Royal College of General Practitioners

**RCGP Written Evidence**
# Health Select Committee Inquiry on Emergency Care

The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care.

## 1. Overview

1.1 We welcome the opportunity to contribute to this Inquiry. Patients accessing out of hours, urgent and emergency care are often doing so when they are at their most frightened and vulnerable, and it is vital that health and social care professionals work together to ensure that they receive the right care, in the right place, and at the right time.

1.2 We have the following key points to contribute to this Inquiry:

- We urge the Committee to focus attention on the need for a 'whole system'[1] approach to meeting the challenges facing urgent and emergency care, and to move the debate on from 'blaming' any one part of this system, as some of the recent media coverage focusing on general practice has sought to do.
- There is no evidence to support the claim that problems within general practice – either in or out of hours – are the cause of the recent additional pressures we have seen in A&Es. GPs should not be seen as part of the 'problem' but will be essential to finding a long term solution to improving urgent and emergency patient care.
- GP out of hours services are well regarded by patients who use them and their performance has been shown to be improving. We must move on from debate about the 2004 GP contract and focus on how we can continue to improve GP OOH services and ensure patients are more effectively signposted towards them.
- With this in mind, it is disappointing that the implementation of NHS 111 has met with so many problems. In some areas – particularly those run by GP-led social enterprises – NHS 111 roll out has been more positive, but urgent action is needed to ensure that the failures seen in some areas of the country are not repeated.
- Rising numbers of patients - often frail and elderly people – are living with multiple long term conditions, and this is placing additional strain on the system as a whole. General practice is facing its own workforce and workload crisis, and in recent years has seen a real terms drop in funding.
- We need to redesign services in a way that delivers better integrated urgent and emergency care, including better coordination between the NHS and social care, and promotes more effective self care. Part of this solution must be a shift in investment towards primary care. We should also avoid raiding the NHS budget to plugs gaps in social care, although with the right safeguards locally agreed budget pooling may deliver more integrated services.

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[1] RCGP Guidance for commissioning integrated urgent and emergency care, August 2011 http://rcgpauthoring/sitecore/shell/Controls/Rich%20Text%20Editor/~/media/Files/CIRC/Audit/Urgent_emergency_care_whole_system_approach.ashx

## 2. Analysing the pressures facing A&E

2.1 Significant public debate has focused in recent weeks on challenges facing A&E departments. Whilst this is an important issue in itself[2], it must be considered in the context of pressures impacting on the NHS as a whole, both in and out of hours. The factors behind these pressures are complex.

2.2 Whilst overall A&E attendances have risen in the last ten years, the majority of this increase has taken place not in emergency departments, but in Walk in Centres (WICs) and Minor Injury Units (MIUs) – many of which are actually staffed by GPs. Emergency Department attendances have remained relatively stable over this period (rising by around 1-3%) whilst attendances at WICs and MIUs have risen by around 15%[3]. This strongly suggests that an increase in supply (with the introduction of WICs and MIUs) has led to a corresponding increase in demand. We should also be careful about assuming that A&E attendances are constantly increasing; NHS England's May 2013 A&E Improvement plan[4] notes that total A&E attendances in Q4 of 2012-13 were actually 1.7% lower than the previous Q4.

2.3 In the meantime, the number of acute hospital admissions from A&E have been rising much more rapidly - by around 40% between 2003/04 and 2010/11[5]. This suggests that issues around patient flow within hospitals, including potential unintended consequences of the four hour waiting target, and capacity issues within Emergency Departments are important factors.

## 3. The role of general practice

3.1 Around 90% of patient contact with the NHS – much of which can be classed as 'urgent' – takes place in primary care, with GPs dealing with around 300 million consultations annually (based on 2005-2006 activity data published in 2008). GPs' generalist training means they are ideally placed to support patients with complex needs – such as those living with long term conditions – in the community. General practice can and does play an important role in preventing unnecessary hospital admissions by supporting patients to manage their care in the community.

