



**All Party Parliamentary Group
Primary Care & Public Health**

**Inquiry Report on
GP Access & Health Improvement in Primary Care**



July 2008

Contents

	Page
1. Introduction	4
1.1 GP Access.....	4
1.2 Delivering Health Improvements.....	6
2. Executive Summary	7
2.1 Key Recommendations.....	8
3. Summary of Evidence from Inquiry Participants	10
3.1 Public Engagement.....	10
3.2 GP Access.....	12
3.2.1 Registering Near Work.....	13
3.2.2 Walk in Centres.....	13
3.2.3 A&E Departments.....	14
3.2.4 Pharmacies.....	14
3.3 Health Improvement.....	16
3.4 QOF & Commissioning.....	18
3.5 Our Future, Our NHS – Lord Darzi’s NHS Review.....	22
4. Oral evidence from Government	25
5. Conclusions & Recommendations	33
5.1 Public Engagement.....	33
5.2 GP Access.....	34
5.3 Health Improvement.....	35
5.4 QOF and Commissioning.....	36
5.5 Lord Darzi’s Review.....	38

5.6 Recommendations Stemming from the Inquiry Process..... 39

6. Annex i:

 Members of APPG on Primary Care & Public Health..... 40

7. Annex ii: Organisations who submitted evidence..... 42





1. Introduction

The All Party Parliamentary Group on Primary Care and Public Health held an Inquiry into patient access to General Practitioners in early 2008. The Inquiry also focused on the policies implemented to deliver health improvements in primary care. The Group invited a number of stakeholders to participate in the Inquiry through oral and written evidence. In total, nineteen organisations gave their expert views to the Inquiry through written submissions whilst eleven of these organisations contributed further during three oral evidence sessions (please see Annex ii for details). The Government also added its voice to the Inquiry at an extra oral evidence session in February 2008 (see page 25).

This is the report of the Inquiry, providing a summary of the evidence submitted in written and oral formats together with the APPG's conclusions and recommendations.



1.1 GP Access

GP consultations have been rising dramatically over the years; the 2007 Wanless report states that consultation rates rose by over a third between 1989 and 2005 with figures amounting to 250 million consultations a year. The 2004 GP contract was designed to allow GPs to manage their workload more effectively and to improve the quality of care they deliver to their patients. Four years later general practice is still under considerable pressure. Various factors have contributed to workload pressures including health policies such as those outlined in the 2006 health White Paper, *Our health, our care, our say*. The White Paper centred on shifting healthcare services into the local community. This

means a number of services that were previously dealt with in secondary care are slowly being moved to the primary health care sector.

In addition to the pressure for extended services in primary care, are the demands being put on the service by those seeking medical attention for minor ailments (according to DH figures 300,000 consultations per day¹). The view from the BMA is that, whilst there is increasing awareness of “inappropriate” consultations amongst doctors, only a small number of practices are implementing ways of promoting better use of NHS services.

The DH 2007 patient survey found that the majority of patients were pleased with GP access, with 84% of people satisfied with surgery opening hours. However, Government is adamant that primary care access has to be widened.

DH statistics² show that a significant number of patients wrongly use A&E for their primary care needs and so turning A&E into a legitimate primary care provider might be an appropriate alternative.

Another option, suggested by the NHS Confederation is to add all primary care use, including A&E and walk-in centres in the GMS contract. Practices, rather than the PCT would therefore be charged for the costs of patients on their list using A&E services unnecessarily, which, the NHS Confederation feels, might incentivise practices into managing their urgent care system more effectively.



¹ DH 2005: Self care -a real choice. Self care support – a practical option

² DH 2005: Self care -a real choice. Self care support – a practical option

1.2 Delivering Health Improvements

The 2007 Wanless report announced that the NHS is failing to deliver on health improvements for patients. In 2004 a series of measures were introduced to help improve health benefits to patients in general practice. One of those was the Quality and Outcomes Framework (QOF). There has been wide take-up of the programme, however Wanless criticised QOF for simply measuring practice activity whilst the focus should be around good health outcomes for patients.

Wanless also found a lack of systematic data being collected to show the impact of NHS interventions on people's health status. He revealed also that policies were being implemented without prior evaluation and made the point that reforms to the NHS needed careful evaluation.

The evidence base was also an issue with other programmes such as choose and book; payment by results and practice based commissioning. Although these programmes have been around since 2004, uptake has been slower than Government thought. Designed to help drive a patient-centred NHS, Wanless revealed there is very little evidence these programmes so far yielded the kind of benefits that were expected.

Continuing along the theme of an NHS which is clinically led, patient-centred and locally accountable, Professor Ara Darzi is conducting a wide-ranging review of the NHS engaging patients, NHS staff and the public. One of the key challenges for Professor Darzi is to ensure there is more accessible and convenient care which is integrated across primary and secondary care providers, reflecting best value for money and offering services in the most appropriate settings for patients.

It is against this background that the APPG took its decision to conduct an Inquiry which would provide the members with the necessary views of providers, commissioners and users of the NHS to contribute to the Darzi Review and the primary care debate.





2. Executive Summary

A number of stakeholders were invited to participate in the Inquiry through oral and written evidence. We received nineteen written submissions and twelve organisations gave oral evidence.

Opinions and comments were diverse. For GP access, quality of service was of particular importance for patients, whilst the issue of access itself was considered to be less of a priority.

Equity was the biggest issue for the choice agenda with there being a view that affluent patients were more able to use the choices offered.

In the GP arena, the Quality and Outcomes Framework elicited a wide range of opinions. There was a view that it focused the activities of practices whilst there was doubt that it improved health outcomes for patients.

For the Next Stage Review, building on existing systems that work in the NHS was thought to be crucial as was the practice of engaging patients, staff and the public in shaping all future health policy.

