

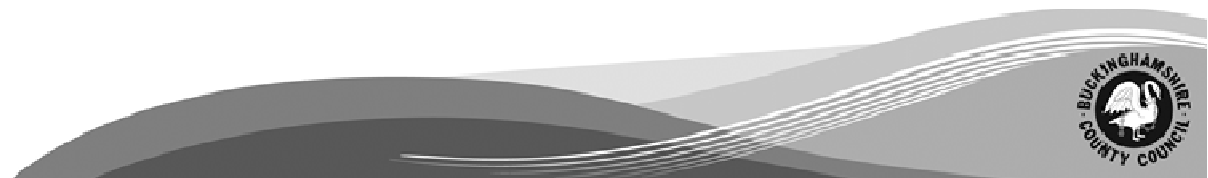
Buckinghamshire County Council

Health and Adult Social Care Select
Committee

General Practice

*An inquiry into General Practice Services
in Buckinghamshire*

Published November 2014



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Executive Summary

In response to concerns over appointment waiting times and access, and variable patient experience satisfaction scores between local practices, the Buckinghamshire County Council Health and Adult Social Care Select Committee undertook this inquiry into local GP service provision.

The focus of the inquiry was not on the quality of care, but we were reassured by the evidence we saw on this and the oversight regime in place to monitor and address any failings. Our focus was instead on the variation in patient experience, and understanding some of the factors behind this and pressures on services.

The inquiry group considered evidence from a range of sources including patient feedback received by the committee and from secondary sources, evidence sessions with GP Service commissioners, representatives and regulators, and via visits to 12 GP practices across the county where we spoke with practice staff.

We have found evidence of an imbalance between capacity and demand on GP services locally, but this is certainly not confined to Buckinghamshire. Capacity is constrained by service funding levels and premises, but most critically by staff recruitment and retention issues which is not straightforward to address. Service demand has undoubtedly increased in the last 10 years, and whilst we recommend more to be done on demand management, demand is only likely to be fully met by the more radical changes to the model of service delivery being called for nationally.

Waiting times for appointments, and how appointment administration is managed, are particular areas of patient experience concern. Whilst this is closely linked to capacity and demand issues, we feel there should be closer monitoring of waiting time variation for non-urgent appointments, given urgent needs seem to be being met. Patient Participation Groups have an important role in identifying patient experience issues, and we have recommended that steps be taken to ensure these function effectively in every practice.

GP premises investment is deficient locally and nationally. Whilst some facilitation for this will happen nationally, it is for local commissioners and providers to ensure they are sufficiently organised and forward thinking in how opportunities via developer contributions and newly commissioned primary care services are grasped to resolve this.

Encouragement is being given for Clinical Commissioning Groups (CCGs) to assume greater responsibility for primary care provision. We feel this is positive and a response to shortcomings in the levels of oversight and support for General Practice in the commissioning structure currently. It is important this extra responsibility on CCGs is adequately resourced and supported.

There will potentially be significant change to how General Practice is delivered over the next five years, and we consider it vital that individual GP practices are guided and supported in leading this. It is also vital that patients are effectively engaged at an early stage on these changes.

List of Recommendations

1) NHS England should publish a national benchmark indicator of general practice funding per capita, facilitating comparisons with the funding received in different CCG areas. This benchmark should then be published as a routine at least annually in future. (paragraphs 28-30)

2) The Area Team should facilitate a suitable set of benchmark indicators which can provide greater awareness of waiting times for non-urgent appointments experienced by patients, and which GP Practices can generate efficiently on a regular basis. This should be used by the Area Team to identify problems much sooner, and support the current peer review activity between GP Practices. (paragraphs 37-54)

3) A GP Demand Management Action Plan should be agreed by the CCGs and NHS England Area Team as part of the Primary Care Strategy to facilitate a coordinated and shared approach to reducing avoidable appointments and demands on GP services, as well as promoting greater self-care. This should be delivered either by the local CCGs or as an early co-commissioning project undertaken with the NHS England Area Team. (paragraphs 55-63)

4) The NHS England Area Team, in liaison with local CCGs and the Local Medical Committee, should clarify roles, responsibilities and contacts for NHS engagement on land use planning matters, and how information will be shared between themselves and with local practices. The Area Team should review whether they have the processes and data in place to secure developer contributions for general practice investment. (paragraphs 64-73)

5) Following the publication of the Primary Care Strategy, the NHS England Area Team should agree with the local CCGs a plan for how the necessary investment in primary care premises will be encouraged, supported and delivered over the next five years. (paragraphs 64-75)

6) Healthwatch Bucks in liaison with the CCGs should lead on the identification of less developed PPGs and the formulation of a support

package for them which should be publicised on the Healthwatch Bucks website. (paragraphs 76-81)

7) The Primary Care Strategy should outline what the future of GP service delivery in Buckinghamshire should look like in five years' time, and how individual GP practices will be supported to deliver this. (paragraphs 82-89)

8) NHS England acknowledge our concerns over the imbalance in local GP service capacity and demands, and commit to additional funding for CCGs undertaking co-commissioning of GP services with the Area Teams so this additional CCG activity is adequately resourced. (paragraphs 82 -90)

Acronyms

CCG	Clinical Commissioning Group
CIL	Community Infrastructure Levy
CQC	Care Quality Commission
DES	Directed Enhanced Service
DNA	Do Not Attend
FTE	Full Time Equivalent
GP	General Practitioners
HASC	Buckinghamshire Health and Adult Social Care Select Committee
LMC	Local Medical Committee
NHS	National Health Service
PPG	Patient Participation Group
RCGP	Royal College of General Practitioners

Background

1. The Health and Adult Social Care Select Committee (HASC) agreed to undertake an inquiry into GP services at their meeting on 20 May 2014. Local feedback and national media coverage had highlighted an issue with waiting times for appointments. The national GP patient experience survey scores also indicated a wide variation in satisfaction with GP practices, opening hours, appointment booking, telephone access, and ability to see preferred doctor.
2. The committee also wanted to contribute to the Primary Care Strategy which was being developed for Buckinghamshire by the two local Clinical Commissioning Groups (CCG's) on behalf of the NHS England Thames Valley Area Team. In addition to GP services this strategy covers dental, community pharmacy and optometry services. The strategy should align with and contribute to the Buckinghamshire Health and Wellbeing Strategy agreed by the Health and Wellbeing Board.
3. GP service provision was an area the committee had given limited attention to in recent years, and with a new strategy being developed for primary care, this inquiry presented a good opportunity for the committee to learn more about general practice to equip them for more effective scrutiny of it in future years.
4. The HASC appointed an inquiry group to conduct the inquiry and report on their findings. The inquiry group totalled nine members of the HASC and consisted of six county councillors, two district councillors and one Healthwatch Bucks member:

Brian Adams, County Councillor
Margaret Aston, County Councillor
Noel Brown, County Councillor
Lin Hazell, County Councillor
Roger Reed, County Councillor (Inquiry Group Chairman)
Jean Teesdale, County Councillor
Tony Green, Wycombe District Councillor
Wendy Matthews, South Bucks District Councillor
Shade Adoh, Healthwatch Bucks

5. Considered a cornerstone of the NHS with roughly 1 million people visiting their GP every day, NHS England spends in the region of £7 billion a year on core primary medical services each year¹. GPs are independent contractors commissioned primarily by NHS England to deliver the bulk of their services. They are also commissioned to deliver services by other agencies too, such as CCGs and Local Authority Public Health Teams. Since the Primary Care Trust was disbanded in April 2013, the NHS England Thames Valley Area Team has been responsible for commissioning and paying for the bulk of GP services provided locally.

¹ Para 1: <http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf>

6. GP Practices in Buckinghamshire deliver their core services under either the General Medical Services contract (the majority) or the associated Personal Medical Services contract, which are based on nationally negotiated contractual frameworks. NHS England has recently proposed to merge the 24 area teams outside London into just 12. It is understood that, while the number of area team directors will reduce, NHS England will retain some staff presence in each of the existing 24 areas. Thames Valley area team is proposed to merge with Bath, Gloucestershire, Swindon and Wiltshire area teams (Health Service Journal, 1/10/14).
7. In Buckinghamshire, Aylesbury Vale and Chiltern CCGs commission secondary care on behalf of all the local GP practices which form their membership. NHS England is currently inviting expressions of interest from CCGs to co-commission GP services with them², however there are issues of conflicts of interest concerning the commissioning of services by CCGs from their own member practices. The Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee (LMC) is the local representative committee for NHS GPs. The Care Quality Commission is the quality regulator of GP Practices. All these agencies, alongside NHS England, play a role in overseeing and supporting local GP service delivery.
8. Patients are free to register with any practice they wish to, providing they live within its catchment area. Closed registration lists are discouraged by NHS England, so in most cases GP practices will accept new patients. Patient choice is proposed to be further enhanced from January 2015, when the out of area registration scheme will be rolled out nationally. Already piloted in some areas, this will allow people to register with any GP regardless of where they live and the practice catchment, and is likely to appeal to people who wish to register at a GP near their place of work. The scheme is a voluntary arrangement by GP practices and they have the right to refuse registration³.

Inquiry Scope

9. The inquiry group met on 25th July 2014 to agree an inquiry scope. In addition to the justification for the inquiry detailed above, members also highlighted an issue with the variation in the range of services provided by GP practices. The overall inquiry aim agreed was:

To enhance the committee understanding on GP service provision, explore the variation in local GP service provision and experience and identify any actions and improvements that should be included in the Primary Care Strategy being developed

Overall the inquiry group hoped to be able to recommend how local patient experience of GP services could be improved and/or made more consistent. The full scope is included as appendix 1. Whilst GP funding and contracts was considered out of scope, this was only insofar as the committee felt improvements in these areas

² <http://www.england.nhs.uk/2014/05/01/power-improve-pc/>

³ <http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/patient-choice-GP-practices.aspx>

were beyond their influence, and the inquiry could not ignore these issues which transpired to be key factors in patient experience of services.

Evidence

10. Having agreed the scope of their inquiry the group issued a call for evidence from anyone with recent experience of their GP service to contribute feedback to the inquiry. GP Patient Participation Groups were also invited to contribute to the inquiry with their own feedback. Feedback received (5 responses representing views of surgery PPGs, and 22 additional patient responses) was considered alongside other public feedback on local GP Practices available from the NHS Choices website (www.nhs.uk), and the national patient experience survey conducted by Mori. This provided an insight into service user experience of local GP services.
11. The inquiry group held an initial fact finding evidence session on 27 August 2014. This was attended by representatives from the NHS England Thames Valley Area Team, the Aylesbury Vale and Chiltern Clinical Commissioning Groups, the Berkshire, Buckinghamshire and Oxfordshire Local Medical and the Care Quality Commission.
12. Following this, members of the inquiry group undertook 12 visits to GP Practices across the county. All practices in the county were invited to take part in the inquiry, and those which were visited comprised a good cross section of practices (at least two selected from each district, a mix of urban and rural practices, large, medium and small practices, and practice populations classed at varying levels of socio-economic deprivation). Importantly the practices visited had a range of patient experience scores with some scoring relatively highly and some among the lowest locally against key indicators. The visits ranged in length from an hour to two hours, and gave members of the inquiry group the opportunity to discuss with practice staff the variation in patient experience, how the practice service was delivered and the issues staff experienced. Some visits involved just the practice manager, while nearly all included some time with a senior GP at the practice, and some were with as many as ten of the practice team of staff.
13. Once all the practice visits were complete the inquiry group held a final evidence session in public on 24th October 2014⁴. At this meeting the inquiry group put their findings from their visits to representatives from the NHS England Area Team, the Clinical Commissioning Groups and the Local Medical Committee.

