

# Written submission

## House of Commons Health Committee Inquiry into the challenges affecting primary care services in England: evidence from The King's Fund

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Our response to this Inquiry focuses on our insight into the challenges affecting general practice in England, rather than primary care services more broadly, although we also refer to the role community health services will need to play if the vision outlined in the *NHS five year forward view* (Forward View) is to be achieved.

### Summary

- The future of general practice rests on a combination of investment and reform. Investment is needed to reverse the declining share of the NHS budget going into general practice. Reform is needed to address workforce issues and improve services for patients.
- A lack of robust data about the volume of demand, nature of activity carried out by general practice and quality of the services it provides makes it difficult for us to confidently assess the extent of the pressures on general practice and the standard of care it provides to patients.
- However, contextual factors lead us to believe that quality is unlikely to have improved since the independent inquiry into the quality of care in general practice commissioned by The King's Fund in 2011, and in some respects may have declined.
- Anecdotally there are reports of significant pressures on the GP workforce, with rising demand and increasing commissioning and regulatory responsibilities

resulting in difficulties recruiting and retaining GPs. At the same time, the size of the GP workforce has not kept pace with population growth. These issues must be addressed if general practice is to successfully develop the new models of care outlined in the Forward View.

- The prize on offer is for general practice to lead the development of integrated out-of-hospital services. This means working in new ways, at scale in federations and networks, to provide a wider range of services and better access for patients and to embrace the opportunities offered by information technology. To encourage this, we have proposed that a new type of contract should be available to GPs.

## **The current picture - quality and standards for patients**

1. The results of an independent inquiry, commissioned by The King's Fund, into the quality of services in general practice was published in 2011 (The King's Fund 2011). The main conclusions were that:

- the majority of care provided by general practice was good, although there were wide variations in performance, suggesting significant scope for improvement
- a greater focus on quality improvement was required, as well as a need for quality to be defined more broadly from the patient's perspective
- general practice should take a wider responsibility for their populations and contribute to improvements in health, working with others to reduce inequalities
- the lack of consistent publicly available information about quality in general practice should be addressed: measuring performance, improving care standards, and transparent reporting should be key features in the provision of primary care.

2. Four years have now passed since we published these findings. Since then, it has been reported that an increasing number of GP practices are considering entering into federations and networks (British Medical Association undated; Primary Care Commissioning 2015) – a development which The King's Fund welcomes. However, the lack of robust information on the volume and quality of services in general practice makes it difficult for us to assess current levels of quality with any confidence.

3. The current pressures on general practice would suggest that levels of quality as a whole are unlikely to have improved. For example, anecdotal evidence consistently suggests that the workforce is experiencing significant pressures, due to the growing volume and complexity of workload.

4. In some respects levels of quality may even have declined. While patients report consistently high levels of satisfaction with GP services overall, there has been a small and consistent reduction of between 1 and 2 percentage points across many of the overall satisfaction and access measures since 2010 (NHS England 2015). Results of the British Social Attitudes survey show that, although satisfaction remains high at 71 per cent, satisfaction with GP services is now at its lowest reported level since the survey began (Appleby and Robertson 2015).

5. Research conducted since the independent inquiry (The King's Fund 2011) also confirms that wide variations in the quality of care provided by general practice persist, for example, in rates of diagnosis, prescribing and ordering of diagnostic tests (Right Care 2013, 2011).

6. Given that around a quarter of patients attending primary care have a mental health component to their illness (Joint Commissioning Panel for Mental Health 2012), mental health is an area that should be a particular priority for quality improvement in primary care. However, the quality of mental health care delivered in general practice is highly variable, and inadequate support for mental health often adds to the burden of work for GPs, as well as increasing costs in the wider system by exacerbating physical health conditions (Naylor *et al* 2012).

7. We note with interest the work being undertaken by the Health Foundation (commissioned by the Department of Health) to develop metrics for GP practices, intended to stimulate improvements in care quality through the transparent reporting of information. Although there will be considerable challenges in developing these metrics, this could play an important role in supporting quality improvement in general practice.

