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“Primary health care offers the best way of coping with the ills of life in the 21st century: the globalization of unhealthy lifestyles, rapid unplanned urbanization, and the ageing of populations.”
Margaret Chan, Director-General, World Health Organization, 2008

The role of GPs and of general practice is evolving across the UK. In another 10 years, the core aspects of the work that GPs do will endure but there will be a range of significant differences.

A vision is needed of how general practice can be a driving force in delivering the changes needed to provide better patient care and improved population health in the face of growing social and economic pressures. Such a vision is provided by the Royal College of General Practitioners’ (RCGP’s) publication *The 2022 GP: a vision for general practice in the future NHS,* and accompanying action plan. At the heart of the vision is the call for more GPs, with longer training, spending more time with their patients. At the same time, it sets out how GPs will need to lead redesign of the delivery of health care, to improve continuity and integration of care and enable as much care as possible to be provided out of hospital.

This compendium of evidence supports *The 2022 GP vision,* drawing on an extensive body of national and international information and research. It discusses the challenges faced by all health services in delivering high-quality, accessible and fair health care in the twenty-first century and how these challenges impact on general practice in particular. It also provides evidence for the value of investing in primary care, now and in the future and how, with this investment, the GP of the future will be able to adapt to meet patients’ needs and, at the same time, retain what works.
Governments across the world are trying to address the increasing demand for health care against diminishing resources and rising real-term costs.

The challenges faced by all health services include:

- an increase in the number of patients with long-term conditions and multimorbidity, and ageing populations
- fragmented care
- delivering integrated care
- the challenge of addressing health inequalities and the greater need for disease prevention
- the challenge of engaging patients in their own care
- financial constraints

Next, we look at these challenges in more detail.

Long-term conditions, multimorbidity and ageing populations

Mary is an 86-year old widow, living alone in her own home, where she has lived since she married 60 years ago. Mary has a number of problems. She is partially sighted due to macular degeneration. She has chronic back pain from osteoporosis and has hypothyroidism. She has poor mobility – partly due to her pain and poor eyesight but, increasingly, because she is fearful of moving around in case she falls – something she has done on a number of occasions. Mary is on many medications and attends a day centre for the blind once a week. She has two hours of home-help per day, mainly to help her prepare her meals. She is thinking of moving into a care home as she feels unsure whether she can cope with another cold winter alone. However, this means selling her house to fund the care home.

If there is a typical user of the NHS, it is likely to be a patient like Mary: elderly, suffering from many long-term conditions, on multiple medications and requiring monitoring and coordination from a number of health, housing and social care agencies. The success of our health and social care system is manifested in our longevity – living longer with more illnesses and disabilities. By 2025, the number of people in England with at least one long-term condition will have risen by 3 million to 18 million. The picture elsewhere in the United Kingdom (UK) is similar. In Northern Ireland, the prevalence of hypertension, coronary heart disease, stroke and diabetes is predicted to rise by 30% between 2007 and 2020. In Wales in 2003/2004, one-third of adults (an estimated 800,000 people) reported having at least one chronic condition, and in Scotland in 2007 there were 2 million people living with long-term conditions.

Though patients with long-term conditions account for around 29% of the population, they make up 50% of all GP appointments, 64% of all outpatient appointments and 70% of all inpatient bed-days, as well as 70% of the total health and social care spend in England. That means 30% of the population accounts for 70% of spending.
Alongside long-term conditions, the prevalence and complexity of disease increases with age. The number of those aged over 80 years is expected to double between 2010 and 2030. Older patients aged over 80 years consult more frequently – between 12 and 14 times a year in 2008/2009, compared with between 6 and 7 times in 1995. It is estimated that by 2025 there will be 42% more people in England aged 65 years or over than currently; and between 2010 and 2035 the number of people of pensionable age is projected to increase by 26% in Scotland. The number of people aged 65 years or over will rise by 55% in Wales. In England, people aged over 65 years account for 46% of spending in acute care, 37% in primary care, 60% in social care, 60% of all admissions and 70% of bed-days in hospital. An increasing group among our ageing population is that defined as ‘frail’, characterised by poor functional reserve, weight loss, muscle weakness, slow walking speed and fragility. This group of people are high users of health and social care, in particular with problems associated with falls, immobility, delirium or incontinence.

While the total number of people with one or more long-term condition is expected to remain stable over the next 10 years, the number with two or more long-term conditions is projected to increase, from 5 million today in England to about 6.5 million. Those with multimorbidity are also the people who are most expensive to treat – on average, someone with three or more long-term conditions costs £8000 a year, compared to £3000 a year for someone with one long-term condition (see Figure 1).

Multimorbidity is not simply a problem of chronological ageing, or randomly distributed in the population. For example, the Scottish School of Primary Care has shown that people living in more deprived areas develop multimorbidity 10–15 years earlier than those in more affluent areas. A recent analysis of nearly 200,000 patients registered with over 300 GP practices in Scotland has shown that multimorbidity is the norm for people with chronic disease and, although its prevalence increases with age, more than half of all people with multimorbidity are younger than 65 years.

The most socioeconomically deprived young and middle-aged people have substantially more multimorbidity than do their most affluent peers. Moreover, a greater mix of mental and physical health problems is seen as deprivation increases. This illustrates the need for holistic person-centred care, taking into account social as well as physical factors.

Figure 1: Multimorbidity

Multimorbidity is rapidly becoming the norm among people with long-term disease, especially in deprived populations

Multimorbidity means more people are sicker for longer and present more complex problems to their GPs and primary care teams
**Fragmented care**

Fragmentation means having multiple decision-makers make health decisions for an individual, where a unified approach would be better. It can also be defined as a lack of continuity of care.

Fragmentation of care is perhaps the biggest pressure facing every modern health service and is at the root of rising costs, poor quality of care and rising health inequalities (see Figure 2).

**Figure 2: Fragmented care**

Fragmentation results in providers caring for parts of a patient’s health rather than the whole person. Fragmentation is at the root of rising costs, poor quality of care and rising health inequalities.

There are many causes of fragmentation, which vary across the world depending on the funding mechanisms and organisation of health care. In the NHS, multiple competing providers, the emphasis on choice, short-term contracts, reimbursement and payment systems, direct access to specialist services, and the narrowing focus of treatment services all result in multiple providers caring for parts of a patient’s health rather than the whole patient. This fuels fragmentation.\(^\text{16}\)

At service level, fragmentation manifests itself as lack of coordination, duplication of services and increased costs, owing to multiple contacts with health services. For example, a patient with chronic airways disease may receive medical care from GPs, hospital doctors and therapists (e.g. a physiotherapist). They may get their oxygen from another provider, their medicines delivered by another and their rehabilitation service from another. Since a patient with chronic lung disease is likely to have another long-term health problem, they are also likely to have another set of services, with another multiple set of providers. Commercial sensitivities will make it unlikely that different providers will share information with each other, and short-term contracts inhibit the formation of trusting relationships between providers and with providers and patients.

At general practice level, fragmentation results in the loss of continuity of care, something that is a vital component of generalist care. The evidence shows that continuity of care — especially for those who are older, have long-term disease or have multimorbidity — improves health outcomes and reduces the need for hospital care. Patients at the end of their life are more often enabled to die in the place of their choice (often their own home), when continuity is provided.\(^\text{17}\)

Continuity of care is highly valued by patients and is a key process through which therapeutic relationships are built and maintained over time. It is an essential prerequisite for effective generalist care.

In general practice, ‘generalism’ makes little sense without continuity of care.

There is significant evidence that many of the strengths attributable to primary care (in terms of health outcomes and use of resources) depend on an effective and long-term therapeutic relationship with a freely chosen primary care doctor. Together with communication skills, continuity of care is one of the most important tools of general practice.\(^\text{18,19}\)
Continuity of care is important both clinically and financially and plays a major role in reducing hospital admission, as well as improving quality of care (see Figure 3). A study examining the impact of continuity found that a 1% increase in the proportion of patients able to see a particular doctor was associated with a reduction of 7.6 elective admissions per year in the average-sized practice for 2006–2007 and 3.1 elective admissions for 2007–2008. This equates to considerable cost savings across a whole practice of £20,000 per year for a 1% increase in continuity, and a saving of £2641 per hospital admission.\(^2^0\)

The trend towards larger general practices and public demand for access has led to a decline of personal care by GPs. This loss of continuity, such that a patient no longer sees ‘my doctor or my nurse’, is one of the most important victims of the modern health service. The pressure to offer increased access, loss of personalised GP lists, the multiplicity of providers and skill mix, the increased workload and overstretched workforce, and healthcare professionals working less than full time all contribute to this loss of continuity of care.

Figure 3: Continuity of care

The opening of general practice boundaries in England, due to be implemented in the near future, will mean that patients can register with any GP irrespective of their place of residence, breaking the bond between the GP, their patient and their local community. This policy initiative will also widen health inequalities if patients who are able to travel further afield switch their registration away from GPs in deprived areas, draining resources away from the areas that most need them.\(^2^1\)

Continuity of care leads to:
- better health outcomes
- more satisfied patients
- better cost control
- more personalised decisions on appropriate care
- more effective care outside hospital
- earlier diagnosis\(^2^2\)
- better targeting of expensive interventions to those most likely to benefit
The challenges of twenty-first-century health care

- limited use of interventions that have a significant harm rate
- better acceptance of self-limiting illness
- better medicine usage and adherence
- uptake of screening programmes and of immunisations
- cost savings in investigation, prescribing, hospital referral, admissions, use of accident and emergency departments and the overall cost of health care.

Continuity does not mean a continuous need for regular face-to-face consultations – quite the contrary. A trusting relationship with a GP facilitates the use of non-face-to-face mechanisms of contact, such as email, text messages and telephone, as the GP and the patient are more readily able to make decisions remotely. New approaches to care, such as telephone, email, text messages and social media work best as an adjunct to face-to-face care, rather than as a replacement for the traditional model of face-to-face contact with ‘my GP’.