⁴ For papers see: <https://democracy.buckscc.gov.uk/ieListDocuments.aspx?CId=861&MId=6566>

Findings and Recommendations

14. One of the initial questions we were keen to answer was what constitutes good GP service provision. We were advised in our initial evidence session that the GP contract is quite vague, and does not specify this but leaves it with GPs to meet the reasonable needs of patients. The most useful summary of good service we found comes from The Kings Fund and Nuffield Trust Report *Securing the Future of General Practice* (2013⁵) which provides a set of 12 design principles for future models of primary care and illustrate what 'good' primary care would look like:
- a. A senior clinician, capable of making decisions about the correct course of action, is available to patients as early in the process as possible. Providing more effective triage and decision making.
 - b. Access to primary care advice and support that is underpinned by systematic use of the latest electronic communications technology
 - c. Minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations.
 - d. Patients are offered continuity of relationship where this is important, and access at the right time when it is required.
 - e. Care is proactive and population-based where possible, especially in relation to long-term conditions.
 - f. Care for frail people with multi-morbidity is tailored to the individual needs of patients in this group, in particular people in residential or nursing homes.
 - g. Where possible, patients are supported to identify their own goals and manage their own condition and care.
 - h. Primary care is delivered by a multidisciplinary team in which full use is made of all the team members, and the form of the clinical encounter is tailored to the need of the patient.
15. We were also curious as to why there is not uniformity on the services provided by different GP practices. During our evidence gathering it became apparent there were a number of factors behind this. One of the principle reasons is that in addition to the core contract, practices can choose a variety of additional optional services to provide for a number of agencies (as outlined in paragraph 5). As independent businesses practices can also choose to deliver various services themselves in addition to the core contract which they feel meets their patient needs. Decisions on additional services will vary according to a number of variables such as surgery capacity (staff, premises,

⁵ http://www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice_full_report_0.pdf

skills) and the financial circumstances of the practice. Local circumstances and opportunities are also a factor such as the willingness of other agencies and professionals to co locate and deliver services from the practice premises (physiotherapists, counsellors, mental health and acute trusts etc).

Satisfaction with the quality of care from GP Practices

16. The latest national Patient Experience Survey results suggest high levels of confidence in both GPs (93%) and GP Practice Nurses (86%) in Buckinghamshire. These scores are same as England average and higher than Thames Valley average (see Appendix 2).

17. Some examples of the positive feedback we received on local GP services included:

I cannot commend all staff at the practice enough, but particularly my GP, for the help and support which I have received during this difficult period.

As someone who works in London I find the opening hours at this surgery particularly responsive to my needs - they have early opening, from 7am and also a late evening, staying open to 8pm. They are generally available to 6.30pm, meaning things like collecting a prescription when I get back from work is possible. They provide a range of health services available within the surgery, including phlebotomy.

My wife and I have both recently had appointments at this practice and can only say how well the doctors and office staff deal with patients. We have admiration for the care and attention, not just at the current time, but over many years. Appointments are given without undue delay, and urgent calls are dealt with swiftly.

They manage, in spite of the increasing pressures facing the service, to continue to maintain that precious balance of both warmth and efficiency. I have total faith in the doctors and nurses and appreciate the caring efficiency provided by the support and administrative staff.

18. In terms of oversight and monitoring of GP services, the local NHS England Area Team (Thames Valley) commission GP services, and are ultimately responsible for the service provided. Clinical Commissioning Groups have a duty to improve the quality of primary care as laid out in the Health and Social Care Act, which includes GP services. The Care Quality Commission is the independent regulator of GP services, ensuring services provide people with safe, effective, compassionate and high-quality care. In addition to this there is a degree of self-regulation by the GP practices as independent businesses, responding to their own data and assessments of their service levels, and the views from their patients.

19. At our evidence sessions we heard there is no single measure of GP quality and the triangulation of various measures (national patient survey scores, Quality and Outcomes Framework data, clinical systems data, complaints, anecdotal information) alongside feedback from the CCGs and the LMC is needed to identify concerns of

poor practice. During the inquiry we have seen evidence used by the Area Team to identify local practices that fall outside the national threshold for some quality indicators which is an example of how outcomes/quality is monitored. We have also heard from the Area Team that of the 243 practices they commission across the whole Thames Valley, they are working with some 10% of these on aspects of their quality. The Area Team monitoring of GP Practices is by exception, where resources are targeted at those practices where data suggests a practice is an outlier. We have also seen the scorecards used by the local CCGs at their monthly locality meetings which are used to support peer review, and encourage the sharing of best practice and service improvement overall.

20. CQC regulation of GPs, as with their regulation of other health and social care services is through the provider registering with them, the monitoring of data and intelligence, and periodic expert inspections resulting in a rating of Outstanding, Good, Requires Improvement or Inadequate. A new inspection regime was agreed in 2013⁶. In conducting their inspections the CQC asks five key questions:
- Are they safe?
 - Are they effective?
 - Are they caring?
 - Are they responsive?
 - Are they well led?

In their inspections the CQC are giving focus to particular population groups who may find accessing primary care services difficult. These include: 'Older people', 'people with long term conditions', 'mother, babies, children and young people', 'working age people (and those recently retired)', 'people in vulnerable circumstances that may have poor access to primary care', 'people experiencing poor mental health'.

21. An assessment of the quality of service standards was not an aim of this inquiry. However from published patient satisfaction outcomes, and from other evidence we have heard, we are satisfied with the overall quality of care provided. We are also satisfied with the oversight arrangements in place to address any instances of unsatisfactory performance concerning the quality of care provided.

General Practice is under significant pressure and facing 'crisis': Demand

22. A common theme throughout our evidence gathering from local NHS commissioners and GP providers was that the service is under great pressure and on the verge of crisis. General practice suffers from finite capacity and unlimited demand, and we came across a number of practices where reduced capacity was putting tremendous pressure on GPs.

⁶ http://www.cqc.org.uk/sites/default/files/documents/20131211 - gp_signposting_statement - final.pdf

23. General practice is becoming ever more complex with the effects of an aging population, a baby boom and more patients with mental health problems. Extra demand is generated also by a more proactive approach with NHS health checks uncovering conditions requiring follow up, and increasing instances of complex and multiple conditions requiring longer appointment times. It has become more common for GPs to be working from 8am-8pm, and we heard stories locally of GPs having to go part time simply to enable them to meet the needs of the patients they were seeing adequately, due to the workload outside of appointments (form filling, referral notes, test results etc).
24. In addition to demographic pressures there has in recent years been a shift in activity from secondary care (such as hospitals where activity is typically more expensive, but also providers are paid per activity) to Primary Care (such as General Practice where providers are paid mostly via a block amount per patient with limited activity based payments). This shift in activity has not been followed by a shift in resource. This shift is set to continue with a desire to strengthen the role of community and primary care to further reduce expensive hospital based activity.
25. Growing demand is demonstrated by increased consultation rates. On average a patient had 3.9 consultations each year in 1995 with this increasing to 5.5 consultations each year by 2008. There are higher consultation rates among the elderly, with a rate of 13.8 and 13.3 for males and females in the 85-89 age bands⁷. The consultation rate currently is likely to be in excess of 6 per patient per year⁸. Locally we heard it is not uncommon for a practice in Aylesbury to have 100 calls for appointments in a Monday morning⁹ and daily variation at some practices for appointment request being from between 250-800¹⁰. A GP we met said they see 52 face to face appointments in a day working from 8.30am-7.30pm, and many doctors work past 8 or 9pm.
26. The Local Medical Committee supplied the inquiry with a lot of evidence on the pressures faced by GPs. *Why we can't do any more in Primary Care*¹¹ was an account from a practicing GP from Oxfordshire which highlighted issues with a lack of clarity on the GP role, work demands, constrained capacity, limited time to explore new initiatives, top down demands, reduced attraction of being a partner, and a need for more resources. *Are you in despair for your future in General Practice Final Report*¹² (a July 2014 report based on 2,769 mostly GP responses) provided evidence of unsustainable workloads and GP burn out, leading to GPs taking early

⁷ <http://www.hscic.gov.uk/catalogue/PUB01077/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf>

⁸ Based on NHS England's own estimates, the number of consultations in general practice now stands at 340 million per year, an increase of 40m since 2008

<http://www.rcgp.org.uk/news/2014/january/rcgp-response-to-daily-telegraph-article-on-gp-patient-numbers.aspx>

⁹ G Jackson, Evidence Session 27/8/14.

¹⁰ L Patten, Evidence Session 17/8/14

¹¹

<https://democracy.buckscc.gov.uk/documents/s53100/Why%20we%20cant%20do%20any%20more%20in%20primary%20care.pdf>

¹² <https://pracmanhealth.files.wordpress.com/2014/08/are-you-in-despair-for-your-future-in-general-practice-final-report1.pdf>

retirement, career breaks or emigrating, and a lack of newly qualified doctors becoming GPs. Survey results included:

- 80% of the GPs reported that one or more GPs in their practice is suffering 'burnout' due to increasing and unsustainable pressure of work
- 50% of GPs indicated that they will either retire or take a career break within the next five years with a mode age band of 45 – 54
- 11.6% of GPs indicate that they intend to emigrate within the next five years with a mode age band of 35 – 44
- 97% feel their practice is experiencing an ever-increasing and unsustainable workload.
- 52% feel that the partnership model of General Practice is becoming unsustainable for the future.

Some of the additional feedback themes included unrealistic patient expectations and low morale due to constant GP criticism by politicians and the media.

27. A detailed briefing paper which the Local Medical Committee had compiled for a meeting they were having with the Prime Minister David Cameron at the end of November 2014, was shared with the inquiry group. This is included as Appendix 3, and provides further evidence on the pressures on General Practice stemming from the imbalance between capacity and demand which this report now outlines.

General Practice is under significant pressure and facing 'crisis': Capacity

28. Between 2005-2006 and 2011-2012, the percentage share of the NHS budget spent on general practice across England, Scotland and Wales fell from 10.75 to 8.4% – a historic low” (RCGP¹³). This led to calls from the Royal College of GPs for a UK wide increase in the share of funding that goes into General Practice from 8.4% to 11% of the NHS budget by 2017 to enable GPs to deliver consistent, high quality patient care and enhanced services.
29. In our evidence gathering we were informed that GP funding allocations for Buckinghamshire, in keeping with those for secondary care commissioning by the local CCGs, were among the lowest in the country due to the areas perceived affluence. A common message throughout our visits and evidence sessions was that the level of funding provided to practices did not match the activity they were being expected to deliver.
30. We have not been able to obtain actual figures to illustrate GP funding relative to other areas in England. We understand there is a fixed funding pot for general practice and the Carr-hill formula used to allocate this among practices nationally takes into account the socio-economic deprivation and age profile of the practice population. It is surprising a snapshot of general practice funding per capita is not published periodically, to allow analysis of funding between areas and over time.

¹³ <http://www.rcgp.org.uk/campaign-home/about.aspx>

This limits a fuller understanding of service delivery and pressures locally, and associated debates on the adequacy of service funding. Some understanding of this will be essential as work to better integrate health and social care services progresses as part of the Better Care Fund. We would like the National NHS England Team to publish a benchmark indicator for CCG areas of general practice funding per capita, on a regular basis (at least annually), facilitating comparison to other areas and trends over time.

Recommendation 1: NHS England should publish a national benchmark indicator of general practice funding per capita, facilitating comparisons with the funding received in different CCG areas. This benchmark should then be published as a routine at least annually in future.

