come via general practice. They are in a good position because of their contact with patients and patients appreciate the fact that the service has come from their personal and individual contact with the GP or practice nurse.*

(Public health manager, primary care trust)

Visions of what general practice can achieve in population health have been articulated by many people in recent decades (Ashton, 1990; Gillam, 2002; Toon, 1994; Tudor Hart, 1981). What seems to be important is to allow local practices to define what this means for themselves, alongside identifying a cadre of GPs and other primary care staff to act as leaders, as underlined by Ashton (2011) in his reflections of building community-oriented primary care in Cumbria. Ashton stresses that staff, particularly GPs, must be allowed to explore the tensions between dealing with individual patients and any fears about rationing that might be implied by a population approach. They must also be given the space to develop their own ideas: 'Much of the achievement to date has rested on the initial talent-spotting of motivated and able clinicians. ... Getting alongside them with expertise and experience that they could apply in their own way and in their own time, has paid dividends' (Ashton, 2011, p.3).

### Identifying the patients at risk

Ideally, population health includes meeting the needs of those who are already ill (and already incurring costs in the hospital and social care system), as well as reaching out to those who are currently healthy but at risk of illness in the future.

Some staff in general practices interviewed for this research expressed a strong interest in reaching out to the wider, well population and had a clear sense of the kind of person they felt they wanted to reach, as well as ideas about how this might happen.

*We want to reach the people who don't come, unemployed people stuck at home, or those working in low-paid jobs who don't have the time to come to our surgery. We know they need help, with diet, smoking and so on.* (Practice manager)

*We'd like to be able to send a nurse out into some of our medium-sized employers, and get some basic screening done in the workplace. Employers are often under pressure and are reluctant to allow their workers much flexibility to take time off for something like the Health Check. If we could persuade them of the benefits, we'd reach a whole new demographic this way.* (Practice manager)

Good-quality data and risk stratification tools will be essential to support this task. Routine data on smoking, body mass index and other lifestyle indicators for patients who do not normally come into contact with their GPs represent the biggest challenge. This is currently filled by local-level estimates derived from the national Health Survey for England (Ghani and Majeed, 2006).

Outreach to the broader (healthy) population might require collaboration with local government. Interviewees explained that many councils have successfully made use of population profiling tools originally designed for the commercial sector, which can describe the broad attributes of local communities, in terms of their shopping or communication habits.

*The council has the know-how, but we add legitimacy. People ignore a letter from the council, but they will respond to us. The council can give us access to the gyms, schools and leisure centres. (GP)*

Interviewees from the network offered examples of innovative approaches to identifying those at risk who do not attend a GP practice regularly, for example a project in which GPs and public health workers used a community setting – in this case a supermarket – to conduct instant health checks on members of the public (Dachsel and Lee, 2011).

### Case study example: screening on the high street

*Some of us from the practice took part in a project we did with the PCT, where we stood outside a supermarket near here on eight consecutive Saturdays and did some basic on-the-spot screening – blood glucose levels, blood pressure and so on – of people who were walking by and wanted to take part. We found abnormal readings in over 40 per cent of people, for example elevated blood sugar – nearly three quarters of those with elevated blood sugar had not been previously diagnosed and we referred them back to their GPs. A third of these people wouldn't have been picked up by the NHS Health Check screening as they were outside the age range. I'm proud of the work we did. It shows what potential there is for outreach work, but also how many people we are missing, although I think a more systematic approach is needed in the future. (GP)*

Primary care data sources and risk stratification tools to identify patients who already have chronic conditions are better developed and established across the NHS than person-level data about lifestyle risks (Battersby, 2012). The presence of more robust data about chronically ill patients, coupled by the more immediate costs incurred by them if their illness is poorly managed, mean that some practices prefer to direct their energies towards this group rather than lower-risk patients.