Consider the case of Peter, for example:

Peter is a 35-year old man with schizophrenia. His mental health is currently stable and he is living with his parents. The family has been registered with their local practice for 30 years; Peter is well known to the practice and a trusting relationship has been built up between him and his GP, over the course of his life. He maintains contact with his GP via text message or email and appointments are arranged as and when they are needed, with an annual face-to-face review carried out by the practice nurse.

The current GP workforce is spread across a number of different access points and access to a GP has moved outside the traditional community-based surgery. GPs are now delivering care to registered and unregistered patients with acute, routine and urgent problems, in supermarkets, pharmacies, hospital outpatient departments, accident and emergency departments, walk-in clinics, Darzi centres and gyms, to name but a few. Delivering care in sites patients attend is important but makes continuity of care more challenging.
Delivering integrated care

Leading on from the problems of delivering continuity, is the challenge of providing integrated care. The growth in the prevalence of long-term conditions and multimorbidity means that the NHS’s success in integrating care will play an increasingly important role in shaping the future trajectory of healthcare expenditure. The largest potential cost gains lie with those patients with multimorbidity. Integrated care is especially relevant in an environment in which finances are constrained and the number of people with multimorbidities and long-term conditions is rising. A central feature of integrated care is partnership working between patients, carers and the teams of professionals around them, in which patients are encouraged to be active participants in their care and provided with the information and support to do so.

Integrated care can be described as a fuzzy or ‘wicked’ issue, with nearly 40 definitions and models, and the simple concept of joint working, within and across different professional groups, is at risk of being drowned in complexity, affecting its promise to deliver utopian care. The Nuffield Trust uses the term integrated care as an umbrella term, encompassing diverse initiatives that seek to address fragmentation but that differ in underlying scope and values. Integration is a continuation of health policy that began with multidisciplinary working in the 1960s, followed by shared planning and coordinated working in the 1980s, disease management in the 1990s and patient-centred care in the 2000s (see Table 1).

Table 1: Trends in integration initiatives

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Integrated care has several meanings and in this context could be considered to be similar in shared care, intermediate care, disease management (UK) and managed care (United States of America – USA), also referred to as continuous care, comprehensive care, transmural care or transition care.
The challenges of twenty-first-century health care

There is no one ‘right’ model of integration. Different approaches will be appropriate, depending, for example, on patient needs, geographical factors and organisational characteristics. For example, integration can refer to:

- integration of care across different conditions, treating the whole person in a joined-up way, not just focusing on a specific disease
- integration of care over time (also described as continuity of care)
- integration between the working practices of different professional groups
- integration between the services provided by different providers
- integration of the way care is accessed (e.g. through co-location of services under one roof)
- integration in the way healthcare needs are identified and commissioned.

The RCGP’s preferred definition of integration describes the approach general practice should take in leading the integration of care. This can be summarized as ‘patient centred, primary care led shared working, with multiprofessional teams, where each profession retains their autonomy but works across professional boundaries, ideally with a shared electronic GP record’. This definition emphasises the importance of joint working that goes beyond the simple exchange of letters and includes, wherever possible, face-to-face contact between the different parts of the multidisciplinary team.

Whatever term is used, the future will involve much greater team working, with generalist-led multidisciplinary teams providing shared care and using advanced skills networks for acute care, children, mental health problems, chronic and complex medical conditions, frail elderly and palliative care services. The multidisciplinary teams will use approaches, such as care coordination, shared care and joint working, to reduce fragmentation of care, combining this type of working with improved ways of identifying high-risk patients and the use of digital health to allow for closer monitoring of patients in their own home.

The prerequisites of integrated care include:

- continuity of care, which is an essential component of achieving high-quality care
- cooperation between different parts of the health and social care system
- coherence and common vision for the patient at the centre of the service
- communication and information exchange
- collaboration that goes beyond the simple exchange of letters coordination at different levels of the system (strategic, management and clinical levels).

The Deep End study in Scotland b identified the following criteria for integrated care, as illustrated in Box 1.29

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b The Deep End study (GPs at the Deep End) identified 100 general practices that served the most severely deprived populations in Scotland and examined differences between these practices and others in less deprived areas.
Box 1: Deep End summary on integrated care

Integrated Care

This report and recommendations draw on research evidence, previous Deep End reports and discussion groups at the second national Deep End conference at Erskine on 15 May 2012.

- To avoid widening inequalities in health, the NHS must be at its best where it is needed most.
- The arrangements and resources for integrated care should reflect the epidemiology of multimorbidity in Scotland, including its earlier onset in deprived areas.
- Better integrated care for patients with multiple morbidity and complex social problems can prevent or postpone emergencies, improve health and prolong independent living.
- Polices to provide more integrated care must address the inverse care law, whereby general practitioners serving very deprived areas have insufficient time to address patients’ problems.
- Patients should be supported to become more knowledgeable and confident in living with their conditions and in making use of available resources, for routine and emergency care.
- The key delivery mechanism for integrated care is the serial encounter, mostly with a small team whom patients know and trust, but also involving other professions, services and resources as needs dictate.
- The intrinsic features of general practice in the NHS, which make practices the natural hubs of local health systems, include patient contact, population coverage, continuity of care, long term relationships, cumulative shared knowledge, flexibility, sustainability and trust.
- Health and social care professionals working in area-based organisations (e.g. mental health, addiction and social work services) should be attached to practices, or groups of practices, on a named basis.
- Practices should be supported to make more use of community assets for health via a new lay link worker role.
- The quality and timeliness of hospital discharge information should be a consultant responsibility and audited as a key component of the quality of hospital care.
- Practices needed protected time to share experience, views and activities, to connect more effectively with other professions, services and community organisations, to develop a collective approach and to be represented effectively.
- Collective working between general practices is best achieved with groups of 5/6 practices, as shown by the Primary Care Collaborative and Links Project. Larger groupings are less likely to achieve common purpose.
- Locality planning arrangements should be based on representation (not consultation), mutual respect and shared responsibility.
“General Practitioners at the Deep End” work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners, the Scottish Government Health Department, and the Department of General Practice and Primary Care at the University of Glasgow.

Reproduced with permission General Practitioners at the Deep End. What can NHS Scotland do to prevent and reduce health inequalities? Proposals from general practitioners at the Deep End.

Full report available at www.gla.ac.uk/media/media_238713_en.pdf

Integration will require redesign of services around the needs of the patient, and development of care pathways for patients that can deliver real benefits. The Royal College of Physicians, RCGP and Royal College of Paediatrics and Child Health joint paper, Teams without walls, set out a vision for a health system in which clinicians would work together in ways that transcend the traditional boundaries between primary and secondary care. The three colleges called for an aspiration to create an NHS that puts the patient at the centre of everything we do – involved, empowered and enabled to achieve the very best outcomes for their health.

Under this model:

- services would be designed around patient pathways, with the right balance between prevention, early identification, assessment and long-term support
- generalists and specialists would work together in new ways as part of multiprofessional teams, establishing clinical networks
- the emphasis would be on keeping patients out of hospital and managing outpatient care and minor complications in the community but teams would also have the skills to enable them to support patients during hospital admissions if required.

Integration and continuity of care are especially important when caring for the frail elderly – minimising the risk of creating gaps in care, medication errors and a breakdown of communication between carers.

Developing integrated services will require services to be redesigned, and while the redesign of care pathways can deliver real benefits, there is a danger that, if limited to a disease-specific focus, this approach will create new silos and will fail to deliver integrated care for those with multimorbidity. Consider for example:

Mr Jones, a 78-year-old widower with diabetes, hypertension, prostate cancer, depression, incontinence of urine, poor eyesight and limited mobility, is currently on 12 different tablets per day. These are administered through a dosette box, delivered weekly by the local pharmacist. He is ‘under’ the care of four hospital specialists and two community nursing teams. He attends a local authority day centre once a week, requiring an ambulance to transport him back and forth. His daughter lives 100 miles away.
Patients like Mr Jones frequently receive care from multiple sets of providers and decision-making concerning their treatment is often complicated by the potential for interaction between conditions. This is why it is vital that the leadership of service redesign, care pathways and integrated care is undertaken by GPs, trained to take a population health perspective on care, with time to consult with key stakeholders and to deliver and lead the services.

The RCGP federation of practices model builds on the single practice model, and promotes practices working together, bound by a legal framework to deliver care to a larger population of patients. The size of registered populations would vary depending on local factors. Motivations for joining a federation would be to enhance capacity to develop new services out of hospital, to facilitate better joint working relationships among GPs within a given area, and to enhance joint working across different practices. In time, practice federations could act as the provider arm of local communities and work together to provide extended primary care services as well as community nursing services and GPs with extended clinical roles.

Factors that help to create the environment for sustaining federations include:

- shared vision, values and objectives among GP members
- strong GP leadership
- strong clinical engagement/commitment
- dedicated executives to manage the organisation
- strong communications within the organisation.

Providing continuity and developing integrated services requires time and stability of services – time to build up and sustain relationships between the different health and social care players and time to fully involve the patient. Constant reorganisation makes it difficult to make and sustain the relationships necessary to develop the trust between different practitioners required to make integrated care a reality.

The challenge of addressing health inequalities and the greater need for disease prevention

The aetiology of important twenty-first-century health problems, such as obesity, child health, mental health and comorbidity, are highly complex and are increasing in numbers, putting a greater burden on health services. There is a continuing challenge of non-communicable diseases such as cardiovascular disease, cancer and liver disease, alongside the new lifestyle-related challenges of obesity, alcohol dependence and type 2 diabetes.

Many of the problems associated with patient access, quality of care, and fragmentation of care are disproportionately found in areas of high deprivation, the so-called ‘inverse care law’. These areas manifest themselves in having patients with high levels of physical and mental illness (commencing at a younger age than in more affluent areas), more multimorbidities and greater problems with being able to self-care.