We believe this Inquiry comes at an important time when primary care services are being carefully considered as part of the health system in England. Crucial policy documents are soon to be published such as the Primary Care Strategy and the Darzi Next Stage Review and our deliberations and recommendations will be submitted as contributions to these key Government documents. Another important strategy document, which was published during the time we were holding this Inquiry, is the

Pharmacy White Paper, "Pharmacy in England, building on strengths – delivering the future". We acknowledge that many of the views expressed during the Inquiry have been included in this White Paper; nevertheless, we have comments on areas that need specific direction for implementation.



2.1 Key Recommendations:



Local and national information campaigns are run to increase people's knowledge and understanding of self care, health and NHS services;



Comprehensive educational schools programmes are included as part of the schools curriculum to encourage greater health awareness in the next generation and achieve long term health goals;



Health professionals take on a more proactive role in strengthening people's capacity to self care, ensuring consistency of advice and education;



Government, nationally and locally introduce information campaigns to educate the public on self care of minor ailments and to highlight the services provided by pharmacists;



A public campaign is carried out to have the pharmacist recognised as the first port of call for minor ailments;



The GMS contract is changed to recognise health improvements and prevention are seen as "essential services" with practices required to take a more proactive role in strengthening individual's ability to self care;



There is more flexible and extended opening hours for GP access targeted to where demand is high rather than a blanket approach across the country;



Commissioners improve access and quality of primary care, increase capacity of primary care services to hard-to-reach groups;



QOF is refined to reflect improvement for patient outcomes;



PROMs (patient-reported outcome measures) are used to measure health outcomes although this is to be piloted first of all;



PCTs support and incentivise GP practices to commission more activity;



Systems are installed that allow for co-operation with other local partners such as social care, housing and leisure to enable a range of solutions which address health outcomes to be delivered;



Case managers such as Community Matrons are closely integrated with primary health care teams;



Patient representation is present on PBC steering groups;



The Next Stage Review must build on existing systems that are working within the health service and that any new policies should only be included if there is an evidence base to support them;



Sufficient investment is spent in public health approaches to engage the public into taking more responsibility for their own health;



Government continues to engage staff and patients when developing policy.





3. Summary of Evidence from Inquiry Participants

We invited a number of organisations to submit evidence based on a series of questions. A synopsis of the oral and written evidence has been produced and batched into six main topic areas: public engagement; GP access; health improvement; QOF & commissioning and Lord Darzi's NHS Review. The questions put to the respondents are highlighted in the box preceding the synopsis.



3.1 Public Engagement

1. Can you suggest ways practices can combat the problem of those seeking medical attention for minor illnesses?
2. Do you think it is more appropriate for patients to be sent to the pharmacist for advice on minor illness, therefore allowing the doctor to have more time to devote to the patients who need their skills?

Some respondents forecast GP consultations increasing, with the need for longer time slots for complex consultations such as long term conditions. We were made aware of evidence³ showing that GPs can add an extra hour to their day by shifting consultations for minor ailments to the pharmacist, allowing for the necessary capacity to deal with the increase in complex consultations without extending surgery hours.

Respondents stressed the need for public engagement in self care, especially at a very early age, with a cultural shift in attitudes towards self care seen as being crucial to people's health and wellbeing in addition to being essential to sustaining the health system in the future.

³ IMS 2007: Minor ailments and GP workload

They emphasised the need for local and national information campaigns to educate the public to use NHS services more effectively, and public health messages to increase people's knowledge and understanding of health matters. Many respondents felt it was necessary for the next generation to have more awareness about their health and to use the health system more effectively. One key avenue is through educational schools programmes. This was said to be essential if we were to achieve long term health goals such as obesity.

Respondents also felt there was a need for better engagement by those health professionals working on the frontline such as doctors, nurses and pharmacists, and these professionals should take on a more proactive role in strengthening people's capacity to self care, ensuring consistency of advice and education.

Evidence shared with us showed 18% of GP workload is spent dealing with minor ailments⁴. Respondents believed the NHS does not handle minor ailments efficiently and thought easy, same day access to general practice discouraged self care for minor ailments.

Respondents viewed pharmacists as an under utilised resource for patients and the NHS and were seen as healthcare professionals that were easily accessible due to their location and opening hours.

We were made aware of evidence that showed the transfer of activity away from GP practices to the pharmacy which was cost effective with results from Scotland's 'direct supply of medicine'⁵ pilots showing falls in GP consultations for 'minor ailments' (pain, head-lice, coughs) that ranged from 2 to 3%.

⁴ ibid

⁵ Schafheutle E, Noyce P, Sheehy C, Jones L (2003) Direct supply of medicines in Scotland: evaluation of a pilot scheme - research findings. Scottish Executive Social Research, Research Findings No.29/2003, <http://www.scotland.gov.uk/Resource/Doc/47034/0029655.pdf>

There were some reservations about pharmacists having an extended role such as; the lack of private consultation areas; uncertainty about pharmacists' communication skills and ability to diagnose; and concern the public might not "accept" the pharmacist as a GP substitute. A public awareness campaign was suggested to highlight the numerous health services provided by the pharmacist.

There was also the GP view that pharmacists were reluctant to integrate with their neighbouring GPs and nurses, and should be encouraged to work more closely to benefit the local community and work jointly on developing systems for minor ailments, smoking cessation clinics and the management of long term conditions.



3.2 GP Access

3. To what extent would the proposed measures have the desired impact? (Extending opening hours for surgeries; allowing people to register at a GP near work; allowing people to register with pharmacies, sports centres, walk-in centres and A&E?)
4. If the GMS contract were widened which services would you envisage being included?
5. Do you think the existing primary care access services have been beneficial for patients and practice workload, for example 24/48 hour appointments; choose and book etc?