## **Demand**

8. Despite the fact that an estimated 90 per cent of NHS contacts take place in general practice, data is not collected systematically on the number of consultations, who undertakes them, or the nature of those consultations.

9. Although the annual national GP workload survey has not been carried out since 2007, in the absence of any real alternative it is still the main source used by national bodies and researchers interested in understanding changes in the number of consultations. Extrapolating from this data, there has been an estimated 13 per cent rise in the number of consultations between 2007 and 2013 to 340 million consultations per year (Hippisley-Cox *et al* 2009). More recently, secondary analysis by the Nuffield Trust of GP practice data held by the Clinical Practice Research Datalink found that much of the increased activity in general practice was among staff groups other than GPs: consultations with GPs increased by approximately 2 per cent, whereas consultations with nurses rose by 8 per cent and consultations with 'other' staff (pharmacists, physiotherapists, etc) grew by 18 per cent (Curry 2015).

10. Anecdotally, GPs report increased expectations from patients for appointments, as well as more patients with co-morbidities requiring greater levels of care co-ordination. They also report an increase in other workload demands (for example, regulatory, commissioning and management activity).

11. Reports of an increase and change in activity have also been observed in a number of surveys carried out by organisations including the Royal College of General Practitioners (RCGP), British Medical Association (BMA) and the Centre for Workforce Intelligence. Recent research by Citizens Advice found that GPs in England reported spending almost a fifth (19 per cent) of their time on social issues that were not principally about health, ranging from relationship troubles to housing and work problems. Based on this finding,

their report (2015a) suggests that there could be merit in exploring other ways to meet some of this demand, including co-locating more non-health services in GP surgeries.

12. It is likely that the pressures being felt by GPs are exacerbated by other factors (explored in more detail in later sections) such as funding, changing demographics and workforce.

## **Access**

13. Data on access is also limited – following the abolition of the 24- and 48-hour access targets, the main source of information about access is the GP Patient Survey. Although patient satisfaction with accessibility remains high, there has been a small and consistent reduction across access measures since 2010. For example, in July 2015, 85.2 per cent of patients were able to get an appointment to see or speak to someone at their surgery when they last tried, which is a decrease of 0.9 percentage points since December 2013 and 2.3 percentage points since December 2011. Perhaps in response to this, the government's 'new deal' for GPs includes ambitions to improve access to GP services. Building on the pilot schemes established under the Prime Minister's Challenge Fund, the new deal aims to meet Conservative party manifesto commitments by introducing a seven-day service and same-day appointments for everyone over 75 who needs them.

14. The drive to make better use of information technology also provides opportunities to improve access and convenience for patients, as well as to reduce administrative burdens on practices. However, despite government efforts to encourage general practice to offer online access, a report by Citizens Advice (2015b) found that only 6 per cent of patients normally book their appointments online, while 34 per cent said that they would like to do so.

15. Problems with the unequal distribution of GPs in England persist. A report by Health Education England (2015b) observes marked regional variations in the number of GPs per 100,000 population across England, ranging from 63.4 in the North West to 81.5 in the Thames Valley, with the poorest regions being worst affected. Evidence suggests that recent attempts by policy-makers to address this (such as controls on entry into areas designated as relatively over-doctored and increases in total supply) were not sufficiently targeted to have the desired effect (Goddard *et al* 2010). Pennington and Whitehead (2015) have also reviewed the impact of policies to improve the distribution of GPs over time. They argue that GPs' motivations for location need to be much better understood in order to design better policies to address their inequitable distribution and refer to evidence that GPs in England prefer to work in less deprived areas and experience higher levels of stress with more complex workloads in more deprived practices.