The Inverse care law is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served. Proposed by Julian Tudor Hart in 1971, the term has since been widely adopted. The law states that: ‘The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced’.
For example, if everyone in England had the same death rates as the most socially advantaged:

- people dying prematurely would enjoy 1.3–2.5 million extra years of life
- people dying prematurely would be more likely to be living disability free by retirement age, adding 2.8 million extra years free of limiting illness and disability
- every year, the economy would save £31–33 billion in productivity losses, £20–32 billion in lost taxes and in welfare payments, and more than £5.5 billion per year in healthcare costs.\textsuperscript{35,36}

Health inequalities in the UK are getting worse.\textsuperscript{37}

As described in the Marmot Review, health inequalities arise from a complex interaction of factors including housing, income, education, social isolation and disability.\textsuperscript{38} Marmot described the social determinants of ill health in his World Health Organization (WHO) report: poverty, exploitation, oppression and injustice.\textsuperscript{38} It is these determinants that result in health inequalities and many of the new (and not so new) health problems we see today. However, as Marmot said, ’Simply telling people to behave more responsibly is no more likely to be effective than telling someone with depression to pull his socks up . . . smoking, obesity and heavy drinking are causes of ill-health, but what are the causes of these behaviours?’.\textsuperscript{39} The difference in the determinants of ill health results in the variation of life expectancy that we see across London and across most other major cities in the UK. People with less money and less education are likely to have less control over their lives and their health behaviour.\textsuperscript{40} For example, in Scotland in 2009/2010, the rate of alcohol-related discharges from acute hospitals was 7.5 times higher for patients living in the most deprived areas than for those in the least deprived areas.\textsuperscript{41}

The multifaceted causes of health inequalities mean that an integrated approach between different bodies and agencies at both national and local level is vital. As well as helping individuals who already receive services, this must involve proactively identifying those most at risk, so that their health needs can be met at an earlier stage and they can be supported to achieve better health outcomes.

Over the years, reviews from various think-tanks and independent commissions on general practice have not paid sufficient attention to the pressures on the GP and their team – pressures that derive from increasing complexity, increasing workload and demand and a constant movement of care into community settings without simultaneous movement of staff, resources and expertise. Many do not take note of the inverse care law,\textsuperscript{34} not just in patients’ health but also in the mismatch of resources in deprived areas, which places additional barriers to delivering high-quality care to patients. Without understanding and then redressing these pressures, it will not be possible for the GP of the future to deliver the care they have been trained to provide, let alone to advance their profession to meet changing requirements.

The inverse care law\textsuperscript{34} has a powerful effect on the ability of a GP to offer adequate time to patients and continuity of care. Patients with complex problems are more common in areas of high deprivation, where patients often receive shorter consultations compared with more affluent areas, despite greater need and more multimorbidity.
The maps in Figure 4 show how the areas in England where life expectancy is lowest for men (red, map 1) – concentrated in London, the Midlands, Yorkshire, the North West and the North East – broadly match the areas with fewer GPs per head (red, map 2). The picture is the same for women. Mid Devon, for example, has over twice as many GPs per head of weighted population as Oldham. The current GP system has actually led to a larger inequality in the distribution of GPs across the country over the past two decades, even as the overall number of GPs has increased.42

**Figure 4: Life expectancy map of England, 2002–2004**

Map 1
Male life expectancy at birth by local authority area, 2002–04

Map 2
GPs per 100,000 weighted population, by PCT


Source: Information Centre – Workforce Census 2006


The Deep End study29 found that, on independent health measures, there is a steep social gradient with a greater than 2.5 fold variation across deciles of the Scottish population from the most affluent to the most deprived. On average, the most deprived 10% of the Scottish population has 70% more deaths of male and female individuals aged under 70 years than the most affluent 10%.43 The total number of full-time-equivalent (FTE) GPs is weighted towards the more affluent areas, with 11% more GPs in the most affluent half of the population than in the most deprived half.44
Consequent to this mismatch of need and resource, consultations in general practices serving very deprived areas are characterised by:

- multimorbidity and social complexity
- shortage of time
- less patient enablement, especially of patients with mental health problems
- practitioner stress.

Providing continuity of care and integrating services around the patient can have a role in tackling health inequalities. Preliminary evidence in Glasgow suggested that targeted longer consultations for patients with complex needs in deprived areas led to greater patient enablement. In the long term, the greatest impact of the NHS on health inequalities should be by way of funding – with more resources directed towards the areas of greatest healthcare need.

GPs provide care to the neediest groups and are crucial to tackling health inequalities. One of the objectives of The NHS Plan, and subsequent initiatives, was to increase the number of GPs in deprived areas. However, in 2008, 65% of primary care trusts in spearhead areas still had lower levels of GP coverage than the national average of 60 GPs per 100,000 population, when weighted for age and need.

**The challenge of engaging patients in their own care**

**Shared decision-making**

Shared decision-making between doctors and their patients is important.

Shared decision-making is a process in which patients, when they reach a decision crossroads in their health care, can review the treatment options available to them. With current clinical information, relevant to their particular condition, patients will be helped to work through any questions they may have, explore the options available, and take a treatment route that best suits their needs and expectations.

The benefits of shared decision-making include better consultations, clearer risk communication, improved health literacy, more appropriate decisions, fewer unwanted treatments, healthier lifestyles, improved confidence and self-efficacy, safer care, greater compliance with ethical standards, reduced costs and better health outcomes.

Shared decision-making is also important for commissioners because it can reduce unwarranted variation in clinical practice.

There is good evidence that patients want to be more involved in making decisions about their health and health care. The most recent national patient survey suggests that one in three patients in primary care, as well as one in two patients in hospital, would have liked greater involvement in care decisions. Patients who are active participants in managing their health and health care have better outcomes than patients who are passive recipients of care. However, although most clinicians claim that they involve patients in decisions, evidence suggests otherwise.
There is also a great deal of evidence on what works best in the care of people with long-term conditions. The Wagner Chronic Care Model (see Figure 5),\textsuperscript{50,51} for example, shows that the best outcomes are achieved when three components of care are integrated: a prepared proactive practice team, an informed engagement by patients in their own care, and partnership working between healthcare professionals and patients with long-term conditions.

**Figure 5: The Wagner Chronic Care Model**

![Diagram of the Wagner Chronic Care Model](image)


Processes that facilitate shared decision-making in general practice include care planning and the use of patient decision aids.
Care planning

Care planning is a means of supporting patients to understand and confidently manage their own condition, as well as supporting them to manage the inevitable consequences of living with a long-term condition – consequences for the way they live their lives (roles and responsibilities) and the way they think and feel about themselves and their relationships. It involves preparation of a care plan and coordinating care across a range of health, social care and other professionals, to ensure the provision of support and services to address the patient’s needs. In 2011, the RCGP produced guidance for GPs on care planning for people with long-term conditions.52

GPs are very well placed to share decisions about care plans with their patients and coordinate their care, along with other members of the primary care team – in fact, the more complex the patient, the more important it is that the care is coordinated around their medical home.

Patient decision aids

A patient decision aid is an evidence-based tool designed to facilitate the process of arriving at an informed, evidence- and value-based choice among two or more healthcare alternatives (including ‘watchful waiting’). A patient decision aid systematically guides patients through their decision-making process, by clarifying their knowledge, values, decision certainty and roles, using a series of questions. It presents the risks and benefits of each treatment option, using best clinical evidence, in a simple and accurate manner that can generally be understood by most patients (e.g. numbers, pictures). Patient decision aids may be pamphlets, videos or web-based tools that describe the options available and help patients to understand these options as well as the possible benefits and harms. In 55 trials addressing 23 different screening or treatment decisions, use of patient decision aids led to: greater knowledge, more accurate risk perceptions, greater comfort with decisions, greater participation in decision-making, fewer people remaining undecided about treatments and fewer patients choosing major surgery.53

The key message is that both doctors and patients need to do better. Effective shared decision-making is not yet the norm and many patients want more information and involvement in decisions about their treatment, care or support than they currently experience. Embedding shared decision-making into systems, processes, and workforce attitudes, skills and behaviours will be a considerable challenge for both GPs and their patients.

Implementing these innovations, however, will require more GPs to spend longer with their patients, with enhanced training in care planning and the use of patient decision aids. Cost–benefit analysis shows that this would pay dividends. The likely savings in national tariff costs if rates were reduced by a conservative figure of 10% as a result of using decision aids have been calculated for the most common elective surgical procedures and renal dialysis. The Cochrane review of decision aids53 suggests that reductions in the use of elective surgical procedures of somewhere in the region of 20–25% are possible, but since many of the studies have been carried out in North America where surgical rates are higher, a more conservative assumption of a 10% reduction is preferred. There is evidence that the effective deployment of shared decision-making tools will lead to savings of (at a conservative estimate) £100 million per annum. In addition to these direct savings, indirect savings are also anticipated. As patient involvement in clinical decision-making increases, the potential for those individuals to better understand the risks and benefits of procedures is increased, which may lead to a reduction in personal litigation against the NHS.
Financial constraints

Governments across the world need to address the increasing demand for health care against diminishing resources and real-term rising costs. In the NHS in England, as part of the 2010 Spending Review settlement, there is a requirement to make year-on-year efficiency gains of 4% up until 2015, equating to some £20 billion (euphemistically referred to as ‘the Nicholson Challenge’). However, all four countries and devolved administrations face similar financial pressures.

The pressure on general practice is especially concerning, as expenditure on primary care has lagged behind that for secondary care. Since 2003–2004 in England, spending on general practice has increased at a slower pace than spending on acute hospital care (65.8% and 76.4% respectively; see Figure 6). The majority of the increase in spending on primary care occurred between 2003–2004 and 2005–2006 (47.4%), while between 2006/2007 and 2010/2011, it was 10.2% and over the last two years, only 1.3%. Spending on acute services increased by 24.3% between 2003/2004 and 2005/2006, and by 41.9% between 2006/2007 and 2010/2011, with expenditure rising by 5.1% over the last two years.54

Figure 6: Primary and secondary healthcare costs commissioned by primary care trusts, 2003–2011


Note 1: Primary care total is for GP services commissioned by PCTs only; this includes GMS, PMS, APMS, PCTMS costs and non-GMS services from GPs. It excludes prescribing costs, pharmaceutical, dental and ophthalmic services and ‘other’ costs.

2. Secondary care total is for maternity, general and acute and accident and emergency service costs commissioned by PCTs only. It excludes learning difficulties, mental illness, community health services and ‘other’ costs.