Whilst it was clear from recent surveys that there was a high level of consumer satisfaction with GP access, there were concerns, especially from consumer groups that significant numbers of people were experiencing problems accessing care. Problems such as getting through on the telephone to make an appointment; being unable to make appointments at convenient times to suit patients' needs; and arranging appointments in advance. Care at the weekend was also of concern,

although respondents thought these problems would improve once flexible and extended opening hours was implemented in GP surgeries.

There was some doubt expressed by the King's Fund about the need for extended opening hours however, with Saturday mornings especially said to be underused by practices that currently offer this service. Some respondents questioned whether extending hours would be cost effective as a blanket policy. Surveys suggested only a small percentage of people required access during weekends and evenings. The July 2007, Ipsos-MORI survey of 2.3 million people found that only 4% of people requested evening opening and just 7% at weekend. And although extended hours requested by Government have been agreed upon, the suggestion by some respondents of a target approach where demand was high was thought to be a better way forward than a blanket policy.



3.2.1 Registering near work

It was pointed out that registering near work with a GP would be fine for routine appointments, but, dual registration with a GP near home would also be necessary for the times when patients were too ill to go to work. Respondents also felt that dual registration without the electronic patient records system would risk patient safety.



3.2.2 Walk-in Centres

In general, walk-in centres were given widespread support because of their accessibility. They were said to be particularly popular with younger male adults, a demographic that does not access healthcare routinely. Registering with walk-in centres however was thought to undermine their open-access function and add to existing consumer confusion about the purpose of primary care services. The point was also made that walk-in

centres are not necessarily a cheaper provision of healthcare since consultations take longer and involve lengthier investigations.

NHS Direct was highlighted since it already provides an alternative to standard primary care services and is used as such, especially when GP practices are closed. This kind of 'telecare' service has been studied and shows high levels of patient satisfaction; and there was also some limited effect on equity, those patients in rural isolation or with other constraints that prevent them getting to a surgery can make use of telecare.



3.2.3 A & E Departments

Overall respondents did not feel that A&E departments were the right environment for primary care services, one potential problem was with new rotations of trainee doctors who tend to over estimate risk, and consequently over order diagnostic tests, unnecessarily driving up costs and patient time.



3.2.4 Pharmacies

There was agreement that there was considerable scope for monitoring of long-term conditions, dealing with minor ailments, smoking cessation, weight programmes etc to be undertaken in pharmacies with the necessary support and resources from local PCTs and healthcare professionals. It was noted however that staff would need to have the necessary skills and competence to provide the full range of primary care services to meet patients' needs. Access to patients' care records would also have to be available.

Patients registering away from an area could possibly have a negative impact on funding streams for local health services. The relative

capitation costs of the local patients would rise and PCTs in such places would require relatively higher levels of support for their populations.

Patient surveys also highlighted the point that access was not necessarily a priority for patients and increasing the number of GPs in under doctored areas was felt to be more pressing an issue than extended hours, and might help to reduce health inequalities.

Whilst there are no plans to change the GMS contract beyond extending surgery hours, a number of suggestions were made by respondents who, in an ideal world would like to see some changes in primary care:

- Health improvements and prevention should be a major focus in primary care and shifted from “additional services” to “essential services”. Particular attention should be made to strengthen the capacity of individuals to self care. Practices could take a more proactive role, for example educating patients and providing information such as good quality health leaflets.
- Appointment booking systems should be more patient-friendly enabling patients to book appointments ahead for routine care and check-ups.
- The Choose & Book system should be implemented as intended. Two factors are preventing its progress; 1) patients have insufficient clinical information to make an informed decision, and 2) referrals are being refused by the requested health provider and returned to the GP when lists are full.

There was also the opinion that 24/48 hour access had increased workload and was not necessarily based on clinical need, resulting in dependency in patients who do not practice self care but instead rely on general practice staff to look after their every health need, however minor.

Choose and Book was not viewed by respondents as a great success. A GPC survey of GP opinion in 2007 found that only 20% of GPs reported their most recent experience of Choose and Book as being a positive one and only around 66% of GPs were currently using the software. It was also noted that since its introduction the scheme has encountered problems with the use and usability of the technology and several modifications and versions have resulted. The National Audit Office⁶ (2005), for example, reported that progress has been slower than planned due to problems including the reluctance of users to work with an unreliable 'end-to-end' system, with little progress in linking GP and hospital systems, and a low number of GPs willing to use the system. Some respondents felt that Choose and Book, or some other form of electronic booking service, still has the potential to provide fast and effective co-ordination of care through the facilitation of patient choice.



3.3 Health Improvement

6. If policy is about redistributing care closer to home by shifting workload from secondary to primary to self care, does the definition of primary care need to be redefined?

7. What in your view would be the description of primary care working at its optimum level in both cost and patient satisfaction terms?

Some respondents felt primary care in the NHS is too narrowly defined in terms of the range of services offered by doctors, nurses, dentists and pharmacists, making the point that it should be a wider public health/health maintenance role. A definition offered by a respondent was: *"Integrated community care involving generalists, diagnostics, specialists as well as traditional community service"*.

⁶ National Audit Office (2005) Patient Choice at the Point of GP Referral. London: The Stationery Office.

Others felt it was unnecessary to redefine primary care since ensuring consistent standards of high quality care was considered more important. Respondents thought only those services that can be safely transferred to primary care should be transferred and competence of staff providing these services must be assured. Others wanted the quality of PCT commissioning of services to improve significantly to meet patients' needs, and their understanding of those needs.

There was a need for better public engagement to persuade people that shifting care from secondary to primary was in their best interests. Comprehensive local and national information campaigns were thought to be a good way of improving communications with the public.

Some respondents questioned whether there was, in fact, the capacity and the skills to shift services from secondary to primary care.

Others felt patients are encouraged to have high expectations of a service that is funded to meet their needs – and often fails to do so due to lack of capital investment and revenue resources. And that balancing needs and wants was a political decision.