31. "By the end of 2013, there were 35,561 GPs in England, and this was down on the number in post in 2009, when there were 35,917 (RCGP¹⁴). The Royal College of GPs has reported that record numbers of family doctors in England are leaving general practice due to ballooning workloads in a 'mass exodus' that could spell disaster for the future of patient safety. According to polling, conducted on behalf of the College, 96% of family doctors believe that working in general practice is more stressful now than it was five years ago and 22% have had to seek support, guidance or advice for work-related stress (RCGP¹⁵).
32. Nationally General Practice is not attracting adequate numbers of new recruits. Recruitment to Vocational Training Schemes for GPs has dropped and is 500 short of target in 2014 (Appendix 3, para d). Furthermore General Practice is not retaining newly qualified GPs (especially women). General Practice is an increasingly female workforce but we are particularly failing to retain female GPs: 70 to 80% of the recently qualified GP workforce are female and 40 % of female GPs under 40 leave General Practice (Appendix 3, para e).
33. Locally we heard evidence of the impact of this national GP recruitment and retention problem. One surgery informed us that five years ago you would get 90 applications for an advertised full time GP position, now they were only receiving four for a part time GP post. We heard that GPs were being attracted to being a salaried or locum GP, which avoided the workload and responsibility of being a partner. The average age of a GP in Buckinghamshire is 46¹⁶ and there is a shortage of young GPs entering the profession. The results of a constrained supply of staff and funding was translating into some local practices being understaffed. One surgery reported that they were short of 2 FTE (Full Time Equivalent) GPs and had only 5.5 FTEs. Another reported that they should have 5 FTE partners to cover their population but funding allocated was inadequate to cover this.

¹⁴ <http://www.rcgp.org.uk/news/2014/july/patient-safety-threatened-by-mass-exodus-of-gps.aspx>

¹⁵ <http://www.rcgp.org.uk/news/2014/july/patient-safety-threatened-by-mass-exodus-of-gps.aspx>

¹⁶ Annet Gamell, 24/10/14 evidence session.

34. In addition to a constrained supply of GPs, we heard it was also difficult to recruit GP nurses. A factor in this was also the local cost of living and the attraction of London weighting on salaries in the capital.
35. The practices we visited which seemed under the most pressure were unsurprisingly those that reported not having a full complement of GP or nursing staff. Those practices that were fully resourced, and had a stable workforce, still reported to be very busy but less pressured. The number of GPs per head of population in the two Buckinghamshire CCGs is in line with the national and regional average as shown in Fig 1.0.
36. Many of the reasons behind these capacity issues require national action by Government and NHS England. When we started this inquiry we heard repeated concerns that GP services were heading towards crisis. By the end of our evidence gathering there were indications that the problems were being acknowledged at a national level. The NHS England five year plan published on 23 October 2014, proposed “a ‘new deal’ for GPs and a commitment to invest more money in primary care, while stabilising core funding for general practice nationally over the next two years. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention”¹⁷.

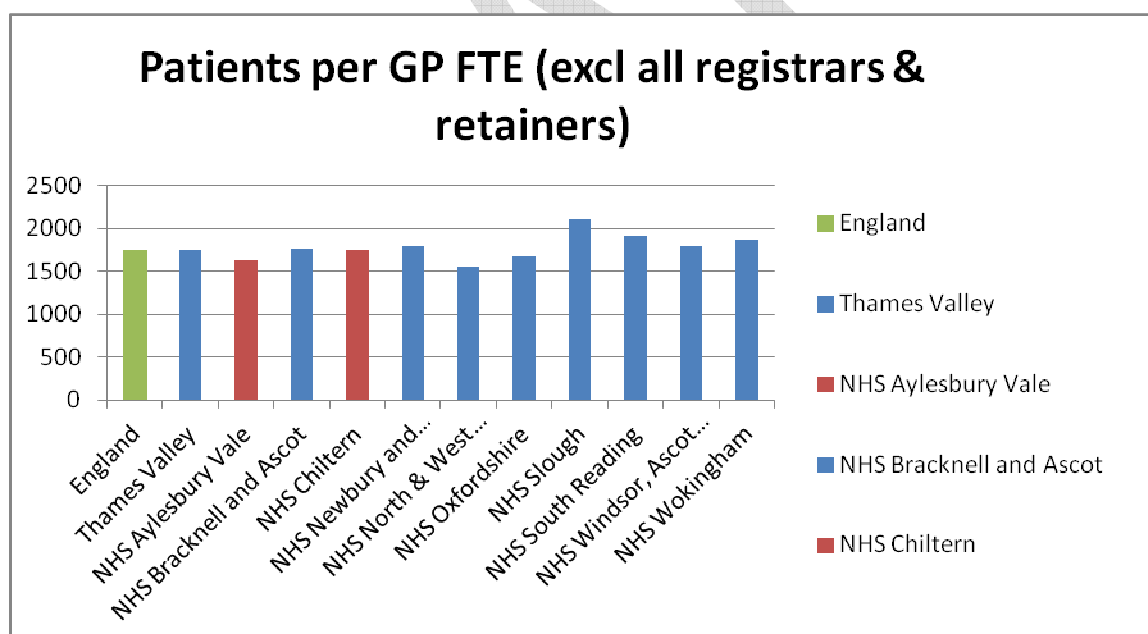


Fig 1.1: Patients per FTE GP (excluding registrars and retainers) for England and Thames Valley CCGs¹⁸.

Appointment access and administration

37. Concerns over the access to GP appointments was a focus of our inquiry, and whilst we were satisfied with the evidence we gathered concerning the quality of care by

¹⁷ Page 4: <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

¹⁸ General & Personal Medical Services Workforce data for England (as at Sept 2013): http://data.gov.uk/dataset/general_and_personal_medical_services_england

GPs and nurses, we remain concerned over the variation in experience of making appointments.

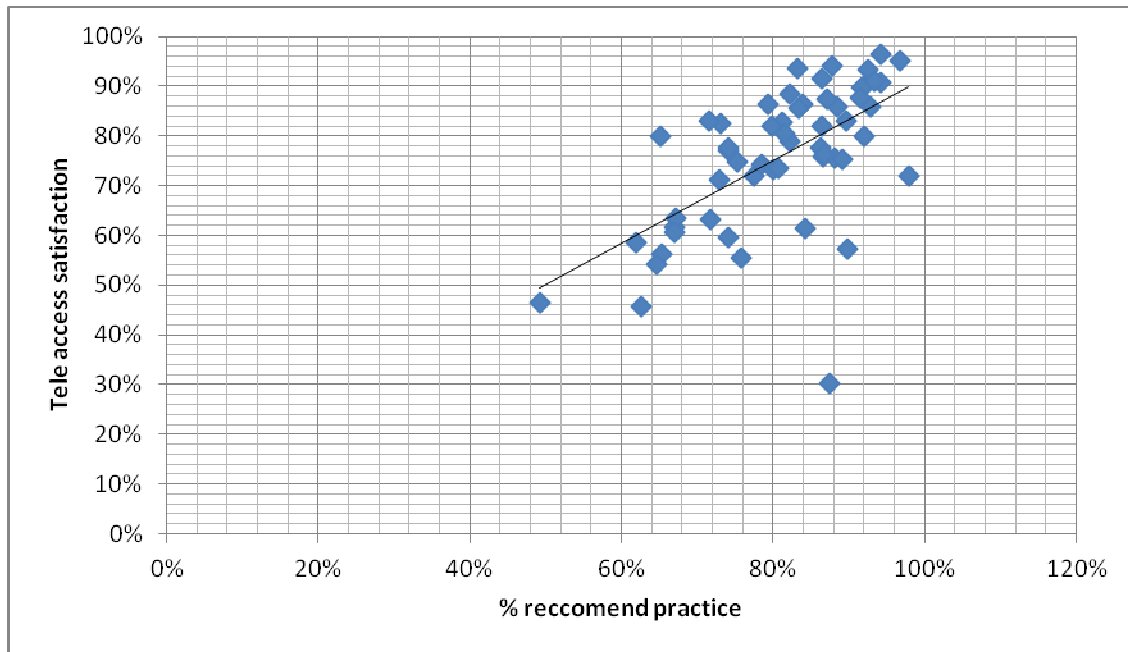


Fig 1.2: National Patient Experience Survey Scores 2013/14 for Buckinghamshire GP Practices (Source: NHS England)

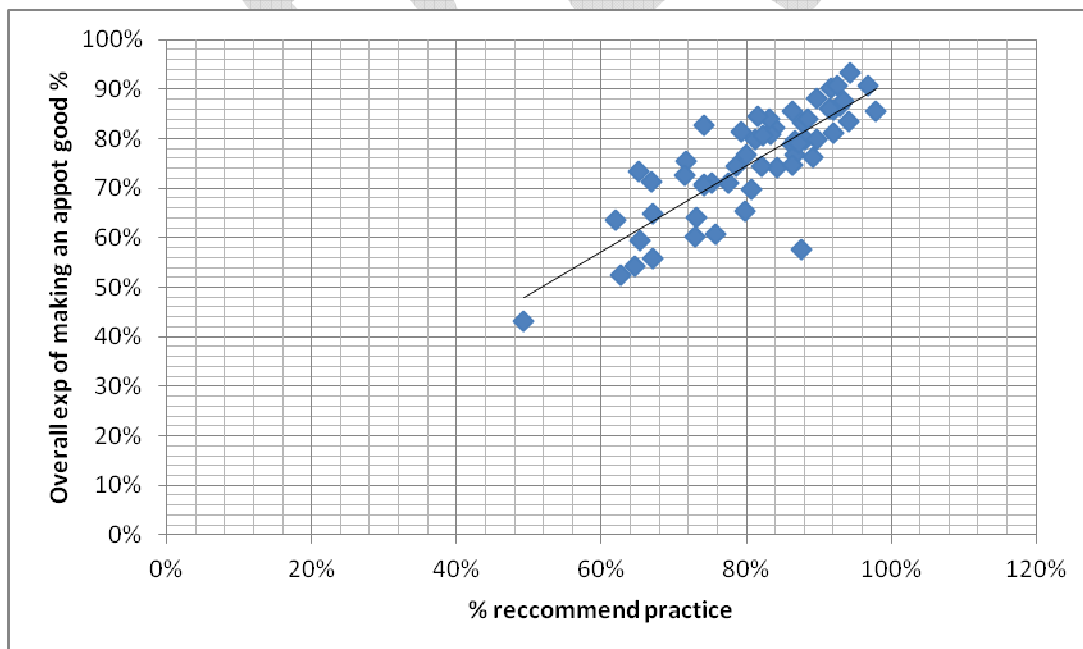
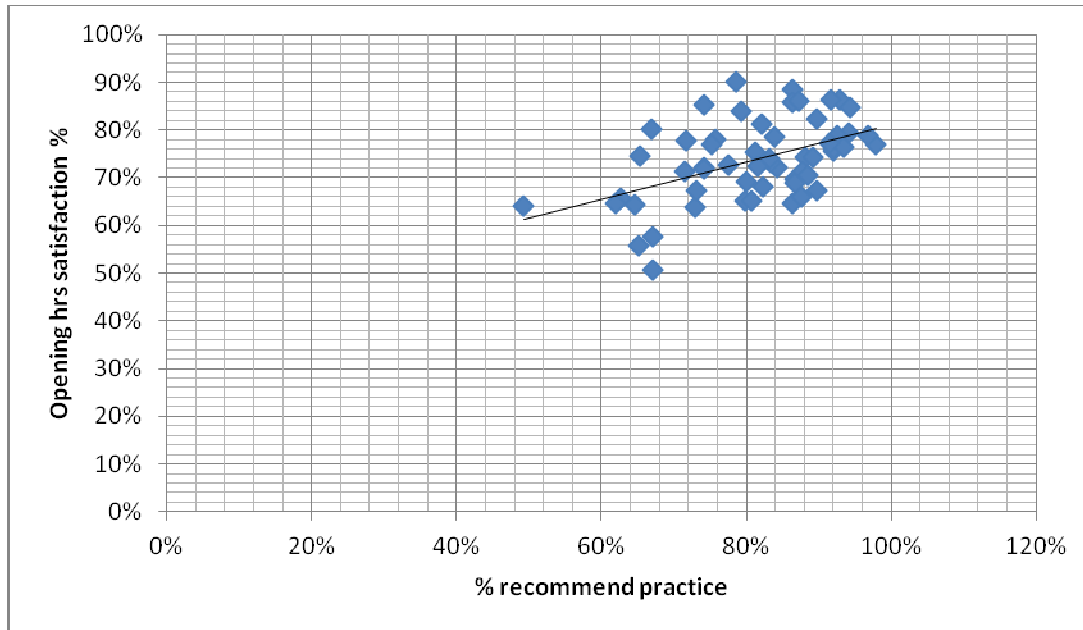


Fig 1.3 (above) and Fig 1.4 (over page): National Patient Experience Survey Scores 2013/14 for Buckinghamshire GP Practices (Source: NHS England)



38. The graphs (Figs 1.2-1.4) show a strong positive correlation between satisfaction with telephone access, overall experience of making an appointment, and opening hours and whether a person would recommend their local practice. The data is taken from the national MORI patient experience survey, and shows the 2013/14 scores for Buckinghamshire GP practices. These graphs would suggest if practices can implement satisfactory appointment administration process and capacity, overall satisfaction with GP services would be greatly enhanced.

