

Primary care today and tomorrow

Adapting to survive

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Deloitte Centre *for*
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The Deloitte UK Centre for Health Solutions generates insights and thought leadership based on the key trends, challenges and opportunities within the healthcare and life sciences industry.

Working closely with the US Center for Health Solutions in Washington, our team of researchers develop ideas, innovations and insights that encourage collaboration across the health value chain, connecting the public and private sectors; health providers and purchasers; and consumers and suppliers.

We aim to bring you unique perspectives to support you in the role you play in driving better patient outcomes, sustaining a strong health economy and enhancing the reputation of our industry.

Foreword

Welcome to the Centre for Health Solutions report, *Primary care today and tomorrow: Adapting to survive*. Since our first report on primary care in 2012 (*Improving general practice by working differently*) the health policy and financial landscape has changed dramatically. Workforce shortages, unprecedented financial pressures, and increasing patient and policy expectations are exerting serious strain on the entire NHS and primary care in particular. Indeed, primary care is buckling under the strain, with a consensus that the current model is not sustainable.

Funding of primary care has fallen well behind funding of hospitals, despite increasing expectations that more work should be delivered in primary care. A number of new care models and changes in working practices are now being piloted and there is growing acceptance of the role that digital health technology can play in bridging the gap between demand and supply. However, plans to recruit and train more GPs are behind schedule and new ways of working are not, as yet, being implemented at scale. Moreover, the shrinking workforce and inadequate facilities remain key challenges for a sustainable primary care system.

The next few years are likely to be even more challenging as NHS organisations seek to implement new place-based Sustainability and Transformation Plans by 2020, aimed at improving services across 44 geographical footprints while restoring NHS financial balance.

The last four years have seen numerous reviews, reports and recommendations on how to effect change, but transformation at the pace and scale required is extremely complex. This second report on primary care, therefore, provides an update on key developments since 2012, and identifies the key challenges and potential solutions for primary care.

Our extensive literature reviews, discussions with stakeholders and experience working across the health and social care system, have uncovered deep concern at the way demographic and technological challenges are impacting both the demand for and supply of primary care services and, in particular, general practice. Indeed, there is an urgent need to relieve the unrelenting pressures on general practice by supporting practices to work differently. However, in the same way that you cannot remodel an aeroplane while it is in flight, or repair a road bridge without closing it to traffic, there is a need to invest now in creating alternative routes of access and new models of care if the NHS is to remain sustainable. While the General Practice Forward View (April 2016), provides a welcome step change in the priority being afforded this transformation, the resources and support that it promises need to be allocated with immediate effect, in a transparent and accountable way, and their impact measured accordingly.

Primary care will undoubtedly become even more important in the future. If providers are to respond effectively to the increasing demands and expectations, the reforms will need to deliver as intended and the healthcare system allocate the resources as promised. The future of the NHS and, in particular, general practice is at a tipping point and how we respond will determine whether our universal healthcare service can survive.

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Executive summary

Primary care, particularly care delivered in general practice, has been at the cornerstone of the NHS since its inception. Numerous national and international reviews demonstrate that a comprehensive and robust primary care system is key to a cost-effective, sustainable healthcare system.

Since our first report on primary care in 2012, escalating austerity pressures have led to a relative lack of investment in primary care, despite numerous policy initiatives directed at moving care from hospitals to the community. Indeed, the share of NHS spending allocated to general practice has reduced from 7.54 per cent in 2012-13 to 6.86 per cent in 2015-16 (in real-terms).

Meanwhile, demographic and societal changes, medical advancements and developments in preventative health, have combined to increase the demands on primary care. However, there is a lack of up-to-date data on the number of patient consultations in general practice and no comparative data on wider primary care activities. Estimates based on secondary analysis of GP patient record systems suggest that more than one million people consult their general practice every working day. Recent research estimates that the average annual number of consultations per person has increased by 10 to 15 per cent in the past five years.

This rising demand has not been matched by an increase in the supply of skilled professionals. Quite the contrary, the numbers of general practitioners, community and district nurses per population have been steadily declining and strategies for recruitment and retaining of staff are unlikely to achieve the planned and much needed increase in staff numbers by 2020.