3.2 However, we have seen no evidence to back the claim that failures in general practice are driving the problems facing A&E at the moment. Rather, we are seeing the effects of rising pressure across the system, caused by a complex set of factors including the UK's ageing population and the increasing numbers of patients living with multiple long term conditions. It is estimated that by 2025 the number of people in England with at least one long term condition will rise by 3 million to 18 million. In its analysis of the current challenges facing A&E, NHS England has noted that: *"There is general consensus (though it is hard to identify the evidence) that patients presenting are more ill and hence more likely to need admission and have longer stays."* This trend towards increasing complexity of care is being seen across the NHS – causing capacity issues in general practice, A&E and social care in particular.

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[2] College of Emergency Medicine "Drive for Quality" report May 2013 http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Quality%20in%20the%20Emergency%20Department/

[3] King's Fund blog "Are accident and emergency attendances increasing? 29 April 2013 http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing

[4] NHS England's A&E Improvement plan, May 2013 http://www.england.nhs.uk/wp-content/uploads/2013/05/ae-imp-plan.pdf

[5] Blunt, I et al (2010) Trends in Emergency Admissions (2004-2009); Nuffield Trust

3.3 As a consequence, general practice is currently facing a workload and workforce crisis. The number of patient consultations rose by 75%, from 171 million to more than 300 million between 1995 and 2008. 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 the over 70s[6]. The Centre for Workforce Intelligence (CfWI) has concluded that: *"the existing GP workforce has insufficient capacity to meet the current and expected patient needs*"[7]. These problems have been exacerbated by underinvestment in general practice in recent years, with just 9% of the NHS budget in England being spent on general practice in 2010/11 (compared to 47% spent on A&E and acute care, 19% on other secondary care such as maternity and mental health, and 10% on community care).

3.4 Despite these challenges, patient satisfaction with GPs remains high, and has been consistently higher (74% in the latest British Social Care survey published earlier this year[8]) than satisfaction with A&E services (59% in the same survey).

**4. Out of hours GP services**

4.1 GP out of hours services are well regarded by the patients who use them. According to the GP Patient Survey most patients (71%) say their overall experience was good, with three in ten (31%) saying it was 'very' good. Furthermore, 82% of patients say that they "definitely" or "to some extent" have confidence and trust in their out-of-hours clinician[9]. A Primary Care Foundation benchmarking report in 2012 found that *"the overall performance of out of hours services is improving… the performance on the most difficult measure of time to definitive clinical assessment is rising."*[10]

4.2 Changes to the GP contract introduced in 2004 transferred responsibility for ensuring that OOH cover is provided to (then) PCTs. This brought an end to an unsustainable situation in which GPs were overstretched, often to the detriment of their own health. The 2004 contract is not in any way responsible for pressures facing A&E over a decade later. There were over 8.5 million calls to GP OOH services in 2007/08 and these services (around half of which are social enterprises run by local GPs) have continued to provide care to patients out of hours across the country.

4.3 However, evidence suggests that not enough patients are aware of the services provided by GPs out of hours, with 42% saying that they don't know how to contact their local service.[11] This reflects the fact that many patients seeking urgent and emergency care are faced with a range

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[6] http://www.deloitte.com/assets/Dcom-UnitedKingdom/Local%20Assets/Documents/Research/Centre%20for%20health%20solutions/uk-chs-primarycare.pdf
[7] CfWI In Depth Review of General Practice, Preliminary Findings: http://www.cfwi.org.uk/workforce-planning-news-and-review/press-releases/press-release-preliminary-findings-of-review-into-gp-workforce-published
[8] NatCen Social Research's British Social Attitudes survey, http://www.kingsfund.org.uk/projects/bsa-survey-2012
[9] GP Patient Survey
[10] Primary Care Foundation Benchmark Report, April 2012
http://www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Benchmark4reports/Benchmarkoverview.pdf
[11] GP Patient Survey

of often confusing and fragmented options. The need for more effective signposting of services was one of the aims behind the introduction of NHS 111, but there have been well-publicised problems with the implementation of this service in many parts of the country (see section 5 below).

4.4 We need to focus on supporting GP out of hours services to continue to improve the care they provide to patients. We also need to look carefully at how these services are commissioned, and how we can ensure they are integrated more effectively with the system as a whole, both in and out of hours. RCGP is concerned that with CCG funding severely restricted, in future social enterprise providers led by local GPs will increasingly find themselves priced out of the market by commercial providers.