APMS = alternative provider medical services; GMS = general medical services; PCT = primary care trust; PCTMS = primary care trust medical services; PMS = personal medical services.
The increasing complexity of health care and growing fiscal constraints are placing new demands on GPs. These demands are concentrated more in deprived communities, widening the inverse care law, and placing pressures on GPs’ ability to deliver health care to their increasingly complex and diverse patients. The biggest challenges facing general practice are how to meet demand for care against an overstretched workforce and how to balance access versus continuity.

Box 2 presents some of the specific pressures faced by general practice that – if not addressed – will impede the ability of the profession to adapt itself to meet the challenges of twenty-first-century health care.

**Box 2: The challenges for general practice**

- How to continue to deliver high-quality care and accessible services
- How to improve coordination and collaboration and reduce fragmentation of care
- How to deliver the workforce to sustain primary care services, now and in the future
- How to address health inequalities and focus care on those who are most in need
- How to improve the use of information and technology to improve care for patients
- How to address variability of care
- How to involve patients in decisions about their health
- How to lead relevant research and development

**Increasing and changing workload**

The role of the GP has changed beyond recognition over the last few decades – and is expected to encompass a wide range of clinical, academic, leadership, commissioning and managerial functions, all learnt within three years of specialist training. GPs are expected to participate in planning services for their local population and to lead service development. Not infrequently, patients present with multiple problems and the GP must master the management of patients taking multiple medications – without the benefit of clinical guidelines that encompass multiple, rather than single, diseases. While the number of home visits might have decreased, the general practice consultation rate has almost doubled in the last decade (from around three to nearly six times per year), with the elderly consulting between 12 and 14 times per year. Providing telephone access has added to, rather than reduced, the GP workload, with telephone clinics or triage clinics often reaching 30–50 contacts per surgery (see Figure 7).
The range of activities provided in general practice has increased considerably – with GPs undertaking many activities that were hitherto the domain of the hospital specialist. Procedures previously carried out in secondary care, such as anticoagulation monitoring, are routinely undertaken in general practice. GPs are leading the management of patients with substance misuse, as well as the homeless, and over 85% of all care of patients with chronic mental health problems is undertaken in primary care. Over the years, GPs have absorbed this work, directly as part of their day-to-day work, and by increasing the skill mix in their surgeries or taking on new roles such as GPs with a special clinical interest (GPwSIs) – rapidly adapting to changing needs and continuously expanding what would be seen as ‘normal’ general practice services. This is now unsustainable.
When asked in an RCGP snapshot of GP opinion in July 2012, the vast majority (81%) of those responding felt that the complexity of their caseload had increased in recent months. This complexity was predominantly associated with complex patients with multiple conditions. For example:

“... more complex cases requiring detailed management are being booked in for 10 minute slots which obviously does not work. Seldom is the time when patients come with problems that can be dealt with in 10 minutes.”

“... each consultation seems to be three or four consultations in one with multiple presentations ‘while I’m here’ and very complex interrelated problems.”

The ageing population, increase in mental illness and demographic change in the UK was highlighted as a main contributor to complexity. The open-ended responses received highlighted the elderly and mentally frail as contributing to the complexity of consultations:

“There are increasing numbers of very elderly patients with complex chronic diseases to juggle.”

“There has been an enormous increase in workload, particularly with the increasing complex elderly with long-term conditions and increase in caring for patients at [the] end of life at home.”

The fact that GPs are working harder is most clearly borne out by the increased number of patient consultations provided. Between 1995 and 2008, the number of patient consultations rose by 75%, from 171 million to more than 300 million. GP consultations rose by 11% and nurse consultations rose by nearly 150%. For the average patient, the number of consultations per year rose from 3.9 in 1995 to 5.5 in 2008, with the biggest increases taking place amongst those aged over 70 years (see Figure 8). If the pattern of consultations remains unchanged, by 2035 there could be a total of 433 million GP consultations in England, of which 180 million would be for people aged 65 years and over, nearly double the current number.84
Figure 8: Change in the average number of primary care consultations per patient per year, 2000–2008


In their 2011 national survey of GP opinion across the UK, the British Medical Association (BMA) identified that of those respondents who had been working in general practice for the last five years, the vast majority (88.1%; 16,163 of 18,348) reported that the intensity of their in-hours workload had increased in the last five years. Just 9.6% of respondents (1753 of 18,348) reported that the intensity of their in-hours workload had stayed the same and 2.4% of respondents (432 of 18,348) said that their in-hours workload had decreased (see Table 2).56
The challenges for general practice

Table 2: Responses to the question: ‘In the last five years has the intensity of your in-hours workload decreased, increased or stayed the same?’, percentage by main current status

<table>
<thead>
<tr>
<th>Status</th>
<th>Decreased, % (n)</th>
<th>Stayed the same, % (n)</th>
<th>Increased, % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP contractor/principal</td>
<td>1.0 (144)</td>
<td>6.8 (975)</td>
<td>92.2 (13,312)</td>
</tr>
<tr>
<td>Salaried GP, employed by:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice</td>
<td>4.3 (92)</td>
<td>16.4 (352)</td>
<td>79.3 (1702)</td>
</tr>
<tr>
<td>NHS trust</td>
<td>5.6 (15)</td>
<td>21.9 (59)</td>
<td>72.6 (196)</td>
</tr>
<tr>
<td>Private sector^a</td>
<td>10.5 (8)</td>
<td>21.1 (16)</td>
<td>68.4 (52)</td>
</tr>
<tr>
<td>Freelance GP (locum)</td>
<td>12.6 (118)</td>
<td>24.2 (226)</td>
<td>63.1 (589)</td>
</tr>
<tr>
<td>GP trainee^a</td>
<td>6.3 (6)</td>
<td>31.6 (30)</td>
<td>62.1 (59)</td>
</tr>
<tr>
<td>Other GPs</td>
<td>12.3 (49)</td>
<td>23.9 (95)</td>
<td>63.7 (253)</td>
</tr>
<tr>
<td>Total</td>
<td>2.4 (432)</td>
<td>9.6 (1753)</td>
<td>88.1 (16,163)</td>
</tr>
</tbody>
</table>

^a Note that the base size of private-sector-employed salaried GPs and GP trainees is less than 100.


Hospital admissions (planned and unplanned) are another useful proxy of GP workload – the lower the admission rate the more work is carried out in the community (including but not exclusively general practice). Activity data collected by the Department of Health (England) show that while hospital and emergency admissions and outpatient attendances have increased year on year, their rate of increase is declining.

Assuming that the total amount of health care is not decreasing across the whole health service, and that the health needs of the population are actually increasing, what this indicates is that the work is shifting to the primary and community care parts of the health services.

Workforce pressures

Against the increasing complexity of patients presenting to general practice care is the additional problem of an overstretched workforce, spread across a number of access points, meaning that GPs of today are finding it increasingly hard to deliver continuous care. The number of FTE GPs in England increased from 28,854 in 2001 to 35,319 in 2011. This represents an average annual change of 2.0%. Between 2010 and 2011, the increase was only 0.2%. In Wales, the number of FTE GPs increased from 1775 in 2006 to 1867 in 2011, a total of 5.2%. In Scotland, the headcount number of GPs (but not the number of FTE GPs) increased by 8.8% between 2005 and 2010, and in Northern Ireland over the same period the headcount number of GPs rose by 7%.

In the 12 months to September 2011, number of consultants rose by 3.5%: GP numbers rose by 0.2% FTE in same period.
In the 12 month period from September 2010–11, consultant numbers rose by 3.5% WTE.

In the same period, GP numbers rose by just 0.2% WTE.

The number of FTE GPs in England increased by an annual average of 2% between 2001 and 2011. The Centre for Workforce Intelligence report on the Shape of the medical workforce in England has said ‘the current growth in general practice is not strong enough to meet the predicted need’. It anticipates that, if current workforce trajectories persist, there will be an over-supply of fully trained hospital doctors, and by 2020 consultants’ salaries (if all eligible doctors become consultants) will increase by over 50% from £3.8 billion to £6 billion. Conversely, if, as they recommend, there is a redistribution of hospital training posts to general practice to achieve a 50:50 balance in workforce numbers, then this increase in GP numbers will go some way towards addressing the needs of our changing population.

In the past decade, the FTE GP workforce in England has grown 18% from its 2000 baseline. In comparison, the number of hospital consultants grew 61% (ostensibly to provide consultant-led care – but in reality to facilitate more and more subspecialisation), over the same period. GP recruitment is, in essence, marking time, owing to a combination of inadequate availability of secondary care posts and no change in funding. For the UK in 2011, there were 3152 accepted offers: in 2012 there were 3263 available vacancies, with only 2821 in England – the prospect of achieving 3250 trainees in England by 2014 seems remote.

The combination of falling numbers of new entrants and returnees (8.9%), a rise in the number of leavers (7.8%) and the projected retirement bulge in the next few years (22.2% of GPs were aged over 55 years in 2010), with a increase in portfolio careers (commissioning, management, education) and a higher proportion of the workforce working part-time, means that general practice is facing a workforce crisis.

The shortage of GPs is not evenly distributed across the country, with shortages more apparent in areas of highly deprived communities (where consultation rates and complexity are higher). Despite the objectives of The NHS Plan in 2000 and subsequent initiatives to increase the number of GPs in deprived areas, by 2008, 65% of primary care trusts in spearhead areas still had lower levels of GP coverage than the recommended number of 60 GPs per 100,000 population when weighted for age and need. Primary care trusts with the highest GP provision have almost twice the number of GPs per 100,000 patients compared with areas with the fewest doctors per capita; this means that the impact of any workforce shortages will be felt most in isolated or deprived communities.

Letter from Department of Health official (July 2012).
There is a similar need to address the changing profile of general practice, with increasing numbers of female doctors and the associated rise in less than full-time working. This changing workforce will require greater numbers simply to maintain historic levels of provision, let alone meet the increasingly complex needs of patients and of the service. In 2010, 56% of medical students and 62% of Foundation doctors were female and the numbers of female GPs have grown by 6% from 2001 to 2010. The Royal College of Physicians predicts that by 2017 there will be more female than male doctors on the General Medical Council register by 2017. Compounding the lack of GPs is the predicted GP retirement bulge (often threatened in the past), which now finally appears to be taking place, with 13% of GPs expecting to retire in the next two years. The Centre for Workforce Intelligence recommends a 17% increase in recruitment into GP specialty training, to be phased over four years, which will necessitate a reduction in recruitment into training in the hospital specialties. This will require significant work to encourage young graduates to enter the specialty of general practice, since at present only 20% of recent graduates have indicated this as their first choice.