39. From patient feedback reviewed some of the common complaints regarding appointment administration concerned patients being asked to call back at a future time when new appointments become available, difficulty getting through on the phone (call handling system queues, and being cut off), and being faced with a choice of an urgent appointment on the day or a 3-4 week wait for a non-urgent appointment. Feedback we received included:

"I have tried on several occasions to make an appointment with this system and every try I have been answered with an automated reply telling me "unprecedented calls, please try later"."

"Whilst emergencies are treated via a Triage system on the day of contacting the surgery, 3 weeks is the normal time to get an appointment to be seen by a GP and is considered barely acceptable." (PPG summary of their patient views)

"I rang to make an appointment at my GP surgery on 6 August and was told the first available with my own GP, not another, was 27 August. I could not book for the following week, but was told to ring back when they had the later weeks open for booking."

40. National results from the MORI patient experience survey¹⁹ gives an indication of patient appointment preferences. Based on their last GP contact 77% of survey respondents wanted to see a GP, 18% wanted to see a nurse and very few (6%) wanted to speak to a GP on the phone. 42% wanted to see or speak to someone on the same day, and 36% in the next few days. Just 6% wanted an appointment for the following week or later (7% had no preference). There is a growing preference for booking appointments online (up from 29% in June 2012 to 34% June 2014).
41. GP practices are independent businesses owned by the GP partners, and have the freedom and flexibility to operate their own appointment management systems and processes in response to their demands. From the visits we undertook we came across one surgery (Cherrymead Surgery in Loudwater) which operated a Dr First system where no advance appointment bookings are taken, and all requests for appointments are handled on the day. Patients are then phoned back within two hours by a GP who assesses whether they need to come in for an appointment or not. We understand that handling all patients in this way is quite unique locally, and the surgery adopted this system as previously there were lengthy waits for appointments (up to 6 weeks), and lengthy waits to get through on the phone. Under this previous system the surgery felt they were not seeing real demand but a filtered backlog of appointments, and the system was very risky as they were not seeing patients in a timely manner. From feedback from this surgery and literature²⁰ on it the case for a system such as this is compelling, as it provides rapid access to a clinical assessment of a patients need, with the potential to reduce surgery visit demand, free up clinical staff time, and drastically reduce appointment non-attendance.
42. The argument against such a system is that it may not suit every practice, and if you fail to reduce the conversion rate of calls into physical appointments at the surgery, you can duplicate the activity and increase GP workload. From our visits we heard that some GPs simply would not like this style of work and considered it either potentially risky to triage over the phone or that it limited the opportunity to make a fuller assessment of a person's health and wellbeing or educate on any health matters. From a patient experience perspective we heard some feedback suggesting some people would not be satisfied with a phone call instead of an appointment in person (as evident from the national survey data in paragraph 40), or who objected to being phoned back to discuss their health at inopportune times such as in the workplace. Feedback we received included:

"They (patients) feel they can no longer book an appointment when they want one – meaning some days in advance. We in the PRG and practice try to make them aware they can have an appointment any day in the future they would like - all they need to do is phone on that day". (Cherrymead PPG/PRG)

¹⁹ July 2014: http://gp-survey-production.s3.amazonaws.com/archive/2014/July/1301375001_Y8W2%20National%20Summary%20Report_FINAL%20v1.pdf

²⁰ <http://www.productiveprimarycare.co.uk/doctor-first.aspx>

“The current process has made me feel like I have to pass a test to qualify for an opportunity to actually see the doctor in person! This system doesn't seem too awful until you receive the call back at the most inappropriate time and find yourself having to discuss your private medical issues in front of colleagues or clients at work, or you miss the call entirely as work commitments have required you to turn your phone off unexpectedly”.

43. Those surgeries not operating the Dr First system relied on their reception staff to filter appointment requests, by allocating appointments according to whether the patient indicated it was urgent/emergency, non-urgent, required a GP or nurse appointment etc. Some surgeries we visited stated they had trialled a GP phone triage system but had decided against adopting it fully. Some were operating similar systems to manage patients who requested an urgent appointment. Each practice varies in the supply of appointment slots they offer, and how far in advance they make these available. Some would only ever open up slots a week ahead, whereas others due to demand would open up slots many weeks in advance.

44. Another source of variation is whether the surgery offers extended hours, which is an enhanced service surgeries can choose to provide, with funding for this from NHS England. Based on the perceived demand in their practices these extended hours can mean appointments being made available outside core hours (8:00am to 6:30pm, Monday to Friday, except Good Friday, Christmas day or bank holidays) in the evening, morning or weekends. Some of the practices we spoke to were providing these, with feedback indicating some were well utilised, whilst others indicated this was not the case. Some patient feedback we received indicated surgeries needed to do more to promote the availability of these, whilst some surgeries we visited were keen to limit access to these to working adults who were deemed to benefit most from them. The LMC cautioned against this as sometimes elderly people reliant on working family members for transport would benefit from them too. Patient feedback we received included:

“We are already fortunate to have access to early morning surgeries at both sites once a week, a late night, and one Saturday surgery every month for pre-booked appointments, in addition to the standard weekday surgeries. Generally all the Saturday appointments are taken which leads us to conclude that it would be useful to have more than one Saturday a month available. It would also be easier if the Saturday surgery could be a regular weekend (e.g. the first weekend of the month) as currently it changes from month to month”. (Surgery PPG)

45. Every surgery we visited assured us that if a patient indicated they had an urgent need for an appointment they would get access to a GP via an appointment at the surgery or over the phone on the day, or at the very latest the next day if this was considered appropriate. This was regardless of what time of day they phoned the practice during core hours (out of hours NHS 111 should be contacted). We were reassured to hear this, and it allayed some of the concerns we had having heard feedback of lengthy waits for appointments.

46. We were also encouraged by the fact that all the surgeries we visited could point to how they would review their demand and capacity and adapt their appointment systems and processes accordingly. Burnham Health Centre was a good example of how changes had been made in response to negative feedback from users, by investing in their administrative systems and capacity, and they were using analysis reports generated by their new IT/tele systems to monitor ongoing effectiveness. Proactive, forward thinking and innovative practice managers with supportive GP Partners were clear factors in how successfully practices were adapting to meet their demands.
47. From our visits we feel there is likely to be a strong link between a surgery having a full and stable workforce, and their ability to offer both timely appointments and a good patient experience of the appointment booking process. Staffing levels is clearly a determinant of the appointment capacity a practice can provide, but having a full and stable clinical workforce also frees up more time for the practice to devote to analysing and adapting their processes to best meet patient demands. Those practices we visited that reported GP and nursing vacancies, also reported long typical waits for non-urgent appointments and reduced ability to step back and take stock of how best to manage their demands.
48. Given the current national recruitment and retention issues (paragraphs 31-35), and that some practices we visited report difficulty even obtaining locums to fill gaps in their GP staff, it is likely that variation in appointment access and experience is only going to become even more variable between practices and seasonally.
49. We have concerns at the potential for lengthy waits for non-urgent appointments to become more and more common, and how promptly this would be identified and remedied. The CQC have advised that they review the published patient experience data and obtain feedback from commissioners and Healthwatch prior to an inspection. If they had concerns during the inspection they would question staff on current appointment waiting times and would include this in their reports if they had concerns. However, the CQC will only inspect practices infrequently, and this would be just a snapshot of performance at that point in time. NHS England only review practices closely if they receive sufficient feedback and complaints triangulated against other data including the national patient experience survey. The national patient experience survey is only published twice a year, and patient responses to it may not reflect recent service levels. The GP contract is quite vague and does not detail appointment waiting time expectations. No data is routinely gathered on actual non-urgent waiting times. There is therefore likely to be a significant time lag in non-urgent waiting times at a practice deteriorating, and this is identified by regulators or commissioners.
50. We are concerned that a lack of contractual requirements for non-urgent appointment waiting times and a lack of timely monitoring of these, puts the onus on individual practices to regulate themselves in this area and/or respond promptly to patient feedback they receive. Given the pressure some practices are under, the need to prioritise urgent appointment requests, and the potential variability in patient feedback levels and quality between practices, this would seem far from ideal.

51. When asked what an acceptable wait for a non-urgent appointment should be the LMC at our first evidence session suggested no more than 2 weeks. We do not think it would be productive to mandate this, as given the current system capacity and demands this would be damaging. However we do think there should be greater visibility of non-urgent waiting time performance, and we feel the local CCGs have a role in this. At our evidence session they informed us that they already compile practice scorecards to facilitate peer review and use these at their locality meetings with practice representatives to monitor performance, share best practice and address performance variation.
52. We understand that most practices in the county use the same appointment administration system, and that this data can be accessed remotely by agencies such as the CCGs. Data gathering from the practices should therefore not be a burden on them. The first step will be to agree a suitable metric to indicate typical non-urgent appointment waits/capacity. Whilst initially this data could support peer review of local practices, it potentially could be published in the future to better inform both Patient Participation Groups and patient choice of practices. Any indicator/s used should be indicative of the patient experience of the surgery, and so reflect the typical wait a patient would face.
53. At our final Evidence Session the monitoring of outcomes was emphasised over numbers (outputs and inputs) and we would concur with this on the whole, but the problem with solely outcome monitoring is there can be a lag in both issue and response identification. A stark contrast (albeit some practices indicated some discretion and flexibility on this choice dependent on perceived need) between an urgent appointment on the day and non-urgent appointment entailing a 3-4 week wait is likely to be self-defeating as will encourage gaming (people saying it is urgent when it isn't) and increased DNAs (Do Not Attends).
54. The intention of the recommendation below is to facilitate a more timely identification of problems and greater readiness and support to consider more radical remedy (such as closer working with other practices, external support, or where applicable the use of Doctor First). We feel this must be driven by the Area Team as the primary commissioner of the service, but suitable benchmarks must be developed in liaison with and with the agreement of local practices. Whilst the benchmark focus should be on patient experience of non-urgent appointment waiting times, it may be worthwhile producing these alongside other capacity benchmarks given their interrelation (for example appointments provided per week per 1000 patients or per clinician).

Recommendation 2: The Area Team should facilitate a suitable set of benchmark indicators which can provide greater awareness of waiting times for non-urgent appointments experienced by patients, and which GP Practices can generate efficiently on a regular basis. This should be used by the Area Team to identify problems much sooner, and support the current peer review activity between GP Practices.