3.4 QOF & Commissioning

8. What would the measurement be to change health improvement activity to health improvement outcomes in QOF?
9. To what extent do you think QOF can be a true indicator of health outcomes and how?
10. Do you think QOF can balance incentives and sanctions for delivering health outcomes?
11. How is your organisation addressing the choice agenda and what is your understanding of patients' views?
12. To what extent can practice based commissioning (PBC) be used to structure services aimed at improved health outcomes?
13. What is the relationship between practice based commissioners, patients and the community in delivering health and well being, managing complex consultations and designing effective care for the elderly?
14. How far would you see PCTs go in introducing mechanisms to implement policy? What is the PCTs role in turning the policy framework into practice and to what extent should they be involved in helping practice based commissioners know how to implement relevant services?

There were mixed views on the effectiveness of the QOF system. Some respondents felt that because QOF measures activity it cannot improve health outcomes. Other respondents thought QOF helped to focus the activities of practices and that whilst it may start off as a tick box exercise, with time, the rationale becomes clearer and is a true indicator of health outcomes. There was also the recognition that there is a limit to how QOF can be used and it is difficult to include processes for patients such as diet and exercise; although QOF is seen as a "work in progress" function that can be made more sophisticated to be personalised and focus on true health outcomes.

Other respondents argue that outcomes are more difficult to measure than processes and the emphasis on process that resulted from the introduction of QOF must not detract from patient care. The point was

made that many diseases are not included in the QOF and the framework therefore required update and review to ensure that clinically important outcomes were not omitted.

There were concerns from consumer groups about QOF being about perverse incentives and 'gaming' such as excluding eligible patients to meet targets. Other worries were expressed by these groups:

- There was a lack of focus on prevention or proactively identifying people at risk of ill-health or particular conditions;
- It has not significantly improved the way GP practices deliver care;
- The extent of patient feedback is limited;
- More focus should be on preventing ill-health with real improvements in health outcomes being achieved by people changing their behaviour to maintain a healthy lifestyle in the first place.

It was felt however that helping to change these behaviours is not simply the responsibility of the GP practice but rather a wide range of policy initiatives and programmes should be implemented. These should include community-based initiatives, public education programmes, initiatives that use health professionals such as community pharmacists, health visitors and school nurses, as well as measures to improve food labelling and reduce the amounts of added fat and sugar in foods. Having consistent public policy and concerted initiatives on these factors, both nationally and locally, was thought to be the best way to secure real health improvements although respondents were concerned to see services that could significantly help drive health improvements such as health visitors and school nurses being cut in many areas.

Respondents suggested the introduction of patient-reported outcome measures (PROMs) across the NHS. Although they felt it was necessary to exercise caution before implementation of PROMs since it has only been used to measure specific surgical treatments.

Some respondents felt it was not possible to use QOF as a true indicator of health outcomes since outcomes are influenced by many factors outside the care provided by general practice. That it will only ever be an indicator of health outcomes in relation to the specific diseases it covers although even then, it will only be possible to judge the full impact of the QOF over time as the longer-term benefits of treatment are revealed.

Other respondents felt that QOF has huge potential to be improved by setting more challenging targets and reducing the levels of exception reporting. Work on incentive structures suggest that QOF has comparative merits over other systems but needs to ensure it covers the full breadth of presenting areas from patients in order to avoid skewing clinical priorities.

Many respondents were of the opinion that there is a widening gap between meaningful patient choice and the 'choice' agenda. Among the many criticisms of existing government policy on choice is the risk that it will worsen inequalities in healthcare. Respondents felt that too often choice is restricted rather than enhanced by other government policies, giving the example that choice of provider has been restricted when trusts return referrals because the patient cannot be seen within the national target times and so the patient is sent to a different provider, rather than being offered the option of waiting longer for the provider of their choice. There were reports that hospitals cease to provide/offer appointments altogether if this threatens their achievement of the 18 week target.

Most respondents were in agreement that effective commissioning could succeed in structuring services resulting in improved health outcomes; they felt PBC had the potential to be a very powerful tool within this process. It will enable decisions on local services to be taken at a level much closer to the day to day experience of local communities; ensuring services are targeted at local health needs.

There was concern amongst most respondents however that currently PBC is not realising its full potential since it is only really able to focus on demand and resource management. Some respondents believed there is a lack of effective clinical engagement in PBC and that there are a number of obstacles preventing effective commissioning from happening. These include:

- lack of support and/or incentives for GP practices in their commissioning activity;
- annual budget setting, which prevents meaningful, longer-term commissioning plans from being put in place;
- a shortage of high level expertise and training;
- lack of co-operation with other local partners such as social care, housing and leisure to enable a range of solutions which address health outcomes to be delivered;
- scarcity of mechanisms that allow robust patient input;
- no leadership from PCTs;
- ineffective communications and IT system.

Respondents felt the most important element in achieving such goals was collaboration amongst those providing the services, especially since services are often fragmented. It was necessary for example that case managers (Community Matrons perhaps) should be closely integrated with primary health care teams.

The point was also made that the elderly are the biggest users of medicines and often have multiple chronic conditions, but for the majority of the time they will be caring for themselves with or without support from family members or paid carers and so effective health care can only be achieved if the person is genuinely consulted in all aspects of their care.

Respondents believed PBC must maintain a broad preventive focus and not simply focus on 'better buying' of secondary care and note this can be achieved by improving access to good quality primary care for deprived

populations; offering more services shifted from secondary to primary care (eg organise to deliver more local and speedy access to diagnostic interventions); and offer local leadership with other community based services (housing, education etc).

Some respondents felt it was too early to judge the functioning of PCTs and their PBC groups, although they agreed PCTs will have to play a considerable part in introducing policy initially and assisting PBC groups in the development of their role. Currently PBC groups are at an early stage of development which is said to reflect the variation in the ability and interest of GPs to engage in this role.