The numbers of other primary care staff are also falling. Between 2010 and 2011, the total number of qualified nurses, midwives and health visitors working in community services (including community psychiatry and community learning disabilities services) in England decreased by 1995 FTE. Over the same period, the number of district nurses declined by 10%, bringing the total lost between 2001 and 2011 to 3590, a reduction of 34%. The number of FTE practice nurses has declined from its peak in 2006. Figure 9 shows the proportion of practice nurses related to the total number of qualified nurses. The data prior to 2010 are not directly comparable with data from 2010 onwards, owing to the change in methodology; however, a declining trend can be seen from 2010 to 2012.

Figure 9: Number of practice nurses (left scale) compared to total number of qualified nurses (right scale), 2009–2010

From 2010 the new headcount methodology is not fully comparable with data for years prior to 2010, owing to improvements that make it a more stringent count of absolute staff numbers.

A diminishing primary care workforce is not unique to the UK. In the USA, primary care generalism has seen a steep decline over the last few decades, with this being responsible for a reduction in the number of GPs. Compared to 1942 when half of US doctors were GPs, by 1989 the proportion of primary care doctors (now comprising a mix of family physicians, general adult internists and paediatricians) had fallen to one in eight, with the drop being most marked in rural areas.

**Time for caring**

This compendium of evidence has already made reference to the ageing UK population and the rise in incidence of chronic disease. Primary care has been demonstrated as being one of the most effective ways of delivering healthcare services and an effective way of delivering care to patients with complex comorbidities. However, the key deficit in maximising the effectiveness of general practice is time, particularly for patients with multimorbidity. Time with the patient is what shapes the relationship between the patient and their GP.

Without time, the GP is unable to deliver health promotion and prevention; undertake opportunistic screening; assess need; diagnose; assess the requirement for specialist care; and so forth. The length of GP clinical encounters is shorter in the UK than in many other developed countries.

Although numerous studies have shown an association between consultation length and markers of consultation quality, such as patient enablement, a Cochrane review some years ago concluded that there was insufficient evidence from controlled trials to conclude that longer consultations improve outcomes or patient satisfaction. However, a subsequent systematic review did indicate a likely benefit of longer consultations for patients with psychological problems. Simple service redesign might allow GPs longer with their patients, without having to increase the workforce (on the basis that longer consultations reduce the number of overall consultations). Ultimately though, given the workload, this is unlikely to be sustainable in the long term without additional GPs.

Table 3 details the average length of patient consultation in the UK in 2006/2007, according to location and staff type. It shows that the average length of time for a surgery consultation by a GP partner was 11.7 minutes, compared to 15.5 minutes for practice nurses and nurse practitioners.

The average length of a consultation with a GP in 2006/2007 was 11.7 minutes.

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e An argument for 15 minute consultations. Presented to RCGP Annual Conference 2012, by Tom Nolan GP ST4, King’s College Hospital VTS, London and Sarah Bruml Brockwell Park Surgery London. tom.nolan@nhs.net
GPs are increasingly offering longer times in the consultation – but with increasing consultation rates and complexity, this can only be achieved by reducing access or increasing work. The average length of surgery consultations with GP partners (as opposed to all GPs) increased from 8.4 minutes in 1992/1993 to 11.7 minutes in 2006/2007, with salaried GPs requiring an average of 12.1 minutes in 2006/2007.¹⁸ Time in the consultation is especially important for patients with mental health problems. The increase in recession-related mental health problems has a significant impact on GPs (see Box 2).

Table 3: Average consultation length for GPs and other healthcare professionals in 2006/2007

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Surgery</th>
<th>Telephone</th>
<th>Home visits</th>
<th>Carehome visits</th>
<th>Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP partner</td>
<td>11.7</td>
<td>7.1</td>
<td>26.3</td>
<td>14.8</td>
<td>17.3</td>
</tr>
<tr>
<td>GP salaried</td>
<td>12.1</td>
<td>9.1</td>
<td>21.6</td>
<td>21.8</td>
<td>17.6</td>
</tr>
<tr>
<td>GP Registrar¹</td>
<td>164</td>
<td>10.6</td>
<td>33.7</td>
<td>12.9</td>
<td>23.5</td>
</tr>
<tr>
<td>All GPs (exc. locums)</td>
<td>11.9</td>
<td>7.4</td>
<td>25.9</td>
<td>15.3</td>
<td>17.5</td>
</tr>
<tr>
<td>GP Locum</td>
<td>11.1</td>
<td>9.4</td>
<td>27.1</td>
<td>22.0</td>
<td>None</td>
</tr>
</tbody>
</table>

¹. GP registrars contain ‘foundation 2’ doctors

<table>
<thead>
<tr>
<th>Other clinical staff</th>
<th>Practice nurses</th>
<th>15.5</th>
<th>7.9</th>
<th>31.4</th>
<th>14.5</th>
<th>11.3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurse practitioner</td>
<td>15.5</td>
<td>8.6</td>
<td>15.3</td>
<td>37.5</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>12.9</td>
<td>13.0</td>
<td>30.6</td>
<td>30.6</td>
<td>12.3</td>
</tr>
<tr>
<td></td>
<td>Midwife</td>
<td>27.3</td>
<td>22.8</td>
<td>63.8</td>
<td>90.2</td>
<td>38.2</td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
<td>32.9</td>
<td>13.1</td>
<td>None</td>
<td>None</td>
<td>23.2</td>
</tr>
<tr>
<td></td>
<td>Counsellor</td>
<td>96.6</td>
<td>29.7</td>
<td>34.0</td>
<td>76.1</td>
<td>127.4</td>
</tr>
<tr>
<td></td>
<td>Phlebotomist</td>
<td>9.2</td>
<td>7.2</td>
<td>14.1</td>
<td>None</td>
<td>8.6</td>
</tr>
<tr>
<td></td>
<td>Podiatrist</td>
<td>*</td>
<td>*</td>
<td>28.2</td>
<td>None</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Other therapist</td>
<td>30.9</td>
<td>15.7</td>
<td>73.1</td>
<td>36.4</td>
<td>46.5</td>
</tr>
<tr>
<td></td>
<td>All other clinical staff</td>
<td>15.9</td>
<td>9.0</td>
<td>36.3</td>
<td>22.9</td>
<td>12.6</td>
</tr>
</tbody>
</table>

HCA = healthcare assistant.

The challenges for general practice

Box 5 Mental health and the impact on GPs

The impact on GPs of an increase of recession-related cases of mental health conditions.

MORE TIME

96%*

Said patients with these conditions typically needed longer appointment times

1. In general, physical complaints are quicker to manage. Psychological ones are more complex and time consuming. Particularly when the stress relates to social change, which is beyond control. Support takes time and I tend to try and see patients in the afternoon, towards end of week, when things are less hectic.

GP in London

1. I think just letting the patient talk and if they understand that you are sympathetic to their plight they feel better. I guess we are prescribing more antidepressants; I reluctantly refer patients for counselling because the waiting times are ridiculously long now.

GP in North-West

1. It takes time to see these patients who often take more than the allotted 10 mins, meaning the next patient may have to wait to be seen. It’s not ideal, especially on a busy day. [Mental health conditions] increase waiting times for counsellors and puts pressure on our appointments.

GP in Wales

1. We’ve just done a search on our most frequent attenders and they are all psychological/psychiatric patients. They take up a lot of time. We’re finding that we are so much more accessible than the mental health teams, so the appointments are not always appropriate. I think we are going to have to limit our availability.

GP in South-West

1. We really have nothing to offer people who are depressed/anxious regarding work/money. What they need is a decent job; pills and an 8 month wait for very poor quality counselling is not going to make any difference.

GP in North-East and Cumbria


Given the increasing complexity of patients presenting for care in general practice, it is unsustainable to continue to offer care within the ‘traditional’ 10-minute consultation window. The RCGP believes that 10 minutes is too short to combine a patient-centred approach to information gathering, do a proper examination and make an effective shared management plan. Longer consultations, of at least 15 minutes, need to become the norm, with flexibility for changing patient needs.
Delivering out-of-hours care

High-quality care out of hours is important in terms of patient safety, for reducing unnecessary admissions to secondary care and delivering a cost-effective NHS. The Commission on Generalism highlighted a major concern about access to out-of-hours care and the impact this has on continuity of care. The requirement for GPs to have overall responsibility for their patients 24/7 would have major contractual, political and professional implications, and the old system of out-of-hours care would not be acceptable to the vast majority of the workforce – especially given the intensity and complexity of work within hours.

However, a system must be found to allow the restoration of personalised care to those patients with complex needs or at the end of their lives, in and out of hours. Extended teams, cross-practice or federation provision, named out-of-hours leads, and shared electronic records are all possible solutions, and across the UK some primary care providers are already making progress to resolve this.

Work-related stress

The NHS Plan 2000 emphasised that the development of primary care services was key to the modernisation of the NHS. The plan set out its ambition to make primary care more accessible, offer patients more choice and move more services from secondary to primary provision, as well as creating new roles for GPs as GPs with special clinical interests (GPwSIs).

According to the BMA’s 2011 National survey of GP opinion across the UK, the median number of hours worked per week by those respondents considering themselves to be full time was 46, with a mean of 46.8 hours. For part-time GPs, the median was 30 hours and the mean 29 hours. Two-thirds of respondents (65.5%) reported that the amount of work-related stress they experience is heavy but manageable, while 10.7% said it was heavy and unmanageable.

High workload and job stress is associated with lower practice performance, and providing more time in the practice, more time per patient and experiencing less job stress are all associated with perceptions by patients of better care and better practice performance.
A number of approaches have been adopted to develop and utilise the available skills and resources to meet growing patient demand and complexity (see Figure 10). These are reviewed on the following pages.