Demand Management

55. A common theme from every practice visit was that managing down patient expectations and demand fuelled by these, as well as the media and Government would make the biggest difference to GPs service delivery. Similarly there was a view that not all the demand for GP time was 'real' or justified, and that the current pressures went beyond that being generated by demographic change. With reference to the previous section on appointment management, only Cherrymead Surgery with their 100% GP triage model could feel confident that all the people attending appointments at the surgery had a real clinical need to be there.
56. On our visits GP practice staff felt that the threshold for seeking GP intervention had reduced over the years and people were often seeking an appointment for a health concern too early. It was felt that young people were more demanding and 'want' to be seen rather than 'need' to be seen in some cases, with the elderly more stoic and prepared to give it a few days or weeks before contacting the practice. It was also felt that the capacity for self-care had reduced and in some cases this was down to a breakdown in the family unit/ support network. A tension was highlighted by some practices that by improving access to GP services you can fuel greater demand, whereas more constrained access can be a limiter on demand, albeit clinically risky.
57. There was a genuine reluctance by a lot of GP staff we spoke with to label some patients as 'time wasters' and some felt there were not 'service abusers' just heavy users. Some staff were more forthright in accepting there was a problem with some service users presenting unnecessarily to a GP and taking capacity away from those more in need of an appointment. One practice we visited informed us there was a patient who had apparently visited the practice over 100 times in a year, but they were fairly relaxed about this and happy to accommodate them.
58. It is widely acknowledged that secondary care services have been successful at reducing demand for their services by passing demand down onto primary care, and this has been encouraged by service commissioners as secondary care is more expensive and payment is activity based (unlike GPs where payment is capitated). With current GP capacity constrained by concerns over the adequacy of funding and staff recruitment and retention problems, there is a need for GP services to better manage their demand, and not simply to struggle in catering for it, potentially at the expense of those patients with genuine need.
59. The level of DNAs is an issue for some surgeries, and we heard from one where they were paying for a text message reminder system to tackle this. This had been effective in reducing the DNA rate by 45% but they were still experiencing 260 per month. We were informed that unlike dentists who can charge for appointment non-attendance, doctors are unable to apply any sanctions. We are aware some surgeries in England do remove patients from their registered list for multiple DNAs, but this would reduce the practice capitated income, and possibly incur extra admin effort if the patient subsequently attempts to re-register.

60. Some of the suggested solutions to avoidable demand from our visits included a greater profile nationally of the 111 service to educate people on how to access the NHS 'front door' and continued promotion of self-care guidance and the role of pharmacies. One surgery in Aylesbury had an initiative involving health educators who play a role in the local community advising and signposting people to the appropriate health services. Denham Surgery had published a booklet for patients on 'Minor Illness' to encourage self-care, and Haddenham and Burnham Surgeries had 'self-care areas' in their reception with measuring equipment (blood pressure, height and weight) and educational material. There was some scepticism as to how far marketing campaigns can go in effecting behaviour change and encouraging the public to use the system appropriately.
61. GPs retain a high level of trust from their patients and have a role in educating their patients on appropriate use of the health systems to educate them on alternatives to GP and hospital care where appropriate. From the practices we spoke to we felt there was an inconsistency in how prepared GPs were to both recognise and tackle inappropriate/unnecessary GP use. At a time when the Royal College of GPs is calling for more resource to be invested in general practice, and there are clear pressures in the system, we feel there is scope for more to be done to better manage demand. No data is collected on the scale of 'unnecessary GP attendance' and there is unlikely to be an agreed definition as to what this comprises, but we do not feel this should be an excuse for inaction.
62. Another issue we were made aware of in some of our practice visits and evidence sessions, are the demands placed on general practice by external agencies, which practices are left to tackle or cater for largely on their own. This included the burden from employers for sick notes, where we understand GPs are not obliged to issue NHS medical certificates for periods of sickness of less than seven days' duration²¹, yet some employers are not according with this and requiring staff to see a GP earlier. In general GPs should not be providing medical certificates for school children as a parent's explanation is generally sufficient for the purpose of the school. We also understand some demand for GP time is generated by benefit agencies too, and the Department for Work and Pensions has issued guidance on what this should entail²². A further additional demand which the LMC acknowledged is generated by Care Homes to fulfil CQC requirements.
63. What we have outlined above are a few areas where we feel there is scope to reduce some of the demand on GP services, which individually practices may either chose to ignore or tackle in various ways. However we feel if there are demands common to all practices there would be merit in exploring the scale of these and how best to manage these demands in a more coordinated and consistent fashion. By perhaps focussing on a single practice as a pilot, thinking on these could become more developed. This could inform the basis of an agreed demand management action plan as part of the Primary Care Strategy covering all local practices, and be either

²¹ <http://www.patient.co.uk/doctor/sickness-certification-in-primary-care>

²² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249923/gp-benefit-guide.pdf

led by the CCG or be a joint exercise at an early stage of their co-commissioning with NHS England.

Recommendation 3: A GP Demand Management Action Plan should be agreed by the CCGs and NHS England Area Team as part of the Primary Care Strategy to facilitate a coordinated and shared approach to reducing avoidable appointments and demands on GP services, as well as promoting greater self-care. This should be delivered either by the local CCGs or as an early co-commissioning project undertaken with the NHS England Area Team.

Land use planning and GP Premises

64. We were concerned over indications NHS engagement in the planning process had been a victim of the restructuring of the NHS in 2013, and the subsequent constrained resources of the NHS England Area Team. Coupled with this is the limited investment in GP premises in recent years which is acknowledged nationally.
65. A general concern emerged from surgery visits over how the capacity and quality of GP practice premises would adapt now in some cases, but in the future for most cases, to rising demands and changing service requirements. There was uncertainty among practices over who is responsible for GP premises investment now, as this was much clearer under the Primary Care Trust where there was a Premises Manager in post.
66. On a number of our visits the GP practices informed us that the practice building was designed for much smaller practice populations than it was currently serving (in one case the disparity was in the order of 4,000 registered patients, in another by 3,000). Our final section (paragraph 82 onwards) looks at the shape of future GP service provision, but practices are going to struggle to adapt to accommodate elements of the future vision, if they have inadequate building capacity.
67. A British Medical Association General Practice Committee has warned that four out of ten GP practices nationally do not have adequate facilities to deliver safe patient care²³ with the Royal College of GPs responding that “over the last ten years the UK has had one of the largest hospital building programmes in the world, but this has not been matched for practice premises”.
68. Premises are typically either owned by the practice partners or leased. Investment in premises is currently largely dependent on NHS England agreeing to increase the notional rent they pay for the premises which can cover the increased rent charged by the landlord or finance the borrowing of the GP partner owners. The limited notional rent pot size locally limits investment in premises properties. The Area Team informed us that there is a minor capital grant scheme for improvements, but

²³ <http://www.rcgp.org.uk/news/2014/july/state-of-gp-practices-another-symptom-of-chronic-lack-of-funding-in-general-practice.aspx>

there is no significant stream of capital available to them so they must assess individual business cases from practices in allocating what limited capital funding they have.

69. Clearly, if there is limited scope to fund investment in practice property, and the NHS England Area Team is overstretched and facing further reductions in capacity, then it is unsurprising there is limited monitoring of premises investment requirements, and forward planning on increasing premises quality and capacity. The ongoing CQC inspections of local practices under their new regime, may tell us more on the current deficiencies in local practice premises. At our final evidence session the Area Team confirmed the most recent stocktake of premises was undertaken by the Primary Care Trust which was dissolved in 2013, so is likely to be at least two years old by now.
70. A lack of up to date understanding of practice capacity requirements and plans for this, will impact on the potential to capture developer contributions via the planning process and contribute meaningfully to strategic land use planning. At our final evidence session the Area Team informed us it was variable as to whether they were made aware of planning applications, and there was a view that the NHS were overlooked during strategic planning discussions.
71. The NHS is not a statutory consultee for planning applications as laid out in national planning practice guidance²⁴. Nationally the Community Infrastructure Levy (CIL) has replaced S106 as the primary mechanism for securing developer contributions for most off-site infrastructure improvements. A CIL has been adopted in Wycombe district and as part of this they publish an R123 list for what contributions will be spent on. Their latest list agreed in April 2014 includes no NHS infrastructure²⁵.
72. In contrast to the varying NHS structures at a county and regional level, the individual GP practices and Local Medical Committee provide some continuity and organisational memory of planning contributions and local infrastructure need. It is therefore important that they are kept up to date on NHS interaction with planning matters locally.
73. Overall we consider there is a need for greater clarity locally for NHS providers, commissioners and local planning departments on who the NHS contacts are for planning matters, what circumstances they should be contacted, and what the process is for sharing intelligence on planning proposals between the Area Team, CCG, LMC and individual practices. Fundamentally the local NHS commissioners need to review whether they have the processes and supporting data in place to be able to take advantage of developed funding when the opportunity presents itself.

²⁴ <http://planningguidance.planningportal.gov.uk/blog/guidance/consultation-and-pre-decision-matters/table-2-statutory-consultees-on-applications-for-planning-permission-and-heritage-applications/>

²⁵ <http://www.wycombe.gov.uk/council-services/planning-and-buildings/planning-policy/community-infrastructure-levy/spending.aspx>

Recommendation 4: The NHS England Area Team, in liaison with local CCGs and the Local Medical Committee, should clarify roles, responsibilities and contacts for NHS engagement on land use planning matters, and how information will be shared between themselves and with local practices. The Area Team should review whether they have the processes and data in place to secure developer contributions for general practice investment.

74. There is potential with the development of co-commissioning between the CCGs and NHS England, and in the CCG development of their strengthened community and primary care strategic plans (working with the Health and Wellbeing Board), for this to give greater certainty over funding for new and/or enhanced primary and community care services. This could give the confidence to GPs and/or their landlords to invest in their properties. Nationally the health regulator Monitor has acknowledged issues with the lack of incentives for GP premises investment²⁶ and NHS England has accepted investment in primary care facilities has lagged behind resulting in inadequate practice buildings and facilities. NHS England have committed to publish a new framework on decisions regarding GP premises reimbursement, and work with Government on the current reimbursement system (notional rent) to promote value for money and innovation²⁷.

75. Whilst there is some facilitation required nationally for property investment, the indications are that it is for local commissioners (the Area Team and CCGs) to take a lead on addressing this issue. As such we recommend that following the publication of the Primary Care Strategy, and the future shape of service delivery it outlines, the Area Team should agree with the local CCGs a plan for how the necessary investment in primary care premises will be encouraged, supported and delivered over the next five years.

Recommendation 5: Following the publication of the Primary Care Strategy, the NHS England Area Team should agree with the local CCGs a plan for how the necessary investment in primary care premises will be encouraged, supported and delivered over the next five years.

Patient Participation Groups

76. Patient Participation Groups (PPGs) are not an entirely new concept (the National Association for Patient Participation reports that the first group was set up by a GP in 1972), and a number of practices in the county have had some form of patient or friends group for many years. To strengthen and encourage these initiatives in all GP practices nationally a Patient Participation Directed Enhanced Service (DES) was agreed in April 2011 to continue for two years until April 2013. PPGs were to

²⁶ Pages 12-13:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/288429/GPDiscussionDocFinal_0.pdf

²⁷ Para 92-99: <http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf>

“promote the proactive engagement of patients through the use of effective Patient Reference Groups and to seek views from practice patients through the use of a local patient survey”²⁸. The terms of payment required the practice to establish the necessary feedback and engagement structures, collate and publish views via a patient survey, agree actions and publish outcomes from this. For 2014/15 the General Medical Services Contract extends the PPG scheme for a further year, but with the requirement to conduct a local survey removed due to the introduction of the Friends and Family Test²⁹.