**5. NHS 111**

5.1 NHS 111 must be more effectively supported if it is going to properly direct patients to the most appropriate form of urgent NHS care. The implementation problems of the NHS 111 service are extremely worrying and we are concerned that patients are losing confidence in the new service before it is even fully up and running. The RCGP has also called on NHS England to provide more reassurance about its effectiveness and ability to deliver the necessary standards of care for all patients using the service.

5.2 We believe the overarching principle behind NHS 111 – providing patients with a memorable number they can call to access urgent and emergency care services that is 'less urgent' than calling 999 – is a good idea. If properly implemented, NHS 111 has the potential to make it easier for patients to get “the right care, in the right place, at the right time from the right care professional”. This approach is supported in the RCGP’s Commissioning Guide: *Urgent and emergency care: a ‘whole system’ approach.*

5.3 In many areas where there have been problems with NHS 111 implementation it has been GP out of hours services which have 'picked up the pieces' and ensured that safe care is delivered. Whilst GP-led social enterprises have won some NHS 111 contracts, many have been unable to compete on cost with NHS Direct and commercial providers. RCGP would like to see a move towards more NHS 111 services being provided by local GPs in this way.

5.4 In RCGP’s view NHS 111 was rolled out far too early, with unnecessary pressure placed on some sites to go live before they were ready. We are also concerned about how the service itself is being run - some areas seem to be properly resourced with well-trained clinical staff whilst in other areas it is struggling to cope with insufficient numbers of call handlers, some of whom have received only a few weeks training.

**7. A 'whole system' approach**

To successfully meet the challenges of delivering urgent and emergency care in the 21st century NHS we must redesign services based on a ‘whole system’ approach, more effectively integrating care across different parts of the system, and between in and out of hours care. Key elements of this will be:

- **Shifting investment towards primary care**: As noted above, a disproportionately small amount of the NHS budget is spent on general practice, and if current trends continue

this will further drop by nearly £200m in the next three years[12]. In particular we need to focus this investment on increasing the GP workforce, which in turn would enable GPs to spend more time with patients – such as those living with multiple morbidities – who require complex care. The standard 10 minute consultation is not long enough to deliver 'anticipatory' care which will help avoid unnecessary hospital admissions. There is also a significant gap in the data around GP capacity and workload – the latest substantive evidence on GP activity and workload is from a Health and Social Care Information Centre (HSCIC) report on consultation rates from 1995 to 2009 and the 2006/07 UK GP Workload Survey. This needs to be rectified urgently.

- **Embedding a multi-disciplinary 'care planning' approach within primary care**, with GPs working alongside other health professionals to support patients with long term conditions to self manage their care. We must move away from reactively treating individual episodes of illness – often in secondary care settings – to better anticipating patients' needs by planning and managing long term care in the community. Key to this approach is patient empowerment through the promotion of shared decision making and self care, putting patients in control. Major trauma and hyper-acute services should continue to be focussed at dedicated centres with sufficient infrastructure, whilst 'urgent' (as opposed to 'emergency') healthcare needs to be developed locally, underpinned by models of primary care working with community services.

- **Improving the interface between primary, secondary care and social care:** Part of the solution in addressing the current difficulties around emergency care is to strengthen the interface between primary care and A&E. There are challenges around discharge planning, shared access to patient records and ensuring A&E departments are aware of services available in the community. This is especially important for vulnerable patients such as the frail elderly, for whom the greater continuity of care and integration of services that general practice can offer are particularly important.

- **Greater integration with ambulance services:** We should work towards greater integration of ambulance services within the system as a whole, including with general practice services both in and out of hours. Ambulance services should continue to develop alternative care pathways, offering treatment and transfer to a range of clinical services without the need to take patients to A&E. Local CCGs could also benefit from more data intelligence from the ambulance service, for example in the identification of particular nursing homes and/or post code areas with high call out rates.

- **Building confidence and awareness of NHS 111:** Part of the problem facing the current urgent and emergency care system is that patients are faced with a fragmented range of options. In principle, NHS 111 has the potential to provide patients with a single, clear access point as an alternative to calling 999. However, due to the problems with its implementation so far in some parts of the country patients do not currently have confidence in the system.

[12] RCGP Press release, May 2013: http://www.rcgp.org.uk/news/2013/may/spending-on-patient-care-set-to-plummet-by-millions.aspx