## **Funding and workforce**

16. Like other parts of the health care system, general practice has been under financial pressure. Relative to other health services (eg, the acute hospital sector), general practice's share of NHS funding has been declining: between 2005/6 and 2013/14, total investment in general practice fell by 6 per cent – equivalent to nearly £560 million. This is in contrast to a real rise in total NHS spending of 4.4 per cent since

2010/11. In recognition of this, in January 2015, the government committed to investing £1 billion over four years through the Primary Care Infrastructure Fund.

17. The GP workforce is also under pressure – although the total number of GPs in England has increased by 2.3 per cent, from 31,356 in 2010 to 32,075 full-time equivalents (FTEs) in 2013, the number of GPs per 1,000 population has reduced by around 3 per cent, ie, has not kept pace with population growth. This is confirmed by recent modelling by NHS England and the RCGP (Health Education England 2015a), which demonstrates that the current rate of increase will not even come close to meeting future demand.

18. There are also substantial difficulties in recruitment and retention: in 2013/14, 8 per cent of GP places and 12 per cent of GP training places remained unfilled (Health Education England 2015a), while the number of GPs over-50 who intend to 'quit direct patient care in the next five years' rose from 42 per cent in 2010 to 54 per cent in 2012 (Hann *et al* 2013). The Centre for Workforce Intelligence (2014) has said that there is likely to be a significant undersupply of GPs by 2020 unless immediate actions are taken to redress the imbalance between supply and demand and to increase training numbers for longer-term sustainability.

19. In this context, the situation has been described as an 'emerging workforce crisis' (Dayan *et al* 2014). Survey data and measures of workload and stress indicate significant pressures on GPs, who had the lowest morale among all medical graduate groups in the BMA's most recent cohort study (British Medical Association 2014). All this points to a profession increasingly perceived as unattractive by medical trainees as well as by existing GPs.

20. To achieve the vision set out in *Transforming primary care* (Department of Health and NHS England 2014), the number of non-GP staff in general practice will also need to expand, yet from 2010 to 2013 the number of primary care nursing staff stayed relatively stable (at just over 14,500 FTEs), increase by just 2 per cent (Dayan *et al* 2014).

21. To tackle these pressures and support service development the government has pledged to increase the NHS workforce by at least 10,000 by 2020, including an estimated 5,000 GPs, as well as more practice nurses and district nurses, physicians' associates and pharmacists. While this is welcome and much-needed, it is not yet clear how this will be achieved: workforce shortages are difficult to rectify quickly because of the time it takes to train staff.

## **Commissioning**

22. GPs in England have been involved in the commissioning of health services for more than 20 years. Since 2012 this has been through clinical commissioning groups (CCGs) – GP-led organisations that now control around two-thirds of the NHS budget. The King's Fund has been working with the Nuffield Trust on a three-year joint research project to understand how CCGs are evolving and operating in practice. Our research shows that although significant energy has been invested in involving GPs in these groups (and with some success), the sustainability of GPs' role in CCGs is at risk as a result of other

pressures on their time and restrictions on the funds available for back-filling GPs' clinical time (Holder *et al* 2015; Naylor *et al* 2013). Over the next few years, CCGs could find it difficult to retain their GP leaders, as many reach the end of their initial terms of office and new, potentially more attractive leadership posts arise in GP provider organisations (Holder *et al* 2015).

23. The Health and Social Care Act 2012 gave responsibility for commissioning primary care services to NHS England rather than CCGs, in response to concerns that conflicts of interest could arise from GP-led organisations purchasing GP services. However, it has been difficult for NHS England to be sufficiently local and flexible, and so since April 2015 NHS England has been encouraging CCGs to 'co-commission' primary care services in their local area, including GP services.

24. Although CCGs are better placed than NHS England to understand challenges in local GP services, and to have leverage over local practices where performance issues exist, the impact of the new co-commissioning arrangements has yet to be seen.