*Our focus is to reduce the number of over-65s who go on to need massive packages of full-time care as their health deteriorates. (GP)*

There is now a range of risk tools to identify these high-risk patients, which combine hospital and GP data (Lewis and others, 2011; NHS East of England, 2012). The next frontier is to develop more sensitive tools that include social care data. Some local health

### Case study example: improving data for COPD care

*We are working with our local CLAHRC [Collaboration for Leadership in Applied Health Research and Care] to develop better data systems for COPD [chronic obstructive pulmonary disease]. People with COPD have to receive a lung function test as part of QOF [Quality and Outcomes Framework], but QOF doesn't require the practice to record the actual result of the test, just whether it has been done. We have modified the local IT systems to allow the results of the test to be recorded, which we can combine with other data, to give us a much clearer picture of who has more severe problems that might need more intensive management. This is just the first step, as we plan to add other metrics that show the quality of COPD care as defined by NICE [the National Institute for Health and Care Excellence], but your average practice just doesn't have time to plough through 168 pages of NICE guidance to work out what it needs to do. The information will be fed back to practices and also to patients, to enable them to take better care of themselves. (GP)*

economies are developing their own, localised tools based on non-commercial open source software. In other cases, there are projects to add specificity to existing data collection systems, for example by improving the information collected about the results of COPD lung function tests.

This last example raises the question of how practices should best access support with profiling or risk-stratifying their populations. Smaller practices, for instance those with fewer than 2,000 patients, may need to collaborate in order to get access to data tools (or indeed provide preventative services to local communities). An obvious source is clinical commissioning groups, which are expected to demonstrate a detailed understanding of population needs as part of their authorisation process (NHS Commissioning Board, 2012a) and may also commission risk stratification and other kinds of population profiling from commissioning support units (NHS Commissioning Board, 2012b).

Even with access to risk and other data tools, practices are likely to need support in using them. A qualitative study of how practice managers and GPs in practices in Wales were using PRISM (a risk stratification tool) found that opinions were mixed. The tool was considered potentially useful at practice level, particularly where staff could use their knowledge of individual patients to back up the findings of the risk 'scores' produced by the tool, but there were concerns about information governance, IT capacity for remote access to data, and the time needed to become familiar with how to make best use of the tool (Kingston, 2010).

## Workforce and capacity

Data and risk stratification are only valuable if practices are able to use them and act on them. A very commonly expressed concern from interviewees was the growing workload in general practice, the result of increased demand, pressure from the Quality and Outcomes Framework and so on, and a perception that there is limited or no capacity to design and implement new services.

A priority, therefore, is to identify ways of working within general practice to make better use of existing staff, and explore using different kinds of staff in different ways. One of the beneficial effects of the Quality and Outcomes Framework identified by researchers is the effect it has had on accelerating the trend of using non-doctor staff – particularly nurses – to manage both disease registers and at-risk patients (McDonald and others, 2009). A more proactive approach is likely to imply an even more imaginative approach to skill mix within general practice, including a willingness to use other professionals such as staff with different backgrounds, for example as health trainers (Peckham and others, 2011).

### Case study example: a new outreach role for receptionists

*We are working with our local university and neighbouring practices to give some basic clinical training to 50 receptionists. When they are trained as patient liaison officers, they will be responsible for looking after a small group of patients, phoning them up, reminding them of appointments, picking up early on any problems they might have and signposting them on to the GP or nurse or other health professional if they need. I can't coordinate all these sick patients myself in a small practice. It takes me away from my job. (GP)*

*The key is to have a primary care nursing workforce that is engaged and interested. We have a lot of community nurses here, but I'm not sure they are used appropriately: are they seeing the right patients? (GP)*

*I think 50 per cent of the potential gains from prevention will come from practices having good administrative systems. GPs need to lead their practice teams, and step back from thinking they have to do everything themselves. (Public health leader)*

General practice might even consider looking abroad for innovative examples of how to use staff differently (including staff without medical training), particularly from health systems in middle- or low-income countries, which are grappling to find low-cost solutions to rising rates of chronic illness. Well-known examples include the Family Health Program in Brazil, which uses community health workers who visit people in their homes and are responsible for awareness and health promotion for a defined population (Oldham and others, 2012), and the use of volunteers to visit households in Peru for health promotion (Meads, 2012).