77. Locally, given that some PPGs have been established for many years whilst some have only been set up relatively recently, as well as the lack of specificity on what a PPG should look like in the DES terms, there is variation in how developed PPGs are, how they operate and the roles they perform. Some have physical meetings, while some operate entirely virtually and also use online forums and blogs. Some perform an additional fund raising role, whilst others have members which volunteer to assist with admin and promotion tasks at the practice.
78. On our visits we heard many positive comments about the practice PPGs such as that they had good skills within the group, were constructive and proactive, and that they were of real value and performed a critical friend role. Many practices could point to improvements that had been implemented such as with administrative processes or the physical environment due to feedback received from their PPG.
79. The impression we received was that practices struggled to attract PPG membership which was reasonably representative of their practice population. Some confirmed that young people and working age adults were members but on the whole it seemed it was mostly elderly age groups that were involved. Some practices also informed us it was difficult to engage ethnic minority and other hard to reach groups. In some cases the size and representativeness of the PPG affected the enthusiasm the practice staff had for the initiative. Some also felt it was a box ticking exercise to have a PPG, and that existing patient feedback mechanisms such as complaints and GP feedback direct from patients reduced the need for a PPG. Having put effort into establishing a PPG initially, some practices doubted whether further effort to engage more people would be productive, and others were not sure if their PPG would continue once funding or a requirement for it ceased. Some practices were under such pressure delivering care for patients, they were sceptical on their ability to act on feedback so questioned the benefit in gathering it.
80. We are satisfied that the form and function of PPGs will vary, and practices should have the freedom to shape their PPG as they see fit. However, we are concerned that PPGs in some practices may be left to wither without support to such an extent that they become completely ineffective and cease to become an attractive route for patient engagement and communications in future. We consider PPGs to be a

²⁸ <http://bma.org.uk/practical-support-at-work/contracts/independent-contractors/patient-participation-des>

²⁹

<http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/Enhancedservices201415.aspx>

worthwhile facility to give patients more say on shaping their local services, and addressing (sometime very minor) issues that would not be picked up in a timely manner by commissioners or regulators. They also offer potential for a dialogue on service changes likely to be crucial in the next few years, and a means to educate people on NHS services and self-care.

81. Some national guidance and support for PPGs does exist (www.napp.or.uk) and at our evidence session we heard that the CCGs were offering to form a network to help PPGs to develop, which could also contribute to their own commissioning activity engagement. The risk is that it will be only the well developed and motivated PPGs that take advantage of these opportunities. Healthwatch Bucks potentially could play a role in working with the CCG on supporting and developing PPGs, as it is within their remit to support patient feedback and engagement on healthcare. Through the CCG locality meetings and scorecard initiative facilitating peer review, the CCGs have a means to identify those practices with less developed or effective PPGs, which the Area Team processing payments according the DES criteria would be less aware of. A support package could then be agreed, led by Healthwatch Bucks, which would seek to ensure all GP practices have an effective PPG function, whilst accepting the form of individual PPGs may vary.

Recommendation 6: Healthwatch Bucks in liaison with the CCGs should lead on the identification of less developed PPGs and the formulation of a support package for them which should be publicised on the Healthwatch Bucks website.

Practices prepared for the future

82. There is an acceptance nationally that the model of GP practice delivery has been largely unchanged in the past 50 years and there is now a need for change. NHS England's *Improving General Practice a Call to Action Phase 1 report*³⁰ (March 2014) details the reasons for this which include; Demographic change, the need to secure better outcomes, financial constraints, impacts on other parts of the system/secondary care, and workforce supply. In order to meet the ambitions laid out against this background NHS England believes general practice will need to operate at greater scale and in greater collaboration with other providers and professionals. This will not necessarily require changes in organisation form and merges but through practices working in partnership through networking and federations. More evidence on the case for this change and the benefits of networks/federations is outlined in the Kings Fund and Nuffield Trust Report on *Securing the Future of General Practice*³¹ (2013).
83. In the last 20 years GP service provision has had to change given the demands it has faced. There is evidence of more patients being seen by nurses rather than GPs

³⁰ <http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf>

³¹ http://www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice_full_report_0.pdf

(in 1995 21% of consultations were undertaken by nurses, by 2008 this was 34% although increased recording on computers of nurse appointments could be a factor in this), and with more consultations conducted over the telephone and fewer home visits (in 1995 3% of consultations were on the telephone and 9% were home visits, by 2008 12% were on the telephone and 4% home visits)³². Practices we visited were using various grades of nurse and Healthcare Care Assistants within the practice to cater for some of the demands traditionally met either by GPs or secondary care.

84. The adaptations above and with GP appointment management have been within individual practices, with each finding their own solution to the varying demands and constraints experienced. The changes now called for rely on practices working much closer with each other, which traditionally has not be very common, given their status as independent businesses, and other practices seen to varying degrees as competitors. From our visits to GP practices we did not sense a readiness for practices to work more closely with other practices, and some were sceptical over the benefits of working in networks or federations.
85. The establishment of CCGs has served to bring practices closer together on the commissioning of secondary care, and there are signs locally of CCGs facilitating practices working more closely together in primary care provision. This is illustrated by the over 75's fund set up by Aylesbury Vale CCG which invites business cases from groups of practices, outlining how together they can better care for this age group outside of hospital.
86. At our October 2014 Committee meeting, we had an item on the Milton Keynes and Bedford Healthcare review where reference was made to that fact that in Milton Keynes GP practices share the same computer system and share patient records so that residents can attend any GP practice in the city. In contrast, in Buckinghamshire there are some surgeries sharing the same building but operating as entirely separate practices with no information sharing and separate reception desks. We are concerned that changes to GP service delivery in Buckinghamshire may not adapt at the scale and pace required in the next few years, and that practices may only explore radical change to how they deliver their services when they reach crisis point, most likely from a failure to recruit sufficient staff to meet demand. At this point the practices will have the least capacity to explore innovation and opportunities.
87. The NHS five year forward view¹⁷ published 23 October 2014 only commits to stabilising GP funding in the next two years, and indicates significant change is required: "The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and co-ordinated health services patients need" (p16). Any new money for GP services looks likely to come from CCGs, subject to their involvement in co-commissioning with the Area Team, by releasing money from secondary care to invest in primary and community care to reduce secondary care demand, but this will not be to cover current GP activity.

³² <http://www.hscic.gov.uk/catalogue/PUB01077/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf>

88. The five year forward plan steers General Practice to evolve and become “extended group practices to form – either as federations, networks or single organisations. These Multispecialty Community Providers would become the focal point for a far wider range of care needed by their registered patients” (p19). If practices do not move at the scale and pace required there is the potential for NHS acute and community trusts to step in given the report states “we will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community services’ (p20)³³.
89. There is a national push for change in GP service delivery, and we see potential reluctance among local GP practices to move at the required scale and pace being called for, or a lack of capacity in practices to explore radical change. We therefore think it is vital that the primary care strategy outlines in more detail what future GP service delivery should look like in five years’ time, and how GP practices will be supported to embrace this change. We suggest either as part of the strategy or as a supplement to it, that it goes as far as outlining what a future model of service delivery appropriate in this location in Buckinghamshire could look like, and what alternative models there could be. This would help facilitate discussions between practices and engage the public on this at an early stage.

Recommendation 7: The Primary Care Strategy should outline what the future of GP service delivery in Buckinghamshire should look like in five years’ time, and how individual GP practices will be supported to deliver this.

90. We are concerned that there is currently an imbalance between the capacity of GP service (as outlined in paragraphs 28-36) and the demand on them (paragraphs 22-27). Given the current staffing recruitment and retention issues (paragraphs 31-35) this situation will not be resolved quickly or easily regardless of funding levels in the short term. This will impact on workforce pressures, service levels and appointment access, and we have received evidence during this inquiry suggesting this is already being experienced. The national steer is for GPs to work closer in partnership with each other and other agencies with co-commissioning between NHS England and the CCGs a facilitator for this. If this is the case it is vital that the proposed co-commissioning giving local CCGs greater involvement in supporting and reshaping GP service provision is adequately resourced, with CCGs receiving additional funding to cover the additional activity required of them to perform this role effectively. The latest update³⁴ on co-commissioning from NHS England gives no indication that funding will follow the additional activity expected of CCGs. This will both limit the CCG appetite for the additional workload, and the resource they put into to performing this well.

³³ <http://www.theinformationdaily.com/2014/10/28/does-the-5-year-forward-view-mean-the-end-of-general-practice>

³⁴ <http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf>

Recommendation 8: NHS England acknowledge our concerns over the imbalance in local GP service capacity and demands, and commit to additional funding for CCGs undertaking co-commissioning of GP services with the Area Teams so this additional CCG activity is adequately resourced.

Conclusion

91. The inquiry has aimed to understand variation in patient experience of GP services. We feel we have achieved this and notable factors include practice staffing, local demography, premises, and appointment management systems. A key variable which should not be ignored is the GP partners and their adaptability and appetite for change and innovation, which will also link to the calibre of Practice Manager they are willing to attract, pay for, and work with. We fully accept one size does not fit all, and there should be variation in the methods of service delivery, but this should not result in markedly different patient experience of the service. We have tried to go beyond merely explaining patient experience variation and causes, but recommend how some of this could be addressed.
92. From conducting this inquiry we feel that the 2013 NHS restructure which replaced the Primary Care Trust has resulted in a loss of more local support and oversight of GP practices. The level of support previously offered to local practices is illustrated by guides such as productive primary care³⁵, and we feel this is lacking now, with the Area Team insufficiently resourced and too remote to perform this same level of oversight and support. Within this context the current encouragement for co-commissioning can be seen as an attempt to remedy some of the existing deficiencies, but this will only happen if it is adequately resourced and sufficiently mindful of Conflict of Interest concerns.
93. It is clear to us that GP service provision is about to enter a period of substantial change. On this basis alone we feel justified in having conducted this HASC inquiry so we now have a much better understanding of the service and the issues it faces, and are better equipped to scrutinise its evolution. We hope some of the recommendations we have made around demand management and PPGs will encourage early patient engagement on the need for change and proposals for this.
94. This inquiry has been difficult given so many of the issues GPs feel they face relate to matters that can seemingly only be addressed at a national level (GP funding, contract, workforce supply, premises investment), and the independent contractor model of GP service provision. The latter makes it difficult to recommend wholesale changes given the multiple providers, and the need to respect the fact that individual providers must be free to meet their demands flexibly as they see fit.

³⁵ http://www.productiveprimarycare.co.uk/Data/Sites/1/dh_accessguide.pdf

Appendices

Appendix 1: Inquiry Scope

This scope was agreed by the inquiry group following their meeting on 25th July 2014.