**Figure 10: The balance of work**

**Improving skill mix in the practice**

GPs work in teams reflecting the needs of the local practice population. ‘Skill mix’ is a term without a precise definition and has repeatedly been suggested as the solution to increasing demand against diminishing capacity. The term is variously used to refer to the:

- mix of different disciplinary groups involved in the delivery of a service
- mix of different skills within a given disciplinary group
- mix of different skills possessed by a single individual.

Skill mix usually results in delegation/substitution and/or diversification of roles.

**Delegation/substitution**

Task(s) formerly performed by one type or grade of professional are transferred to a different type or grade of professional. Change in skill mix in UK primary care is largely focused on the transfer of tasks from highly qualified, expensive professionals to less highly qualified, cheaper professionals. Examples include task delegation from GPs to senior nurses and independent nurse prescribers or physician assistants, and from senior nurses to junior nurses or healthcare assistants. The intention is to reduce costs and improve service efficiency.
Diversification

The range of services provided within primary care is enhanced through recruitment of new types of professionals, or through the acquisition of new skills by existing professionals. Examples include the addition of practice counsellors and the introduction of clinics, such as for monitoring asthma, diabetes and other common long-term disorders. The intention was to fill previously unmet health needs and/or replace services previously provided within hospitals or other settings. In practice, changes in skill mix may involve both aspects.

Many of the professionals providing these services have undertaken specialist training and offer a wider range of services than was previously available. The move towards increased skill mix in primary care is fuelled by:

- rising demand and cost of care, which has increased interest in the possible economies to be made by shifting care from expensive to cheaper healthcare professionals
- NHS policy changes, which encourage a shift from hospital-based to community-based care, thereby increasing the volume and range of services demanded of primary healthcare professionals
- anticipated changes in the GP workforce, consequent on a recent decline in recruitment to the specialty and a shift towards part-time working related to the increasing proportion of female doctors.

There is, however, a dearth of research in this area and many changes in skill mix within primary care have yet to be adequately researched, in particular how effective skill mix is in reducing costs or freeing up GP time.\(^{73,74}\)

What can be said is that skill mix is important but is not the panacea to the challenges facing British general practice and the NHS. Skill mix may in fact exacerbate poor continuity of care by removing ‘simple’ consultations where trust and relationships are built between GPs, their patients and carers.

Use of general practitioners with extended clinical roles

The NHS Plan 2000 signalled the creation of GPwSIs,\(^46\) with the expectation of creating GPs who, with additional skills, knowledge and training, could undertake extended roles within and outside the surgery. The expectation was that these individuals would improve access for patients to specialist care, reduce secondary care costs and cut waiting times. Special interest is a vague term and can refer to a GP anywhere along the spectrum from finding a particular area of practice interesting (maybe the practice lead), through to having a postgraduate qualification and expertise in a defined area of practice or disease. An alternative, and perhaps better descriptor, might be GP with an ‘extended clinical role’.

Many GPwSI positions to date have largely been based on the traditional specialty-based area, for example, dermatology; minor surgery; headache; ear, nose and throat; or epilepsy, all of which have hospital-based equivalents and where the GP essentially behaves as a subconsultant, managing part of the patient’s needs rather than all of them. The expectation for the introduction of GPwSIs was that it would reduce costs, reduce fragmentation and improve quality of care.
There is little or no evidence that GPwSIs have reduced hospital admissions, reduced costs or indeed improved the skills of GPs.75 However, like most people, GPs seek variation in their work and career and undertaking additional training in a specific area can re-energise the GP and help with retention of the workforce and reduce burnout.

Irrespective of workload/workforce issues, the use of GPwSIs needs to be reconsidered and, rather than creating another cadre of 'expert-GPs' working in disease-specific areas, the future GPwSI would be best placed supporting the care of patients who currently fall between gaps within the health and social care system (for example the homeless, frail elderly or patients with dementia), or in sites where the expertise of a generalist, combined with additional knowledge, skills and expertise would ensure better and safer care for the patients within that site (e.g. GPs working in nursing homes, urgent care centres or custodial settings). If used correctly, the GPwSI role has the potential for 'specialist' GPs to bring their unique in-depth knowledge of primary care to the respective clinical area and to work across the physical, social and psychological paradigms, adding value to, rather than replacing, specialist services.76

Related to the growth of GPwSI roles is the fragmentation of what would be considered 'normal' or standard general practice care into distinct clinics or services, and the emergence of stand-alone services (for example, smoking cessation, family planning, heart-failure clinics, learning disability services). The current GP contract facilitates this means of service organisation, with its emphasis on enhanced services – which are contracted separately from core services. Though patients may prefer to receive aspects of their care in stand-alone services, this risks fragmentation of care – including GPs losing some of their generalist skills and expertise, as well as the disadvantages to patients of a lack of communication between providers.

**Joint working with pharmacists**

There remains a significant unexploited potential for pharmaceutical care provided in community settings to alleviate GP workloads and improve health outcomes and service user satisfaction77

Joint working between community pharmacists77 and GPs makes sense in both improving the care for patients and removing work from the GP that more sensibly sits with pharmacists, such as medical reviews and the management of self-limiting illness.78 The community pharmacist is a trusted and respected professional and provides significant first-contact care for patients and the public. This means the community pharmacist is well placed to be the first port of call for minor ailments, and can be a useful partner in the management of long-term conditions and help patients adhere to prescribed medicines, as well as taking on new extended roles, such as caring for patients with substance misuse and providing smoking-cessation services.

The new opportunities for joint working/joint patient management arising from the pharmacist’s prescribing role have been taken up in some areas but greater use of these new skills could bring more benefit to patients. Prescribing from a community pharmacy location is less common currently, except where arrangements have been made to link to practice clinical systems.
Currently, most of the pharmacist prescribers in primary care provide their services from general practice, working closely with GPs and practice nurses. Once referred to the pharmacist-led clinic, patients can benefit from regular consultations that include medication review and monitoring, prescribing and adjustment of appropriate medication, in line with latest evidence and national guidelines. In NHS Grampian, for example, partnership working between prescribing community pharmacists and their local general practices now involves 13 community pharmacists (around 15% of the total).

Despite the obvious advantages of joint working across the two professional groups, in reality contractual and communication barriers mean that this potential is not realised. In addition, the evidence for substitution to pharmacists for routine medical reviews in older people being cost effective is mixed. Therefore, clinical medication reviews in collaboration with GPs may be the approach that offers the most clear-cut benefits, and the community pharmacy may not be the appropriate environment.

**Working differently**

**Advanced access**

Advanced access, developed in the USA, was introduced into general practice in the early 2000s, and reflected insights from queuing theory about the cause of delays in systems. It aimed to improve access to primary care and improve continuity, without a corresponding need to increase workforce or workload, doing so by ensuring that practices provided sufficient capacity to meet the demand for same-day appointments as well as booking ahead.

Advanced access in the NHS shows limited impact. For example, a controlled, before-and-after study comparing advanced access with control practices showed that those using advanced access provided slightly shorter waiting times for an appointment with any doctor, but both types of practices had longer waiting times than NHS access targets and there was no difference in practice workload or continuity of care.

Commentators have pointed out that advanced access, with its focus on prioritising same-day appointments, has led to a decrease in self-care and increase in workload (even if undertaken by others within the primary care team), as patients present very early in the course of what would amount to a minor-self limiting illness, or present too early in the natural history of a disease to be able to exclude a more serious illness, and need to be seen again. Other aspects of advanced access have also raised concern, including claims that the emphasis on rapid access would disadvantage people such as the elderly and those with chronic illnesses for whom seeing a particular healthcare professional may be a higher priority.

It is important to note that translating what has worked in the USA in improving access to the NHS may not be appropriate, owing to the fundamental differences between the two healthcare systems. For example, the improvements in access following the introduction of advanced access techniques in the USA were conducted in the context of healthcare centres that were seeking to reduce delays to obtain an appointment that had been between 18 and 55 days; this is far longer than the delay experienced in any general practice in the NHS.


**Telephone triage**

The evidence for telephone triage reducing the demand for face-to-face appointments with a GP is mixed. A study examining the effects of demand for same-day appointments before and after the introduction of GP-run telephone triage found a reduction of 39%, with most calls taking less than five minutes, and good patient satisfaction. In another study, patients asking for same-day appointments were randomised to telephone triage or face-to-face appointments (patients specifically asking to speak to the doctor by telephone for advice, those deemed very urgent cases and those with no contact telephone number were excluded). While this found that use of telephone consultations for same-day appointments was associated with time saving (shorter consultations), the short-term saving was offset by higher return-consultation rates. Similar findings have been found in other studies.

**Consulting to meet the needs of patients with multimorbidity**

Patients with multimorbidity consult more often and need more complex and structured care than can be provided within a traditional 10-minute consultation. Their care is often shared between other providers and needs to be coordinated between community, hospital and social care practitioners. Multiple providers reinforce the need for a single or main coordinator of care.

Multimorbidity affects the GP consultation in three main ways:

- the amount of clinical information that needs to be elicited for a single patient is extensive, especially where conditions and stability change over time
- clinical care plans, management priorities and information are constantly changing
- there is a constant need for enhanced communication between different health and social care providers, to ensure continuity of care and minimise conflicts in treatment decisions.

An approach to providing continuity of care to patients with complex needs is that of creating ‘teamlets’ in primary care. These consist of different healthcare professionals, drawn from the wider primary care team, working together to deliver routine care, health advice and case management to high-risk patients.

Under this model, the routine appointment time is expanded and the patient encounter involves two caregivers, who are trained in skills such as chronic disease management, shared decision-making and prevention. The goal is to improve the patient experience and enhance patient self-management; to improve outcomes for prevention and chronic care by delegating routine processes to healthcare assistants; to ensure better use of the GP by delegation of routine tasks; to ensure that all practice personnel are working to their fullest potential; and to cut healthcare costs by reducing unnecessary hospital admissions. The model allows for practitioners to move from unstructured reactive care for patients with complex needs to planned proactive care – and maintains continuity and relationship, not just with an individual clinician but with a team.