**GP practices will need to have a much clearer understanding of the different services that can deliver non-medical support**

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However, using staff differently could, according to some interviewees, present challenges for the current configuration of general practices, not least for GPs themselves, who may need to take more of a coordinating, leadership role among their staff.

*I need to stop thinking of myself as simply a GP, but as a GP manager, coordinating other services. I don't have the expertise to do this all myself. (GP)*

### Interacting with the wider system

Proactive population health management will require general practices to work with other groups including, importantly, patients and local communities. General practice staff interviewed for this research were aware of the importance of engaging with their local population, to help articulate a strategy for health improvement and to assist with setting priorities. Successful engagement with patients and the public can often yield a different idea of 'value' in health care: a recent example from Canada found that Canadians valued a health system that was oriented more towards prevention and wellbeing than towards more traditional values such as hospital access and safety (Snowdon and others, 2012).

*We need to work with our patients and local people to decide how to extend our work beyond treating disease. We call it 'salutogenesis', understanding what keeps people well. This is what will make our work special. (Third sector practitioner)*

A focus on wellbeing will require GP practices to have a much clearer understanding of the different services and agencies that can deliver non-medical support. Since many of these services are delivered by non-statutory agencies, it could be challenging for practices to understand the full range of what might be on offer locally, for them to refer patients to. GP practices in Scotland took part in a project designed to enable them to understand the scope of 'social prescribing', a way to link patients with non-medical

sources of support. Part of the project involved teams from practices visiting a range of community-based initiatives, such as women's refuges and school-based projects, to find out for themselves what was on offer (Scottish Government, 2011).

Some of the interviewees in the present research argued that a systematic approach by general practice to population health could only come from strategic alliances with other practices and other providers in the local area, for example end-of-life or social care services. While there is clearly scope for individual practices to do more, it will be important to explore how population health can be enabled within new models of 'federated' or networked general practice in the future (Imison and others, 2010). The report by Imison and others (2010), commissioned by the RCGP, highlights the example of Tower Hamlets, where the primary care trust enabled GP networks to improve population health in one of the most deprived areas of England.

Some interviewees in the present research argued that for change on a wider scale to occur, access to additional resources would be needed, beyond the current regime of practice-level incentives such as the Quality and Outcomes Framework or Locally Enhanced Services payments. One GP felt that there needed to be experiments with new forms of contracting, such as alliance contracting, which has been used in construction and infrastructure projects, in which a range of providers collaborate under one contract (McCormick, 2012).

*Practices alone cannot have a whole-system approach: we have to work with the council, the third sector. We need some sort of alliance contracting to allow this, to share the risks and the benefits. For older people, for example, if we had a capitated budget, if the council could be the lead contractor, we could take holistic care of our over-65s. (GP)*

There are examples of collaborative working of this kind in the NHS, for example in North West London, where 100 GP practices are working with a range of acute, community and mental health providers, alongside local government and the voluntary sector, to improve care for older people and people with diabetes (Harris and others, 2012). Some of these pilots may yield savings to the local health economy (provided reduced hospital use can be released as actual savings), although one GP interviewed for the present research expressed a note of caution about the risk of dominance by hospital providers in such projects:

*GPs don't want to be swallowed up by the hospital system or to be driven into a Kaiser Permanente model. (GP)*

## 5. Conclusion

*If ways could be found to release genuine savings back into general practice, we'd all heave a sigh of relief. We'd love to put more effort into prevention; it's what we're about. (GP)*

Since the 1930s, a minority of GPs and primary care clinicians have made the case for an enhanced general practice that goes beyond the personal, curative relationship with individual patients and sees general practice as responsible for the health and wellbeing of all local people.

This research report has revisited those visions and rehearsed the arguments in favour of general practice taking a more proactive approach in the light of current policy and economic circumstances. The dramatic slowdown in funding growth since 2010 is likely to be sustained over the next decade, just as demand is rising, because of greater numbers of people surviving into old age and the rising cost of treating chronic conditions among people of all ages. The NHS needs to become more effective at helping people keep well as their lifespans extend.