Member-ship	Shade Adoh, Brian Adams, Margaret Aston, Noel Brown, Tony Green, Lin Hazell, Wendy Matthews, Roger Reed (chairman), Jean Teesdale.
Lead Scrutiny Officer	James Povey
Lead / Service officer	Matthew Tait (NHS England Thames Valley Area Team Director)
Back-ground (key facts on why this issue should be reviewed)	<p>A. The most recent GP Patient Satisfaction (2013) scores indicated significant variation between surgeries in the county. This included satisfaction with the practice overall, opening hours, overall experience of getting an appointment, phone access, ability to see preferred doctor, ability to see doctor fairly quickly, with GP Out of Hours (OOH) services and awareness of how to contact the OOH service.</p> <p>B. There has been concerns raised by the committee members on the variation in the services provided by GP surgeries and the ease of getting an appointment.</p> <p>C. Concerns raised nationally, disputed in some quarters, over the links between GP service provision and increasing pressures on A&E services.</p> <p>D. A Primary Care strategy is currently being produced by the CCGs at the request of the NHS England Thames Valley Area Team (who commission GP services).</p> <p>E. GP provision is an area the committee have not looked into in any detail in recent years.</p>
Purpose of the inquiry	To enhance the committee understanding on GP service provision, explore the variation in local GP service provision and experience and identify any actions and improvements that should be included in the Primary care Strategy being developed.
Anticipated outcomes	<ol style="list-style-type: none"> 1. Understand the nature of local GP provision, how it is commissioned, monitored and controlled. 2. Understand the variation in local GP service provision. 3. Identify how patient experience of GP services could be enhanced

	and/or made more consistent.
Key questions / tasks for the review	<ol style="list-style-type: none"> 1. How is local GP provision organised and commissioned? 2. How does GP service provision vary in the county, and what are the reasons for this? (is variation real or perceived, and are there legitimate reasons for this?). 3. What are the impacts and implications of varying GP service provision? 4. What does 'good' GP service provision look like? 5. What is being done and what could be done to provide a more consistent level of GP service user experience?
Out of scope	<ul style="list-style-type: none"> • The budget for GP services. There is debate nationally on the adequacy of the current level of GP funding, and this is determined by NHS England nationally. Royal College of GPs is calling for GPs to receive an increased proportion of NHS spend to fund extra GPs. • GP contracts. Again this is a national debate, and may be beyond our influence. • Issues / questions the primary care strategy already answers /aims to answer (this includes the acceptability of the actual number and location of GP surgeries).
Key background papers and data	<ul style="list-style-type: none"> • GP Patient Survey data (most recent data was published July 2014). http://gp-patient.co.uk/ • Improving General Practice: A call to action phase 1 report (NHS England, March 2014). http://www.england.nhs.uk/2014/03/11/cta-emerging-findings/ • NHS Choices. http://www.nhs.uk/Pages/HomePage.aspx • Improving the Quality of Care in General Practice (Kings Fund, 2011) http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice • Commissioning and Funding General Practice: making the case for family networks (Kings Fund, 2014). http://www.kingsfund.org.uk/publications/commissioning-and-funding-general-practice
Key stakeholders	<ul style="list-style-type: none"> • Local NHS (CCGs and NHS England Area Team) • Local GPs and practice staff

	<ul style="list-style-type: none"> • Local service users /patient participation groups • Healthwatch • Local Medical Committee • Care Quality Commission 	
Timetable	August 25 Aug – 10 Oct Mid Oct Late Oct Early Nov 14 th Nov 25 th Nov	Research and background information Evidence gathering Agree recommendations and draft report Inquiry group agree draft report Draft report to NHS for comment Deadline for final report, papers for next HASC HASC agree report and submit to NHS for response
Reporting mechanism	It is expected the report recommendations will be aimed at the NHS England Thames Valley Area Team for response, but the report will also be sent to the Aylesbury Vale and Chiltern CCGs. BCC Cabinet will be made aware of the inquiry, and may request to receive the final report. The report will also be sent to the Health and Wellbeing Board for their information.	

Evidence Programme

The following is an initial overview of what evidence we are seeking to collect and how.

w/c 28th July	Call for evidence - Public - Patient Participation Groups	Press release promoting the review and asking for public comments on their experience of GP service provision locally. Targeted communication to Patient Participation Groups asking for their input on a number of questions, particularly around probing further into areas of variable patient experience.
w/c 25th August	Fact finding and information session (non-public meeting)	Aim for a session with input / attendance from: NHS England Area Team, CCG, CQC, Healthwatch, Local Medical Committee, GPs (likely to be some known by the members such as Rachael Pope)

		from South Bucks).
Throughout September	GP engagement & surgery visits	2-3 members at a time with scrutiny officer on pre-arranged visits to GP surgeries to discuss variable GP service provision, demands, issues etc with GPs and other practice staff.
w/c 6 October	Public Evidence Session (formal meeting in public and probably web cast)	Reflecting on evidence collected to date, questions to be put to local NHS commissioners (Area Team, CCG). Possibly also to experts in the field to find out more on best practice / innovation.

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Appendix 3: The Crisis in General Practice - Briefing paper for Berkshire, Buckinghamshire & Oxfordshire Local Medical Committee Meeting with David Cameron on 28.11.14

The Problem

General Practice has a Human Resources Crisis.

- a. Morale is poor and continuing to drop
- b. Workload pressures are at or beyond saturation levels and are now dangerous and inefficient. Most GP Principals / Partners and the majority of salaried GPs are working 12 to 14 hour days and 60 hour plus weeks (pro-rate for a Full Time Equivalent). The long hours and intensity and complexity of the work with very limited rest or reflection time places huge physical, psychological and intellectual demands on GPs. Such long and intense hours are not tolerated safety critical working environments in other industries or even elsewhere in healthcare.
- c. The working environment is increasingly pressurized, demanding and unforgiving of human factors. The inexorable workload, shrinking resources, bureaucracy, and media negativity create an increasingly pressurised and negative working environment.
- d. General Practice is not attracting adequate numbers of new recruits. Recruitment to Vocational Training Schemes for GPs has dropped and is 500 short of target in 2014.
- e. General Practice is not retaining newly qualified GPs (especially women). General Practice is an increasingly female workforce but we are particularly failing to retain female GPs: 70 to 80% of the recently qualified GP workforce are female and 40 % of female GPs under 40 leave General Practice
- f. Newly qualified GPs are avoiding GP Principal and Partnership posts, because they are not sufficiently confident in the medium to long term future of General Practice. They therefore opt for short term and limited workload contractual options. This means locum, freelance and salaried work rather than the enhanced commitment and greater workload, responsibility and perceived financial and contractual risks of Partnership or Senior Leadership roles.
- g. The most experienced and efficient Senior GPs are increasingly leaving early. The attainment of the maximum level on limited pension pots tips the balance in favour of retirement. If GPs retire to secure their pension entitlement they can choose to continue working post retirement but almost invariably significantly limit their clinical workload and drop their leadership and management workload. <http://pracmanhealth.com/2014/08/15/80-of-gp-practices-have-one-or-more-gps-suffering-from-burnout/>
- h. GPs of all ages are emigrating. We are losing an increasing percentage of younger GPs and even experienced 40-50 year olds to emigration. Factors quoted by emigrants include more security in their target countries about the importance and role of General Practice, greater opportunity to innovate, less bureaucracy, less intrusive regulation, better work life balance, less political and media negativity about General Practice.
- i. Practices cannot recruit, so younger GP partners increasingly fear that as more senior colleagues leave they are left to become the "last GP standing" with increasing stress, contractual obligations and financial risks from a forced transition to an expensive sessional doctor workforce, estate obligations and redundancy obligations. Many younger GPs therefore seek an exit route
- j. Artificially inflated sessional GP costs contrast to declining Partner incomes. There is a mismatch between inflated costs for sessional GPs driven by scarcity of supply contrasting to the supply shortage of GP Partners and their declining incomes. Partners additional responsibilities, risk, management and administrative workload is undervalued and inadequately rewarded when compared to sessional roles. GPs can be better financially rewarded, feel less stressed and have a better work/life balance as sessional GPs than as Principals / Partners. However service

models based on salaried or sessional GP have considerably lower productivity, poorer patient satisfaction scores and higher overall resource use across the NHS compared to GP Principal / Partner based services. Ref

- k. The rhetoric of the political and NHS leadership that they value and support General Practice is not matched by their actions. GPs do not see clear evidence of political recognition or support for General Practice itself. GPs perceive the NHS system as almost completely secondary care focused: as evidenced by levels of funding, political attentiveness, media interest and Senior NHS Leadership attention and effort.
- l. GPs recognize GP Commissioning is secondary care focused. CCGs and General Practitioners involvement in commissioning is primarily an attempt to address secondary care challenges and is clearly recognized by GPs as having little if anything to offer in improving General Practice itself.
- m. The CCG agenda is centrally controlled and there is little or no scope for local innovation. CCGs are increasingly controlled by the NHS Centre and local CCG leadership is becoming disillusioned as they recognize the increasing constraints and restricted room to innovate and respond to local population needs

What do GPs do?

- n. General Practitioners deliver three major streams of clinical services,
 - a. **an acute clinical workload**
(meeting their populations emergency and urgent care needs).
The overwhelming majority of urgent and emergency care contacts in the NHS are managed by, or through, General Practice.
 - b. **a heavy chronic disease management workload**
(e.g. the vast majority of Diabetes, Cardiovascular, Respiratory, Mental Health etc)
 - c. **a preventative medicine / public health workload**
(providing immunisations, vaccinations, alcohol, drug, tobacco, weight, exercise and lifestyle campaigns and individual interventions)
- o. Long Term condition workload is inexorably and rapidly increasing in:
 - a. volume (numbers affected),
 - b. complexity (multiple co-morbidities, and increasingly complex and involved interventions),
 - c. severity (aging population and increasing frailty with complex secondary, primary and social care needs) and
 - d. extent (patients living with their diseases and conditions for very prolonged periods of time).

GPs manage long term conditions that a decade ago would have required Hospital Specialists based in hospital outpatients. General Practice must continue to develop its capacity to deliver the steady flow of increasingly complex care transferring from secondary care.

- p. Demand is driven by both patients NEEDS and patients WANTS. General Practice has to balance the Wants of articulate and visible sections of the population with the Needs of often hidden less articulate or less visible sections of the community, the 40 year old demanding an assessment of their 2 day cough before they go on holiday versus the identification and care of socially isolated elderly patients with multiple long term conditions. GPs can see the ethical, financial and professional imperatives of targeting their limited time and resources to delivering evidence-based care to those patients where their interventions have the greatest proven impact.

Why is General Practice important?

- q. General Practice is the workhorse of the NHS and workload is rocketing. General Practice delivers over 90% of healthcare professional contacts in the NHS and the workload has grown in volume. General Practice had 240 Million consultations in 2004 and 340 Million in 2013. This compares to 40million consultations in Accident and Emergency Departments in 2013.
- r. General Practice is essential for meeting the health needs of an ageing UK. GPs deliver the vast bulk of Chronic Disease Management and this will grow rapidly and inexorably. GPs understand this reality completely, as they are the front line clinicians dealing with this every working day
- s. Management of risk: GPs are the “Risk Sink” of the NHS. Healthcare is a very complex, interrelated pathway requiring coordination of all sectors and any such system has an unavoidable element of risk. The current NHS system is fundamentally predicated on General Practitioners acting as the gatekeepers, patient navigators and patient advocates and supporters within the system. Therefore GPs are the major “Risk Sink” of the system as a whole and the main instrument for mitigating risk at the level of both the individual patient and the system as a whole. GPs recognize their huge contribution as the “risk sink” of the NHS but increasingly are forming the opinion that political and NHS leadership may not appreciate the importance of this contribution to the system as a whole. A demoralized, under-resourced, overworked and unappreciated GP workforce will inevitably start to question the rationale of holding these risks as individual professionals. If GPs start to operate with even a small decrease in their threshold for holding and managing risk then the knock on workload and resource requirements within the NHS will be very significant
- t. Using professionals other than GPs to deliver care outside hospital (because they are cheaper and more numerous) might seem attractive, but their across the board diagnostic skills and ability to manage risk are not at the same level as GPs. The result will be a system that is actually more costly

Why is General Practice underfunded?

- u. General Practice is severely underfunded. Funding has lagged behind workload: between 2004 and 2013 General Practice had a 10% increase in funding, but its share of the total NHS Budget dropped from 10% in 2004 to 7.6% of NHS funding in 2013. During the same period hospital funding has increased by 46%.
- v. CCGs do not have the resources or flexibility to place significant additional resources into General Practice. They face complex “conflict of interest” challenges, they do not control or influence most of the resources areas that need to be changed
- w. NHSE Area teams are distracted by yet another reorganization and series of mergers / consolidation at their level, with a related increasing shortage of key technical expertise and corporate and local knowledge, a distraction from what should be their key deliverables as they become internally focused during this reorganization.