With no patient representation on PBC steering groups, it was felt that the patient was being overlooked by commissioners.



3.5 Our NHS, Our Future – Lord Darzi’s NHS Review

15. Do you think this (Darzi review) is 'just another NHS review'?
16. What do you want to see in the review?
17. What is your view of the Darzi review presenting opportunities for greater morale to be achieved amongst NHS staff?

There were mixed opinions amongst respondents, some felt it is a new vehicle for delivering existing policies whilst others were more positive and believed the NHS Review has the potential to be a fundamental assessment of the NHS, far-reaching in its impact on the quality, safety, effectiveness and patient-centeredness of healthcare.

Others were particularly pleased that important decisions about the future of the NHS are being made with the fullest involvement of patients and communities, working alongside managers, clinicians and staff.

Others still worried about further reorganisation of the NHS without evidence, piloting or realistic cost assessment causing destabilisation. Respondents thought it was necessary to build on what *is* working in the health system.

Ultimately, respondents wanted the Review to provide a sound foundation for a truly patient centred NHS that can deliver high-quality care consistently across the country, and to all consumers for now, and in the future.

Some respondents felt it was essential to have evidence based policy in the Review. Polyclinics were thought to be one example where there is no clear evidence of efficient use of NHS resources. Inequalities too were of great concern and it was felt that simply funding the regions where inequalities exist was not sufficient, there was a need to have robust evidence based research to understand exactly how resources should be targeted in order to guarantee the intended result.

Respondents were of the opinion that the Review has to take sufficient account of the need to invest in public health approaches to engage the public into taking more responsibility for their own health.

Consumer groups were anxious to see a number of key items in the Review:

- Better access so that people can get the care and treatment they need, when they need it with greater equity of access to services and care;
- Good quality care so individuals can be sure that they are getting the best available care and treatment whoever cares for them and wherever they are;

- Availability of the sorts of choices consumers want about their healthcare, with support to assist them making and taking up their choices;
- Improved provision of information about health and local services to support choices;
- Accessible redress so patients can easily raise their concerns if services fail to meet their needs and lessons are learnt and used to improve services.

Many respondents felt that engaging staff (and patients) should be at the heart of everything the NHS does and a first class NHS can only be delivered when staff, patients and the management of organisations are involved in developing policy and setting priorities.





4. Oral Evidence from Government⁷ 26th February 2008

APPG Members Present

Sandra Gidley MP	Co-chair
Baroness Masham of Ilton	Treasurer

Oral Evidence Speakers

Rt Hon Ben Bradshaw MP, Minister of State for Health Services
Mark Britnell, Director-General of Commissioning & System Management
Richard Armstrong, Head of Medical Primary Care

Report of Session

“Our NHS, Our Future,” Professor Lord Ara Darzi’s forthcoming next-stage review of the National Health Service (NHS), will differ from many previous examinations of the NHS because “it is asking a lot of well-informed clinicians what they think they can do to meet patient expectations in the 21st century,” and the traction and speed of implementing the review’s recommendations will be “all the better for it,” Mark Britnell, director-general of commissioning and system management for the NHS in England, has told members of the All Party Parliamentary Group on Primary Care and Public Health on 26 February, during the final oral evidence session of its inquiry into GP access and health improvement in primary care.

Lord Darzi’s review is just one of several major new health policy documents which the government plans to publish around the time of the

⁷ This is a report of the session by a freelance journalist

NHS's 60th birthday celebrations in July, Mr Britnell said, beginning in a few weeks time with a White Paper on Pharmacy. A new Primary and Community Care Strategy will also be published.

Also addressing the panel was the Minister of State for Health Services, Ben Bradshaw (Labour, Exeter), who told Committee co-chair Sandra Gidley (Liberal Democrat, Romsey) that he did not share the view that the extended opening hours for patients which the government is urging general practitioners (GPs) to provide would mostly benefit the "worried well." In fact, all the evidence suggests that, where extended services are offered, they are used by blue-collar workers who are paid by the hour, many elderly people and young families, as well as professional people.

The Committee's inquiry had previously been told that the latter group are the most dissatisfied with current GP access arrangements, while for other population groups the issue is of lesser concern. But Mr Bradshaw disputed this; every recent survey has shown that the biggest area of patient dissatisfaction is not being able to see their GP at a time which is convenient for them. This is shown not only in official polls but also in the recent study undertaken by Which? he said.

Another new survey, published in The Times newspaper, has revealed that the public is far less resistant to the idea of visiting polyclinics and not always being seen by their own GP, he said. For the first time, we're seeing a generational difference in attitudes to continuity of care; for younger people, this is less important than convenience.

The government believes that patients should also be more empowered and informed, and their relationship with their GP should be a partnership, the Minister added.

The APPG evidence session took place just as GPs were being polled by the British Medical Association's (BMA) GP Committee on extended opening hours. Mr Bradshaw said he hoped GPs would sign up to the

government's proposal that they should open for an extra three hours per week for every 6,000 patients in the practice. We need to offer patients "meaningful chunks of time," he said.

Sandra Gidley then discussed recent new data from IMS which shows that 18% of the GP workload is taken up by dealing with minor ailments alone. She asked the Minister: is this the best way to treat these patients?

He agreed that it is not but, while efforts are being made, no more than 25% of Primary Care Trusts (PCTs) now have contracts with the pharmacy sector. There has not been as rapid a take-up of the contracts between PCTs and pharmacists as the government would have wished, he said, but the hope is that the publication of the Pharmacy White Paper in the next few weeks will give "a big push" to expanding such commissioning by PCTs.