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 We'd love to put more effort into prevention:  
it's what we're about

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The individuals interviewed for this research, alongside perspectives from the literature, have demonstrated that general practice has a powerful base from which to engage in a proactive role: it has a registered list and if neighbouring practices can collaborate, then in many areas it is possible for local populations to have a close overlap with their local general practices. From the perspective of large sections of the public, general practice is a very well-known (and generally well-respected) part of the NHS. In addition, the generalist skills of GPs and practice staff give them unique knowledge of the local context of individual patients and their families.

Reform to general practice since the 1990s has seen an increasing emphasis on prevention and building an infrastructure to deliver it, with financial incentives for screening, immunisations and better management of specific conditions under the Quality and Outcomes Framework. The reform of Quality and Outcomes Framework indicators by NICE, with the aim of including more incentives for prevention, also holds promise. If clinical commissioning can be implemented with the successful engagement of general practice as intended, it will also give primary care a powerful voice in the health system as a whole.

All these factors create a solid base on which a new vision could potentially be built. The interviews with GPs, practice managers and other staff for this research have revealed both an appetite for change and a multitude of ideas about how such visions might be realised. The NAPC's work with the Practice Innovation Network will be a valuable contribution to the evidence base of what can be achieved when general practices choose to make their work more population focused and more proactive.

Nevertheless, the insights arising from this research also suggest that scaling up from this initiative to general practices more widely could present some challenges that policy-makers may need to consider.

First, the move of public health to local government is viewed with trepidation by some in general practice. In the past, public health professionals have not always worked closely with general practice and there are fears that the current reforms will further distance the NHS from the wider public health efforts being coordinated by Public Health England. It will be important for the Department of Health to review the implementation of the new public health architecture, to assess whether public health professionals are working closely with GP communities and clinical commissioning groups, building relationships and adding capacity and expertise so that general practices are able to access and use data and evidence.

Second, many GPs do not accept that population health is their responsibility and lack the training and skills to use public health data and techniques. There have been efforts to include a public health element in medical training (Gillam and Maudsley, 2009), but it is not clear how effective it is at expanding trainees' core focus on identifying and treating disease (Ben-Shlomo, 2009).

Third, there are real capacity and resource limitations facing many general practices, within the larger picture of funding constraint affecting the NHS as a whole. Successful implementation of clinical commissioning could enable some clinical commissioning groups to take on a more systematic prevention role, channelling resources to general practices in the process. But the priorities of NHS England (called the NHS Commissioning Board prior to April 2013), as reflected in the new NHS mandate, may well skew activity towards secondary and tertiary prevention, at the expense of upstream work (Nuffield Trust, 2012). This may be compounded by the financial pressure on the NHS, which may result in a focus on commissioners meeting short-term goals that result in quick financial wins (for example reducing elective or emergency admissions) rather than investing in more prevention initiatives, which can often take several years to come to fruition (NICE, 2011). In theory, NHS England and Monitor should enable flexibility in pricing and contractual systems, which could support innovation between general practice and other providers, and tilt the financial system away from the acute sector. But NHS England and Monitor will have to create space for general practice to innovate as providers, rather than just focus on their role as commissioners, and not be inhibited by concerns about conflicts of interest.

Finally, the NHS will need to create and support leaders from general practice, who have a strong interest in population health, for example by encouraging clinical commissioning groups to fund GP lead roles in population health alongside lead roles for disease groups. The most immediate task facing the NAPC and others wanting to build a vision of proactive general practice is to enable enthusiastic staff to articulate a vision of what they might achieve and, above all, root those visions in the values of generalism in the NHS.

*Many GPs regard public health practitioners as having betrayed the practice of medicine, are not themselves proper clinicians and are in some way preventing them from getting on and doing what they have been trained for. My recent, refreshing experience in Cumbria is that it doesn't have to be like that, and it is possible for general practitioners to be enthusiastic about a whole-population approach while continuing to be excellent clinicians. (Ashton, 2011, p. 2)*

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