## **The future of general practice**

25. In our report, *Commissioning and funding general practice: making the case for family care networks* (Addicott and Ham 2014) we argue for a new approach that brings together funding for general practice with funding for many other services to deliver care that goes well beyond what is currently available in general practice, potentially via models that operate on the scale required for effective integration of services such as federations or networks of practices. At the heart of this approach would be the use of a population-based capitated contract under which providers would be expected to deliver defined outcomes for the populations they serve. The current contract negotiations between the government and the British Medical Association (BMA) provide an opportunity to put this in place.

26. The Forward View (NHS England *et al* 2014) proposes two new models of service delivery – the multispecialty community provider (MCP) and primary and acute care systems (PACS). General practice is a core element of both models.

27. A number of other new models of primary care are emerging to operate at this kind of scale – including networks and federations, 'super-partnerships' of GPs, community health organisations and multi-practice organisations (Smith *et al* 2013). A well-known example is the Vitality partnership in Birmingham – a partnership of 18 GP practices serving more than 65,000 patients – which provides a wide range of services in primary care, including some traditionally carried out in hospital. Another example is Our Health Partnership, a group of 180 GP partners in Birmingham and Sutton Coldfield who recently announced a merger to become 'the largest GP partnership in the NHS' (Matthews-King 2015).

28. In assuming greater responsibility for commissioning and providing care, MCPs would need to demonstrate that they have the necessary capabilities (eg, skills in contract negotiation, financial management and management of clinical quality) to manage the contract and deliver the expected outcomes. Potential conflicts of interest would also need

to be managed, for example by excluding those practices bidding to provide services from the process of commissioning them. Transparent governance and accountability arrangements would also be essential.

29. MCPs will also need to be given sufficient time and support to implement and evaluate the new model, based on early testing, including learning from other systems like New Zealand and the United States, where models of this kind already exist.

30. The second model of care proposed in the Forward View is primary and acute care systems (PACS), described as 'single organisations to provide NHS list-based GP and hospital services, together with mental health and community services'. This model could be formed in a number of ways – for example, by MCPs taking over the running of hospitals or by hospitals becoming more involved in the delivery of primary care. In either case, our research into the role of acute hospitals in delivering integrated care in the NHS illustrates some of the challenges primary and secondary care experience when working together as part of integrated systems, along with case studies setting out how specific areas have overcome some of these challenges (Naylor *et al* 2015).

31. Critical to the success of both of the models outlined in the Forward View will be resolution of some of the workforce issues outlined earlier in this submission. With survey data suggesting that GPs are struggling to manage their current workloads, it is not clear that they have sufficient capacity to create and innovate through new models of care. Consideration should be given to the role of the wider primary care team and how better use can be made of the skills of other professionals (eg, pharmacists) to reduce pressures on general practice staff.

32. General practice also needs to be able to rely on community health services when trying to manage care out of hospital, yet our research (Foot *et al* 2014) suggests that this sector is facing some critical challenges such as staff shortages and a lack of robust data on quality. Again, these issues will need to be addressed if GPs are to deliver the high-quality services that keep patients out of hospital, as envisaged in the Forward View. Without sufficient capacity and capability in the community workforce, focus on quality of services and communication about what services are available, GPs will be unable to coordinate and plan high-quality care that keeps patients out of hospital.

33. Delivering the proposals set out in the Forward View will also require the development of new workforce models in which NHS staff work across acute, community and primary care settings. Our research on the role of specialists in out-of-hospital settings shows that hospital consultants must work in new ways to support primary and community care colleagues to better diagnose and treat patients (Robertson *et al* 2014a). We found promising new workforce models in which consultants take on roles that span acute, community and primary care settings to provide staff outside hospital with better access to specialist expertise. One example is the Imperial Child Health Hubs, where paediatric consultants from St Mary's hospital run an email and telephone helpline for GPs and attend multidisciplinary team meetings, run education sessions and hold outreach clinics at local GP practice hubs (Robertson *et al* 2014). By supporting primary care staff to treat patients themselves, they have reduced waiting times and the number of hospital referrals and receive high patient satisfaction scores.

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