The White Paper will also be looking "more specifically" at proposals that a large proportion of minor ailments can be treated just as well by community pharmacist as general practitioner, added Mr Britnell. Asked by Sandra Gidley if this means minor ailments could be dealt with by pharmacists without the need for any further training, Mr Britnell replied: "we agree that it needs to be looked at – we are looking at it most carefully."

The Group's Treasurer Baroness Masham of Ilton (cross-bencher) stressed that GPs should always provide emergency appointment slots for patients who are seriously ill, and the Minister agreed that good practices will have someone on call at all times to deal with such cases. He also noted that, while the government's target of ensuring that patients are able to see a GP within 48 hours is now being met around 90% of the time, there has been an "unintended consequence" in that some practices have, in order to hit this target, made it more difficult for patients to book appointments ahead. So the government has now provided a guideline, and an incentive

scheme, for GPs to provide a booking-ahead service, and the target here is now being met 72%, he said.

Moreover, with the responsibility for providing good out-of-hours (OOH) services having been taken away from GPs and placed with the PCTs, there should no longer be any reason for such concerns about emergency care, he told Baroness Masham.

She then told the officials that, while the government's declared policy is to shift certain secondary care work into the primary care sector, there are fears that primary care does not have the capacity or facilities to do so. She asked: how can this be improved?

Mr Britnell replied that Lord Darzi's enquiry is looking into this problem, and the upcoming Primary and Community Care Strategy will also be making specific recommendations on how to improve capacity further. However, other solutions are already being actively explored, he added. For example, some secondary care physicians – such as cardiologists, dermatologists and geriatricians – could take their work with them out of the hospital setting and provide these services in community or primary care. Also, some GPs have special interests in field such as rheumatology, dermatology, gynaecology and ear, nose and throat treatments, and they could work more closely with secondary-care specialists in these areas, he said.

The model of providing more services in the primary care setting, "which some people call polyclinics," is "exactly what Lord Darzi is talking about in the context of his NHS review," added the Minister. He pointed out that last autumn's announcement by the government of a £250 million investment in boosting primary care capacity will mean one new health centre in every PCT area, open from 8am to 8pm, seven days a week, plus 100 new health centres and GP services in the 38 most under-doctored PCTs, in order to try to address continuing health inequalities, he said.

And such inequalities still exist very strongly, said Mr Bradshaw; every London Underground station from Westminster to the East End represents one less year of life for residents, while the number of GPs per head of population in the East End is half the number in Westminster.

All the experts emphasised that Lord Darzi's next-stage review of the NHS will not be seeking to impose a "top-down" or "one-size-fits-all" solution for the country. The balance between tertiary, secondary and primary care and community services is different in London, other cities and rural areas, and what is appropriate for one region will not work in others; local solutions must be developed locally, they said.

Sandra Gidley then asked the witnesses why Practice-Based Commissioning (PBC) is thriving in some areas but not in others.

Mark Britnell pointed out that, after 18 months, PBC is still a developing piece of policy, and he felt that success will be based on: the appetite for clinicians to show leadership; the appetite for PCT managers to show support; and the ability of PCTs to give people the tools to do their job properly, most notably in terms of information technology (IT) and systems.

There are some "stunning" examples of PBC, where clinicians, GPs and others have really transformed local services by commissioning and then either providing or shaping services; however, in other parts of the country, where relationships are more fragmented, things have got off to a slower start, he acknowledged. Another problem is that, since 1991, NHS purchasing has been reorganized six or seven times, and it is taking time to get familiar with the concept of commissioning, he said.

Nevertheless, "it is absolutely government policy" for clinicians to take more responsibility and accountability for commissioning and delivering services, and the Department of Health is starting to review PCTs whose

progress is not sufficient. One of the most powerful tools it is using to achieve this is by asking 2,000 GP practices, every quarter or half-year, to conduct a 360-degree review of their PCT's performance and feed back their views.

"PBC is not going away – it's here to stay and we will slowly but surely improve it," said Mr Britnell. However, he added: "I don't believe we have all the skills and talent we need, but we can get help and assistance from the best of the public sector and the private sector and, most importantly, there are lots of clinicians waiting to get engaged." We need to build on those foundations and to be much more focused on the areas that really do make a difference and "less precious about where we get that skill and support from," he told the panel.

Sandra Gidley wondered if there is currently a large enough split between purchaser and providers - one PCT chairman had told her that his biggest problem was preventing GPs commissioning from themselves, she said.

Mr Britnell replied that, as people take more responsibility and accountability for budgets, be they real or indicative, the level of governance in audit has to increase proportionately. As PBC develops, there will be a commensurate increase in the level of probity and governance applied to PBC commissioners; in part, that means getting PCTs in the right place so that they are not "suffocating but supporting" and also legitimately challenging the service commissioned, he said.

The next phase of evolution is to make sure doctors and nurses take more responsibility but also that they are held to account much more explicitly, he said, and pointed out that the debate about community pharmacy "juxtaposes around these issues."

Sandra Gidley asked if enough advice is available upfront for pharmacists, so they don't fall into these traps. Mr Britnell replied that the pattern was mixed; for example, he said audit committees are not always being used

to the best effect. However, he assured Baroness Masham that there was “no risk whatsoever” that doctors might not send patients with specific serious conditions, such as cancer, on to a specialist. The first duty of a doctor is to make sure patients receive the best possible care, although this may of course not always be referral to hospital, he said.

Turning to public health issues, Sandra Gidley asked the experts for their views on criticisms that the GPs’ Quality and Outcomes Framework (QOF) is too performance-based and focusing insufficiently on outcomes.

Richard Armstrong, head of medical primary care at the Department of Health, said the Darzi review will be looking to make QOF more outcomes-focused and “stop rewarding so much of the process.” This is also expected to be a focus of the forthcoming Primary and Community Care Strategy, which will be looking at more primary prevention, as well as an outcomes-based rewards system, he added.