**Integrated care and care planning**

The benefits of joint working across different professionals, to improve the coordination and continuity of care for patients – have already been discussed. GPs are best placed to lead this joint working as they have the overview of end-to-end care for their patients. The best framework for delivering care to patients with complex comorbidity or multimorbidity still needs to be determined, and is likely to depend on many patient, practitioner and local...
factors. Research in this area is urgently needed. Existing models of integrated care for chronic
disease comprise complex healthcare packages or pathways – though there have been few
attempts at systematic evaluation. A recent Department of Health evaluation of integrated
care pilots in England found that although integration did lead to better processes, such as an
increased use of care plans and improved organisation of care following hospital discharge, the
patients themselves did not generally feel that this had translated into an overall improvement
in their experience of care. Moreover, on some measures, such as continuity of care, patient
experiences had actually declined. In addition, although there were significant reductions in
elective admissions and outpatient attendances, these were balanced by increases in the costs of
emergency admissions.

Studies looking at changing the length and structure of primary care consultations to improve
integration of care are currently limited. The ‘guided care model’, which is based on nurse-led
coordination of interactions between the patient, primary care doctors and healthcare teams,
is an example of integrating care of chronic disease. A review, albeit undertaken in USA, has
shown the benefit of involving nurses in case management, including:

- reductions in emergency department visits
- noticeable decreases in medication costs
- reduced inpatient charges and overall charges
- average savings per patient
- significant increases in survival, with fewer readmissions
- lower total annual Medicare costs for those beneficiaries participating in pilot projects
  compared to control groups
- increased patient confidence in self-managing care
- improved quality of care
- increased safety of older adults during transition from an acute care setting to their home
- improved clinical outcomes and reduced costs
- improved patient satisfaction overall.

It is pragmatic to assume that the overarching requirements for complex patients should involve
a care-planning approach through which patients, healthcare professionals and carers work
collaboratively and review outcomes on a regular basis – an approach that has been shown
to be effective in improving patient outcomes. Care planning is an essential component of
coordinated care. However, care planning takes time to undertake the needs assessment and to
engage in collaborative working.

In their editorial on integration of care, Mathers and Thomas concluded that ‘without the right
investment and infrastructure, general practice will not be able to be an effective provider
and facilitator of such models of integrated care’. This means investment in GP capacity,
competence and infrastructure such as IT, to facilitate joint records and sharing of information.
Promotion of self-care/NHS choices

The internet age has driven a number of resources to support patient self-care and to act as an intermediary source of advice or an adjunct to traditional face-to-face care. One such site is NHS Choices (nhs.uk), the public-facing website of the NHS. NHS Choices sets out to offer users greater access to accredited information on health and wellbeing, and material that can prepare them for their consultation with a clinician/GP.

Evaluation of NHS Choices found that a significant proportion of the population of internet users have been influenced by medical websites to change their health-services-seeking behaviour. It suggested that the use of NHS Choices did modify demand for health services – frequent users of the site consulted their GP more often and there are indications that NHS Choices may have encouraged hard-to-reach groups to appropriately consult their GP. Both these outcomes, while appropriate, led to an increased, rather than decreased GP workload, increasing demand rather than preventing it from occurring in the first place. Thirty-seven per cent of NHS Choices users who use the service for the GP consultation (70% of all users) reported that it decreased their use of GP services (and does so appropriately).

Where internet sites, such as NHS Choices, can play a vital role is in disseminating information during epidemic outbreaks, such as with the recent swine flu.

Use of e-health

There has been widespread interest in the use of e-technology to improve the care and coordination of patients, particularly those with chronic complex comorbidities or multimorbidities. Many studies are under way but the existing evidence base is limited.

A recent evaluation of a randomised controlled trial of the effects of remote care for patients with long-term conditions showed that the treatment group (that is the group provided with equipment to monitor blood pressure, control of diabetes, and so forth) had 20% fewer admissions than the control group, which corresponded to a difference of 0.14 admissions per person over a 12-month period.

However, as the Nuffield Trust’s evaluation showed, although the use of e-health was associated with a 20% reduction in emergency admissions compared to the control group, these reductions were from a low base and, furthermore, the control group appeared to experience more emergency hospital admissions shortly after being recruited into the trial, compared to before the trial. The reasons for this are unclear but it is possible that the trial recruitment process affected admissions – meaning that tele-health may have a different impact (maybe less impact) in routine practice compared to practice found in a clinical trial.

The use of remote or e-services to deliver care to patients has been commonplace in primary care for decades. GPs offer telephone appointments, telephone triage and, increasingly, email consultations. They also use text messaging to notify patients of appointments. The Department of Health has highlighted a number of other areas where e-health can add value to the care of patients and at the same time reduce the workload of GPs and other healthcare professionals, as well as the level of complexity to implement (see Figure 11).

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f e-health is used as an umbrella term to encompass all remote, electronically mediated health care.
There is little evaluation of the use of e-health in primary care but the expected benefits are:

- reduction in the number of unnecessary visits to the GP and practice nurse
- reduction in travel requirements for patients
- fewer face-to-face appointments, leading to a reduction in cost
- reduction in the carbon footprint
- patients being seen more quickly, with more availability of face-to-face appointments for serious complaints.
The value of general practice to patients and to the NHS

Primary care and the associated value of GPs has been described extensively and is seen as an evidenced-based priority for all health services across the world. The following is adapted from WHO:\textsuperscript{101}

- primary care provides a place to which people can bring a range of problems
- it is the hub from which patients are guided through the disease system
- it facilitates ongoing relationships between patients and clinicians, within which patients can participate in decisions about their health and health care
- it builds bridges between personal health care and patients’ families and communities
- it provides opportunities for disease prevention and health promotion, as well as early detection of disease, where necessary
- international surveys have found lower rates of patient-reported errors in healthcare systems with a strong orientation towards primary care.\textsuperscript{102}

Medical generalism and the health of individual patients

GPs care for patients, their carers and families from before birth to after death. They diagnose most illness, manage the majority of health problems, promote better health and prevent disease, provide screening programmes, certify sickness and disability, support rehabilitation, monitor and manage a wide range of chronic health conditions, support carers and optimise access to specialist services.

The value of generalism has been recognised for decades. For example, the 1963 Gillie Report states:\textsuperscript{103}

\begin{quote}
He [the GP] acts as an essential intermediary in the transmission of specialized skills to the individual. Without this function of the personal doctor the hospital services can be used wastefully, even damagingly to the patient.
\end{quote}

From the 1970s, a major review of the health service was undertaken,\textsuperscript{104} which identified that a health service based upon the GP is likely to be less costly than a hospital-based service and the aim should be to provide the maximum amount of care in the community.

An Independent Commission on Generalism (2012) concluded that it is essential that the essence of generalism (based in holistic and patient-centred care) is valued and preserved.\textsuperscript{71}

Starfield has shown that while ‘supply-driven care’ in secondary care has been demonstrated to lead to increased costs and reduced effectiveness, increasing numbers of patients in primary care does not have the same effect. She has proposed six mechanisms to account for the beneficial impact of primary care on population health.\textsuperscript{105}

These benefits include:

- better access for relatively deprived population groups
- better quality of care delivered by generalists
The value of general practice to patients and to the NHS

- the impact of primary care on prevention
- better early management of health problems in primary care
- the contribution of primary care characteristics to more appropriate care
- the role of primary care in reducing unnecessary and inappropriate specialist care.

Managing disease in general practice requires more than checking the clinical symptoms and signs, managing medications, or referring for further medical care. It also requires a complex understanding of how aspects of patients’ experiences and individual contexts influence the effects of disease, the way that patients react to them, and their concordance with and response to treatment. For example, an elderly lady who cares for her sick husband and has a fall may not injure herself physically, but may lose her confidence and become unable to retain her mobility, resulting in subsequent deterioration and long-term health impacts to herself and her husband. A narrow assessment of physical injuries alone will miss the wider implications of her fall to her and her husband’s wellbeing in the community.

The intellectual and contextual framework within which expert generalists operate is as demanding as that of expert specialists; however, it is different in several key parameters (see Table 4).

Table 4: The different conceptual parameters of generalism and specialism

<table>
<thead>
<tr>
<th>A generalist must develop the skills to:</th>
<th>A specialist must develop the skills to:</th>
</tr>
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<tbody>
<tr>
<td><strong>Tolerate uncertainty</strong> – generalists must manage a large proportion of patients with undifferentiated symptoms, including those who present early in the course of illness, those with evolving conditions, and those whose symptoms do not form a characteristic pattern of disease.</td>
<td><strong>Reduce uncertainty</strong> – specialists are expected to discover a diagnosis and to investigate until this is achieved. If they are unable to identify a diagnosis within their own specialty, they are usually expected to discharge the patient or suggest referral on to another specialist, rather than to manage the diagnostic uncertainty.</td>
</tr>
<tr>
<td><strong>Explore probability</strong> – generalists see patients from an unscreened population with a relatively low incidence of serious disease. They require highly developed consultation and generalist diagnostic skills, including recognition of common conditions and awareness of the limits of their knowledge. Their clinical decisions are based on the epidemiology of the local community and the consequent probability that any given symptom is medically significant.</td>
<td><strong>Explore possibility</strong> – specialists see a preselected population of patients with a relatively high incidence of serious disease. They require expert knowledge of the rare and esoteric conditions that are relatively more likely to be the cause of the problem in this population.</td>
</tr>
<tr>
<td><strong>Marginalise danger</strong> – a key skill of a GP is to recognise and act on potential danger to patients, even when there is diagnostic uncertainty; this often requires referring the patient or initiating treatment before a diagnosis has been established (e.g. in a case of suspected meningitis or cancer).</td>
<td><strong>Marginalise error</strong> – a specialist must ensure that they reach an accurate diagnosis and treatment for the patient, in order to enable a successful outcome.</td>
</tr>
</tbody>
</table>
Each healthcare system is different, and the use of generalists varies between different countries but, across the world, countries with strong primary care delivered by doctors with generalist training produce better health outcomes, at lower cost, and the numbers of primary care physicians and the consequent availability and effectiveness of primary care relates closely to improved health outcomes and lower costs. Studies comparing generalist and specialist care have reported that the quality of clinical care, when planned and executed by generalists, was either the same for both settings, or that for primary care it was better.\textsuperscript{106–108} In the UK, more GPs per head of population is associated with lower all-cause mortality (especially cancer and heart disease) and the supply of GPs appears to have more influence on lower standardised hospital mortality than the ratio of specialists in a hospital.\textsuperscript{109}

Specialists and GPs, though sometimes perceived as opposites, are inextricably dependent on each other’s skills and, crucially, most are keenly aware of the extent of this interdependency.