- x. NHSE Area Teams have very limited, and increasingly constrained authority or flexibility to address local priorities or innovate at a local level. They merely implement central NHSE policy but that policy is untested, unchallenged and lacking in vital detail or sufficient technical input. There are examples where it is distant from the reality of frontline delivery and not fit for purpose. Decision making is increasingly centralized, delayed and “one size fits all”

The NHS does not have a clear and communicated strategy for General Practice

- y. The NHS Centrally and at Area Team level (possibly distracted by reorganizations and secondary care issues) for a number of years has failed to devote attention and strategic direction to General Practice and has failed to see or respond to, the onrushing crisis.
- z. NHSE and NHS Employers are finally starting to wake up to the crisis in General Practice but there is no clear strategy on how to address these multiple problems currently contributing to the implosion of the UK general practice system, the “jewel in the crown of the NHS”

The Failure of the NHS to commit Strategic Energy and Resources to General Practice.

- aa. GPs look at the current direction of travel and recognize the dangers. GPs are intelligent enough to recognize the glaring mismatch between the need for resource in General Practice and the reality of investment and resources that lags glaringly behind those needs. GPs therefore question the logic of remaining in an under-resourced and neglected branch of medicine.
- bb. Frontline GPs are increasingly concerned that the reorganizations of the NHS over the last 4 years have, and continue, to contribute to Senior NHS Leaderships delayed recognition of the severity of the General Practice Crisis and its impact, failure to develop a strategy to address these issues and failure to hold the confidence of front line GPs

The NHS continues to fail to promote and support innovation and develop leadership.

- cc. The NHS is innovation averse. Innovation is hamstrung by an increasingly bureaucratic and risk averse management, financial, contractual and regulatory framework where a clinician's best insurance is to be the same as everyone else and not to be different. There is almost no availability of significant investment, or liberty to reallocate resource, to try new ways to deliver care. There is a punitive regime to penalize, or sometimes even punish, failure, but no balancing willingness or methodology to recognize and reward successful innovation. A system that has such inbuilt barriers to innovation will inevitably stagnate.
- dd. How is the NHS developing the GP leaders of the future? The NHS lacks any comprehensive system to identify, support and develop a talent pool of current and future innovators and leaders. The age and gender profile of CCG leadership at Board and Clinical Lead level is at odds with the profile of the profession as a whole and most Senior CCG leaders and Boards are within 5 years of retirement.

General Practice needs resources that more closely match its workload and demands.

- ee. General Practice resources have steadily declined in real terms. The inexorable increase in

workload in General Practice has not been matched by a corresponding increase in resources and therefore we have seen a year on year drop in the purchasing power of the sums paid to surgeries.

- ff. The current funding structure for General Practice does not adequately support the scale and diversity of multidisciplinary teams required to adequately address the work now expected on an average patient.
- gg. Since 2004 hospital funding has increase by 46% over the same period general practice has received a 10% increase. Activity in that period has increased from 240 million consultations per year to 340 million per year. Compare this to 40 million consultations per year in accident & emergency
- hh. For each patient (6 face to face consultations on average, plus additional clinical test, telephone, mail and third party communication workload), a practice receives about £105 per annum
- ii. For one first hospital outpatient visit a hospital is paid between £150-£220 for a first face to face appointment and £90 for each follow up attendance. There are additional payments for clinical administrative workload
- jj. The split in commissioning following on from the HSCA means no organisation is in a position to solve this funding problem.

Bureaucracy and contractual mechanisms hamper General Practice

- kk. Bureaucracy is overwhelming GPs and managers. □GPs are managed, monitored and regulated by a multitude of organisations (as both individual clinical professionals and as General Practice provider organizations). This management, monitoring and regulatory regime creates a significant administrative workload, that too often is poorly coordinated and sometimes conflicting between the various organizations, obscures responsibilities and authorities and can distract from clinical priorities.
- ll. GPs are subject to annual stressful change in their contract, something that no commercial business or other group of NHS workers experiences to the same extent. There is usually a significant delay in the notification of these altered contractual requirements (delays of three months after the start of the contractual year are frequent) and with delivery attainment targets set for the end of the contractual year this requires actual delivery several months before then to ensure adequate time for clinical readings to change sufficiently to demonstrate attainment of the clinical outcomes.
- mm. GPs continue delivering front line care while completely reorganising many of the practice working processes. Planning for such change is severely handicapped by the fact that final specifications and related funding, is often not available until several months into the financial year.

nn. GP morale is being sapped by constant media and political comments, blaming GPs for overprescribing antibiotics, diagnosing cancer too late, or contributing to stresses on A+E.

GP Commissioning and Co-Commissioning will not solve these problems

oo. GP involvement in GP Commissioning will not solve the problems of General Practice. GP led commissioning is primarily about addressing problems in the secondary care area, where over 80% of NHS funding flows.

pp. Co-Commissioning is in its infancy, has very limited evidence that it will deliver the hoped for benefits and is again primarily about addressing secondary care issues (partly by seeking alternative provision of patient care outside secondary care). It is not designed or appropriate for delivering the fundamental additional resources that General Practice requires.

qq. Limited positive developments in some areas must not lead to a false reassurance. The overall trend in front line General Practice as described above is overwhelmingly of deep concern.

GPs recognize they must cooperate and confederate but in “coalitions of the willing”

rr. What is big enough but not too big? General Practice needs to work at a scale sufficient to achieve an adequate skill mix and efficiency of resource use. There is very strong evidence however that General Practices can become too big: become less efficient (as the clinicians start to lose continuity familiarity with a manageable size of patient population who have developed a relationship of trust and confidence in their clinical team and over rely on incomplete data systems), less responsive to the individual needs of their patients as they become constrained by corporate systems, are less popular with patients (seen as too distant, corporate and unresponsive and lacking in continuity of care and clear developed relationships of trust and confidence between patients and clinicians)

What are the risks of this current crisis?

ss. Because the job is so unattractive, GPs are retiring from the profession early or emigrating and training places are left unfilled. For a detailed report see <http://pracmanhealth.com/2014/08/15/80-of-gp-practices-have-one-or-more-gps-suffering-from-burnout/>

tt. 4 practices have closed in the BBOLMC area in the last 18 months and more are predicted (eg Bicester)
See also:
<http://www.publications.parliament.uk/pa/cm201415/cmhansrd/cm140909/text/140909w0001.htm>

uu. If one practice falls over, then pressure mounts on neighbouring practices, the domino effect takes hold, and suddenly there are no practices to provide a primary care service.

vv. The public will only realise what it has lost when a service run by local GPs has gone, and turning the clock back is then not possible.

- ww. Big organisations providing primary care might seem attractive to commissioners, but local and national experience is that they perform to contract and no more. □Procurement is not well done in the NHS so initial contracts often have big gaps which can only be sorted later by more money.
- xx. Historically, GPs have provided a very flexible workforce and most have worked to “deliver today’s work today”. □As patient access reports indicate, the current demand to resources mismatch makes this increasingly impossible.

General Practice Estate

- yy. GP Premises are a problem.
For several decades, there has been inadequate investment in GP premises, despite a proven increase in population and increasing requirements in general practice. Most practices have no space for GPs to take on the increasing amounts of hospital activity that the government wants to transfer into the community.

Seven Day Working (12/7)

- zz. Seven day working in the provision of services outside hospital is a laudable aim provided it does not push individual GPs to work unsafely or harm their own health.
- aaa. The main objectives of 12/7 are:
- a. expansion in the hours of availability of general practice for practice patients
 - b. Support of 7 day working by hospitals: enhanced GP services in the evenings and weekend will support hospital admission and discharge of patients
 - c. Improved speed of access for patients to GPs (this will only happen if additional GP resource is made available rather than spreading the current 5 day resource more thinly to cover 7 days).
- bbb. 12/7 GP working will require matching 12/7 support services such as radiology, laboratory and professions allied to medicine as well as community nursing and radiology.
- ccc. However it is not deliverable in the foreseeable future as GPs can barely cope with the current demand over 5 days. There are not enough additional GPs available to staff a 12 /7 service without spreading the service and human resource much more thinly across the 7 days. This will create additional pressures on team working, communication, staff development and training, GP morale and GP recruitment, development, refreshment and retention. The provision of expanded access will inevitably increase overall demand and will this be an evidence based use of taxpayers funding?
- ddd. The NHS “out of hours” system is manned by GPs for almost 2/3 of the week and with some additional support could provide enhanced services over 7 days. However OOH services have been starved of resources by CCGs and their predecessor organisations.
- eee. Boosting funding in this part of the NHS would be a much cheaper and more appropriate change.

How can we solve the crises in General Practice?

fff. Research and data gathering on the current GP workforce crisis.

ggg. Development of a clear long term strategy for General Practice to incorporate education training, contractual Options, Workforce development and refreshment, regulation and estate.

hhh. The solutions will require coordinated and substantial improvements to

- a. The General Practice resource envelope
- b. The education and training of General Practitioners
- c. Addressing the GP recruitment and retention challenge in General Practice, especially in the female workforce
- d. A more flexible contractual format that minimizes bureaucracy and encourages and rewards quality and innovation
- e. A longer term and adequately notified period for clinical service specifications in General Practice
- f. A progressive Estate strategy to deliver the premises required for delivery of the new General Practice and Primary Care services.
- g. Inviting and rewarding innovation and improvement
- h. Limiting the negative impact of bureaucracy and over-regulation
- i. Develop a talent identification and development programme to grow a cadre of GP leaders and innovators

Background Information and Comment

Most GPs are working 12-13 hour days at the surgery, then to keep up with the paperwork remotely accessing their computers later at night or going back into the surgery at weekends to catch up.

According to National Audit Office in the past 6 years GP consultations have increased from 300 million per year to 340 million.

For delivering care for each patient and also funding all organisational overheads, a practice receives a global sum per annum of approximately £70 per patient. This is supplemented by a variable amount for QOF and Enhanced Services and other extras, which may bring in a max of £35. The total per patient then amounts to £105 per annum (or £9 per month) for all services, less than the cost of medical insurance for a domestic pet . Yet many perceive GPs as being overpaid and underworked such is the influence of some in the media . What a GP is paid for each patient for a year compares badly with a first hospital appointment which is priced at between £150 and £220, with follow ups at around £95

Statistics on primary care are given below

- As a % of NHS spend, GP services accounted for 10% in 2005/5 and 8% in 2012/13
- The figure for GPs as a % of the NHS (FTE) work force have dropped from 34% in 1995 to 26% in 2011
- The National Audit Office has reported that £180 million was actually removed from General Practice last year NHS funding may have been protected but General Practice and Primary Care funding have not

Government claims that it has protected NHS budgets, but it never publicises actual NHS spend which takes account of the funding that is regularly returned to the Treasury. □Graph 2 in the letter to the Independent

illustrates this. □Actual spend on the NHS has been dropping for many years

See <http://www.independent.co.uk/life-style/health-and-families/health-news/the-nhs-timebomb-nhs-and-social-care-services-are-at-breaking-point-it-cannot-go-on-9775928.html>

The average take home pay of a GP (derived from government sources) was given to your constituency office on 13.10.14. □Details can be found at <http://www.hscic.gov.uk/catalogue/PUB14924> but the key facts are given below.

The average income before tax in the UK in 2012-13 for:

- combined GPs (contractor and salaried) was £92,900 for those GPs working in either a GMS or PMS (GPMS) practice compared to £94,200 in 2011-12, a decrease of 1.4 per cent which is statistically significant;
- contractor GPs was £102,000 for those GPs working under either a GMS or PMS (GPMS) contract compared to £103,000 in 2011-12, a decrease of 0.9 per cent which is statistically significant;
- salaried GPs was £56,400 for those GPs working in either a GMS or PMS (GPMS) practice compared to £56,800 in 2011-12, a decrease of 0.6 per cent which is not statistically significant.

According to Centre for Workforce Planning, 40% of female GPs are walking out the profession by the age 40.

Big organisations providing primary care might seem attractive to commissioners, but my experience is that they perform to contract and no more. □Procurement is not well done in the NHS so initial contracts often have big gaps which can only be sorted later by more money.

Continuity of care is valued by patients and also reduces costs both in primary care and use of secondary care. Alternative models (large companies employing a salaried workforce) are often bad at delivering this.