The Darzi review differs from previous NHS inquiries because it is about securing and delivering the improvements which the government has been talking about for some time, said Mr Armstrong. QOF needs to become better over the years, not through “huge radical changes” but by developing it in line with patients’ expectations, certainly in outcome-based care. “Clinicians will sign up to this; they want to see improvement in the health of the population, and we are about delivering many things that clinicians themselves want,” he said.

The Darzi review is also different in that this is the 60th year of the NHS and the Labour government had been in power for 10 years when it was announced, said Mr Bradshaw. At that time, the NHS had many very basic quality and capacity issues, such as long waiting times and very poor mortality rates in areas cancer and heart disease. There is still some way to go in most of these areas, but “we’ve done quite well at addressing basic capacity issues,” said the Minister, who pointed out that UK health

care spending has now risen to just slightly below the European Union (EU) average.

The challenges for the next 10 years will include rising public expectations of the Service, he said; people are increasingly used to personalised service, and they sometimes don't understand the lack of personalisation in the NHS.

Another major challenge will be how to contain costs and stop spending spiralling out of control in an era of slower spending growth and against the impact of lifestyle diseases such as alcohol and obesity issues. If we don't get a handle on these, they will become very, very expensive, the Minister warned.

He also saw a greater role in the future for prevention and increased self-care, to help manage demand on primary care.

"We often think the public are not prepared to engage on the question of health care 'rationing,' or even to accept it as a concept," said the Minister. However, during discussions around the country as part of the biggest-ever public consultation on the NHS, he had found that "if you sit down with people and talk about priorities, priority-setting and decision-making, you end up having very fruitful and mature discussions about what is reasonable for a taxation-based health service to deliver."

It is widely acknowledged the UK has the most envied family doctor system in the world, and the "much-maligned" GP contract has delivered real improvements and some of best quality of care, particularly for long-term conditions, anywhere in the world, the Minister added.





5. Conclusions & Recommendations

We would like to take this opportunity to thank those who submitted evidence to the Inquiry. Comments were very broad ranging and extremely helpful in deciding the final outcome of the report. We would like to make it known however that the conclusions and recommendations contained within this report have been agreed by members of the All Party Parliamentary Group on Primary Care & Public Health.

5.1 Public Engagement

5.1.1 We conclude there is a strong need for greater public engagement in health to help achieve a cultural shift in attitudes towards self care. This is crucial to people's health and wellbeing and essential to sustaining the health system in the future. We therefore recommend:

- local and national information campaigns to increase people's knowledge and understanding of self care, of health matters and how to use NHS services more effectively;
- comprehensive educational schools programmes to ensure the next generation has more awareness about their health to help achieve long term health goals such as obesity.

5.1.2 Given the evidence, we agree there is a need for better engagement in encouraging self care by health professionals working on the frontline such as doctors, nurses and pharmacists. We recommend:

- health professionals take on a more proactive role in strengthening people's capacity to self care, ensuring consistency of advice and education;

- pharmacists are encouraged to work more closely with other health professionals to benefit the local community and PCTs should facilitate this.

5.1.3 We were persuaded by the evidence presented of the need for a comprehensive and sustained public awareness campaign. We recommend:

- Government, nationally and locally introduce information campaigns to educate the public on self care of minor ailments and to highlight the services provided by pharmacists.

We recognise the Pharmacy White Paper published on 3rd April 2008 when we were making our deliberations provides the framework for an extended role for pharmacists in minor ailments.

We urge Government to ensure that communications such as national and local campaign highlight the pharmacist's ability to help with advice on symptoms and not only in providing treatments.



5.2 GP Access

5.2.1 We conclude there is a need for more flexible and extended opening hours for GP surgeries, and recommend these hours are targeted to where demand is high rather than having a blanket approach across the country. In addition, we acknowledge that 18% of general practitioners workload taken up with minor ailments is not the best use of their time and recommend a series of educational programmes to encourage self care for minor ailments such as:

- a public campaign to have the pharmacist recognised as the first port of call for minor ailments;
- practice staff implementing an educational model that gives confidence to people to self treat and seek advice from the pharmacist.

5.2.2 Evidence presented to us made it clear that a robust electronic patient records system is becoming increasingly essential in primary care and we strongly recommend a system is put in place and shared with other community health professionals such as pharmacists.

5.2.3 We are of the view that there are two overwhelming omissions in the current GMS contract and recommend the following additions:

- Health improvements and prevention should be shifted from “additional services” to “essential services” with practices required to take a more proactive role in strengthening individual’s ability to self care, for example educating patients and providing information such as good quality health leaflets;
- appointment booking systems should allow patients to book ahead for routine care and check-ups.

5.2.4 We strongly recommend the Choose & Book system be improved to provide fast and effective co-ordination of care through the facilitation of patient choice.



5.3 Health Improvement

5.3.1 We recommend the quality of PCT commissioning of services is improved significantly to meet patients’ needs, and their understanding of those needs.

5.3.2 We conclude there is a need for better public engagement to persuade people that shifting care from secondary to primary is in the public’s best interests and recommend a comprehensive local and national information campaign to help convey this message and improve communications with the public. This would also be an excellent opportunity to engage with the public on the cost of the health service.

5.3.3 We recommend an evolving primary care market should be used by commissioners to improve access and quality of primary care, increase capacity of primary care-type services to hard-to-reach groups, develop choices of practice locations and offer consultations by phone and e-mail; and instigate new 'managed care' models of provision that care for people with long-term conditions and who do not traditionally access a GP.



5.4 QOF & Commissioning

5.4.1 We are agreed that QOF is an excellent tool and are convinced by the evidence of its effectiveness in modifying doctors' behaviour but it requires further enhancement. We recommend it is refined to reflect improvements in patient outcomes.

5.4.2 We acknowledge that many diseases are not included in the QOF; we recommend the framework includes an approach to make it possible to be extended to diseases where it is important to ensure identified clinical outcomes.