Iona Heath, President of the RCGP (2011)\textsuperscript{110}

In the NHS in England, over 300 million consultations take place in general practice per year, which represents 90% of all NHS contacts.\textsuperscript{55} The majority of these are undertaken by GPs.

The traditional gatekeeper and coordinator roles of the GP and the skill of the GP in managing uncertainty, ensures that health service costs, while increasing, represent value for money (see Figure 12). Although the average patient has 5.3 consultations with their GP every year, only one out of every 20 consultations (5%) results in secondary care referral. Everything else is dealt with in primary care.\textsuperscript{111} GP consultations cost less than outpatient consultations, accident and emergency and ambulance calls.\textsuperscript{112} A whole year’s care in general practice costs about one-tenth of a day in hospital, the former receiving around £80 per patient per year (UK) for unlimited numbers of consultations.

In England, an increase in just one GP per 10,000 population is associated with a 6% decrease in mortality.\textsuperscript{113}

\textbf{Figure 12: General practice as a driver of more cost effective care}

<table>
<thead>
<tr>
<th>A year of care by a GP costs 10% of a day’s stay in hospital</th>
</tr>
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<tbody>
<tr>
<td>An increase of just one GP per 10,000 population is associated with a 6% decrease in mortality</td>
</tr>
<tr>
<td>General practice delivers 90% of patient contacts in NHS for 10% of the overall health budget</td>
</tr>
<tr>
<td>More GPs per head of population is associated with lower all-cause mortality</td>
</tr>
</tbody>
</table>
Internationally, policy-makers and researchers are now recognising the clinical effectiveness of the family physician, both in providing continuity of care and in the utilisation of the concept of a ‘medical home’, especially for helping patients with comorbidity. This comes after years of focus on single-condition case management – and an emphasis on technological intervention within strictly controlled care pathways, rather than a generalist, integrated or holistic approach.

In summary, a health service that has a well-established primary care base can:

- improve the quality of patient care in comorbid conditions\textsuperscript{114}
- reduce costs to the health service (through reduced referrals, reduction in prescribing errors and reduction in hospital admissions)\textsuperscript{3}
- improve the care of long-term diseases\textsuperscript{53}
- facilitate more effective shared decision-making
- help to reduce health inequalities\textsuperscript{38,115–117}
- provide better preventative care\textsuperscript{43}
- improve patient self-care and population health.

Primary care works by delivering person-centred, comprehensive, integrated and continuous care to patients and their families. At present, continuity of care in UK general practice is preserved by the registration system at the level of the practice and the primary care team, who are able to provide continuous long-term care through regular discussions and information sharing about patients, shared electronic records, and other communication routes. This allows the GP to be responsible for a defined population and to build up continuous relationships with community and social care providers and other sectors and to coordinate the care provided by hospitals, specialists and community organisations.

The need for the whole population to have access to quality general practice has been highlighted by a large USA-based review of all studies published between 1985 and 2005, which quantified the health benefits of GPs in reducing health inequalities and improving morbidity. The findings suggested that an increase of one GP per 10,000 population was associated with an average mortality reduction of 5.3\%, equivalent to 49 fewer deaths per 100,000 population per year.\textsuperscript{118}

A series of comparative studies published by the Commonwealth Fund on the performance of 12 international health systems has ranked the UK consistently high overall, in comparison to others.\textsuperscript{119} The UK’s comparative performance shows that it has performed strongly in terms of access to care, equity, effectiveness and patient safety. The features that were consistently associated with good or excellent primary care included the comprehensiveness and family orientation of generalist-led primary care practices, within a wider system in which governments regulated the distribution of healthcare resources through taxation or national insurance. England and Wales rated top in both practice and system characteristics (see Figure 13).\textsuperscript{120}
**Figure 13: UK ranking in international comparison of health systems by dimension of quality**

<table>
<thead>
<tr>
<th>Dimension of Quality</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall ranking (2010)</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Quality care</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Effective care</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Safe care</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Co-ordinated care</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Patient-centred care</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Access</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
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<td>6.5</td>
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<tr>
<td>Cost-related problem</td>
<td>6</td>
<td>3.5</td>
<td>3.5</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Timeliness of care</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Efficiency</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Equity</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Long, healthy, productive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>productive lives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health expenditures/capita, 2007</td>
<td>$3,357</td>
<td>$3,985</td>
<td>$3,588</td>
<td>$3,837*</td>
<td>$2,454</td>
<td>$2,992</td>
<td>$7,290</td>
</tr>
</tbody>
</table>

Country rankings

- 1.00–2.33
- 2.34–4.66
- 4.67–7.00

Note: *Estimate. Expenditures shown in $US PPP (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organisation for Economic Cooperation and Development, OECD Health Data, 200 (Paris: OECD, Nov. 2009); Davis et al (2010).


AUS = Australia; CAN = Canada; GER = Germany; NETH = the Netherlands; UK = United Kingdom; US = United States of America.
In England, in its white paper *Equity and excellence*, the coalition government set out its proposals for further reform of the NHS, now taken forward through the Health and Social Care Act. The intention to increase patient choice and competition is likely to result in a greater diversity of primary care providers. The white paper also puts a strong emphasis on involving patients in decisions about their treatment and care—under the slogan ‘no decision about me without me’. This will require GPs to engage patients more actively in decision-making about their treatment and care.

The devolution of commissioning to GP-led consortia gives GPs the lead role in the design and delivery of services on a scale not seen before. The implementation of GP-led commissioning will require rapid transformation in the skills and working practices of GPs. Much greater and more informed use of information, data and indicators will be imperative if general practice is to meet the challenges that are integral to its new role.

The Scottish Government’s 2007 plan *Better health, better care: action plan*, supported the role of general practice as being well placed to support high-quality patient care. This was followed in May 2010 by *The healthcare quality strategy for NHS Scotland*, and in September 2011 by *Achieving sustainable quality in Scotland’s healthcare: a 20:20 vision*. In March 2011, RCGP Scotland published its own 5–10-year vision, *The future of general practice in Scotland: a vision*, setting out the aspiration of a health service where care is safe, clinically effective and person centred and involves:

- empowering patients to play a part in the management of their own health
- the integration of all care services to fully meet the needs of patients
- care that is clinically effective, safe and delivered in the most appropriate way, within clear agreed pathways
- primary care playing an essential role in the effective use of scarce public resources.

In Northern Ireland, the government recently launched a major review of the Health and Social Care system, *Transforming your care. A review of health and social care in Northern Ireland*, which positions the role of general practice at the heart of providing high-quality coordinated patient care. Many of the aspects of the implementation of this review are recognised in *The future of general practice in Northern Ireland. Developing general practice from 2010*, an action plan for delivering on the key challenges for the profession identified by the British Medical Association (Northern Ireland), Northern Ireland General Practitioners’ Committee and Royal College of General Practitioners (Northern Ireland), in 2010, which includes:

- developing a framework for effective management of general practice in the future
- improving leadership and management effectiveness within general practice
- improving organisation within the infrastructure of general practice
- improving service and accessibility
- working with trusts and commissioners
- resourcing general practice
- addressing the educational and training needs of general practice.
In Wales, the main features of the policy environment within which general practice operates are contained in the following documents:

- **Setting the direction: primary and community services strategic delivery programme** (2010)\(^{128}\)
- **Together for health: a five year vision for the NHS in Wales** (2011)\(^{129}\)
- **Programme for Welsh government: 21st century health care**\(^{130}\)
- **Achieving excellence: the quality delivery plan for the NHS in Wales 2012–2016.**\(^{131}\)

Although tailored for their own context, the policies and strategies of the four nations have much in common. Key themes emphasised in the above documents are:

- close alignment of health and social care, based on delivery around primary and community services with patients at the centre, and placing prevention, quality and transparency at the heart of health care
- addressing health inequalities
- systems and processes (including IT) that guide people through services, where individual elements of care are joined up and easily navigated
- service modernisation, including more care provided close to home and specialist ‘centres of excellence’
- supporting service delivery through the formation of locality or neighbourhood clinical and social care networks based on practice areas
- improved access
- workforce development, including training in quality-improvement methodology and enhancing clinical leadership
- improving quality of care through national and local programmes.
Conclusion

GPs have always adapted to change and will continue to do so. But to do so, they and their teams must have the skills and knowledge required and work within systems that allow them to deliver care to an increasingly complex patient population. GPs must be able structure care around both multimorbidity and individual conditions, supporting self-care and shared decision-making and developing evidence-based interventions for the new challenges. The future practitioner will need to become more expert in their generalist skills, especially in the context of managing medical conditions and dealing with polypharmacy.

The issues facing GPs throughout the UK are consistent, even if the structure of healthcare services differs. The pressures on primary care and on the GP to deliver effective care are mounting, as are the challenges of providing continuity of care and accessible services. The crisis of demand versus capacity has not arisen overnight and neither can it be solved quickly. However, solutions must be found to increase the workforce and enable GPs to spend longer with their patients and communities, as well as receiving training that is relevant to their new roles and responsibilities.

GPs must continue to provide first-contact care to patients with undifferentiated illnesses, and must continue in the role of gatekeepers and, increasingly, navigators of care. They will continue to provide holistic care to registered patients, in the context of their families and communities, across the physical, social and psychological domains, from cradle to grave, using the tools of the consultation and continuity of care to deliver this.

The Royal College of General Practitioners believes that:

For general practice to play its critical role in caring for patients in the future NHS, it is important that there are enough GP; that these doctors have sufficient time both in and outside the consultation, to provide the interventions needed; and that they receive sufficient training to develop the capabilities required to deliver the high-quality services that patients, carers and families rightly expect.
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Lead authors
Professor Clare Gerada
Professor Nigel Mathers
Dr Ben Riley
Mr Mark Thomas
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