5.4.3 Given that real improvements in health outcomes will be achieved by people changing their behaviour on eating, smoking, drinking and physical activity, we recommend more focus on preventing ill-health through lifestyle changes is included in QOF.

5.4.4 We recommend:

- that the implementation of PROMs (patient-reported outcome measures) is used to measure health outcomes in primary care although this should be piloted first of all with the involvement of the clinicians whose performance they will help to measure;

- there is flexibility for the PCT and SHA to agree which indicators were best to pursue in accordance to its particular population profile.

5.4.5 We conclude there are a number of obstacles preventing PBC from working optimally and make the following recommendations to remedy this:

- PCTs support and encourage GP practices in their commissioning activity;
- Budgets are set every 2 – 3 years since annual settings prevent meaningful, longer-term commissioning plans from being put in place;
- PCTs implement training to ensure continued high level expertise;
- Systems are installed that allow for co-operation with other local partners such as social care, housing and leisure to enable a range of solutions which address health outcomes to be delivered;
- mechanisms are in place to allow robust patient input;
- PCTs provide more leadership to healthcare providers such as GP surgeries;
- effective communications and IT system are installed to facilitate the commissioning process.

5.4.6 We recommend case managers such as Community Matrons should be closely integrated with primary health care teams.

5.4.7 We acknowledge the patient is being overlooked by commissioners and recommend there is patient representation on PBC steering groups.



5.5 Our NHS, Our Future – Lord Darzi’s NHS Review

5.5.1 We submit the following recommendations for Lord Darzi to consider as part of the NHS Review, *Our NHS, Our Future*:

5.5.2 One of our concerns is Government will, once again, implement substantial reforms, abandoning effective systems and reinventing the wheel. We strongly recommend the Review builds on existing systems that are working within the health service.

5.5.3 We recognise that systems supported by research and evaluations are essential to demonstrate whether systems are likely to succeed or fail and we strongly recommend that only evidence based policy is included in the Review.

5.5.4 We recommend there is sufficient investment in public health approaches to engage the public into taking more responsibility for their own health.

5.5.5 We recommend the Review encompasses the following:

- greater equity of access to services and care;
- good quality care;
- consumer choice with support to assist individuals making and taking up their choices;
- improved provision of information about health and local services to support choices;
- effective involvement in both individual care and the development of services;
- accessible redress to raise concerns if services fail to meet patient needs and systems are in place to improve such services.

5.5.6 We recommend the Government continues to engage staff and patients when developing policy and setting priorities in the future.



5.6 Recommendations stemming from the Inquiry process

5.6.1 We strongly believe that improving health outcomes for the public is not the sole responsibility of the GP practice but rather the wider community including community pharmacists, health visitors and school nurses.

As such we recommend:

- a wide range of local policy initiatives and public education programmes are implemented that make use of all health professionals;
- measures to improve food labelling and to reduce the amounts of added fat, and sugar in foods are introduced both nationally and locally.

5.6.2 We have been made aware of cuts in many areas that have led to a reduction in health visitors and school nurses and recommend these vital services are properly resourced, since, in our opinion, these are the very areas that can be used to significantly drive real health improvements in the community.



Disclaimer:

The views expressed in this report are those of the All Party Parliamentary Group on Primary Care & Public Health. Although PAGB provides the secretariat for the APPG this solely involves the secretarial service necessary for the work of the Group and is totally independent of PAGB.

6. Annex i

Members of the All Party Parliamentary Group on Primary Care & Public Health

Officers

Dr Howard Stoate (Co-chair)
Sandra Gidley (Co-chair)
Anne Milton (Co-chair)
Stephen Hesford (Secretary)
Baroness Masham of Ilton (Treasurer)
Laura Moffatt (Executive officer)

Members of Group

John Austin
Kevin Barron
Dr Vincent Cable
Douglas Carswell
Rosie Cooper
Baroness Cumberledge
Jim Dobbin
Baroness Eccles of Moulton
Clive Efford
Michael Fabricant
Baroness Gardner of Parkes
Andy Burnham
Paul Goggins
Dr Evan Harris
Hazel Blears
Paul Burstow
Baroness Hooper
Joan Humble

Lynne Jones
Andrew Love
Baroness Pitkeathley
Lord Rea
Lord Philip Hunt
Lord Rix
Helen Southworth
Mark Todd
Lynda Waltho
Barbara Keeley
Julia Goldsworthy

7. Annex ii

Organisations who submitted evidence to the Inquiry

Written Submissions from:

British Medical Association (BMA)
Commission for Patient and Public Involvement in Health (CPPIH)
Company Chemists Association
Developing Patient Partnerships (DPP)
Improvement Foundation
King's Fund
National Association of Primary Care (NAPC)
National Pharmacy Association (NPA)
National Primary Care Research & Development Centre (NPCRDC)
NHS Alliance
NHS Confederation
North West Strategic Health Authority
Patient's Association
Picker Institute Europe
Pharmaceutical Services Negotiating Committee's (PSNC)
Royal College of General Practitioners (RCGP)
Royal College of Nursing (RCN)
Royal Pharmaceutical Society of Great Britain (RPSGB)
Tower Hamlets PCT
Unsworth Medical Centre
Which?
Working in Partnership Programme

Oral Evidence from:

British Medical Association's General Practitioners Committee

Government

King's Fund

National Association of Primary Care (NAPC)

NHS Confederation

NHS Employers

North West Strategic Health Authority

Royal College of Nursing

Royal Pharmaceutical Society of Great Britain (RPSGB)

Tower Hamlets PCT

Which?

Working in Partnership Programme



A separate document of the written and oral evidence is available on request. Please contact libby.whittaker@pagb.co.uk (tel: 020 7421 9318) if you would like a copy.