The average number of patients per practice has grown steadily from 6,610 in 2010 to 7,580 in 2016, reflecting the move towards larger practices. There has been a decrease in total numbers of fulltime equivalent GPs (excluding locums) from 35,243 in 2010 to 34,055 in 2015 (-3.3 per cent) but an increase in the FTE number of nurses from 14,644 to 15,398 (5.15 per cent). Moreover, the ratio of GPs to the population has reduced 0.67 per 1,000 population in 2010 to 0.62 per 1,000 in 2015 while the ratio of nurses has remained stagnant.

The funding, supply and demand challenges have generated a huge amount of media debate, qualitative and quantitative research. All of which suggest that primary care today is in crisis. Indeed, the government, Department of Health and NHS England have acknowledged the growing concerns about primary care which have resulted in the launch of a number of key policy initiatives including:

- the Five Year Forward View and its new care model 'vanguards' programme which includes the promotion of multispecialty community provider and primary and acute care systems (October 2014)
- the requirement to develop Sustainability and Transformation Plans (STPs), based on 44 geographical footprints. This represents a radical shift in the way that the NHS plans and integrates services to improve health and social care while balancing finances by 2020-21 (December 2015)
- the General Practice Forward View aimed at shifting NHS priorities towards investing and supporting transformation of general practice (April 2016).

The above reform initiatives are being implemented concurrently but in the absence of robust data on current performance or clarity on how progress will be measured. While STPs have the potential to achieve the long sought after integration of health and social care, the scale and speed of the STP process is large and ambitious and the organisations that make up an STP have very different challenges, funding models and accountabilities. Moreover, there has also been limited public engagement or input from staff in primary care, and the enormous challenge of trying to remove costs from the hospital sector will place further pressures on an already constrained and stressed primary care workforce. Indeed, the experience of previous integration initiatives both in the UK and in other countries, suggests that the levels of integration required will take more than five years to implement.

The individual pilots implementing these initiatives appear to be progressing at variable rates but those making the most progress have started to deploy the wider primary care workforce more effectively, freeing up GP time for more complex cases. There is also increasing evidence of the pivotal role of digital technology and benefits to be realised from much needed improvements to the primary care estate.

“It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.”

Charles Darwin

Good access to general practice matters to patients, especially prompt access to diagnosis and treatment. It also helps reduce pressure on other parts of the NHS, particularly hospital accident and emergency departments. Given that a typical consultation in general practice costs £21, whereas hospitals are paid £124 for an A&E visit, investing in primary care also makes good economic sense. Although patient satisfaction remains high, it has started to decline. According to the British Social Attitudes survey, in 2015 overall satisfaction with GP services was 69 per cent, the lowest since it started reporting in 1983.

Some of the changes in general practice have been driven by both workforce and service-users demanding new ways of accessing care through technology solutions such as online triaging and app-based patient management. A number of case examples featured in our report show that the success of new primary care models depends on multiprofessional and multiservice delivery, and teams complying with evidence-based clinical pathways.

The current plans for improvement are more rhetoric than reality. The solutions and enablers discussed in this report provide building blocks that all stakeholders should utilise in the design and implementation of reform programmes such as the new care model vanguards and STPs.

Our research suggests that the following measures could help commissioners and providers overcome the challenges we have identified and help deliver a more sustainable system of primary care for tomorrow:

- collecting robust, comprehensive and timely activity and performance data across primary care on both supply and demand is a critical requirement if the full potential of new care models is to be realised
- securing adequate levels of funding for general practice of over ten per cent of the healthcare budget (as prioritised in the General Practice Forward View) and investing more in prevention, wider primary and social care
- prioritising innovative and proactive workforce strategies that include effective workforce planning, recruitment and retention strategies for GPs, practice nurses and the wider primary and social care workforce
- shifting from medicalised models of care towards sharing out responsibilities and risks across permeable professional boundaries among the wider primary care team
- aligning incentives through integrated funding and commissioning
- improving health literacy to help patients take more responsibility for their own health and enhance patient participation and engagement in healthcare planning and delivery
- improving, as a matter of urgency, the primary care estate and extending the adoption of digital health technology through effective partnerships.

The transformation of primary care is an ongoing challenge and the outcomes from current reforms remain uncertain. Having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, local community partners including the independent and voluntary sectors, and local government health and wellbeing boards will be key to success. It is also critical that sufficient funding is provided to support the development and enhancement of primary care. While there is better recognition of the need for primary care to be participatory, proactive and adaptable across systems, none of the current solutions is, as yet, being implemented at sufficient scale.

Part 1. The changing face of primary care

“It is one of the hardest jobs in medicine.”

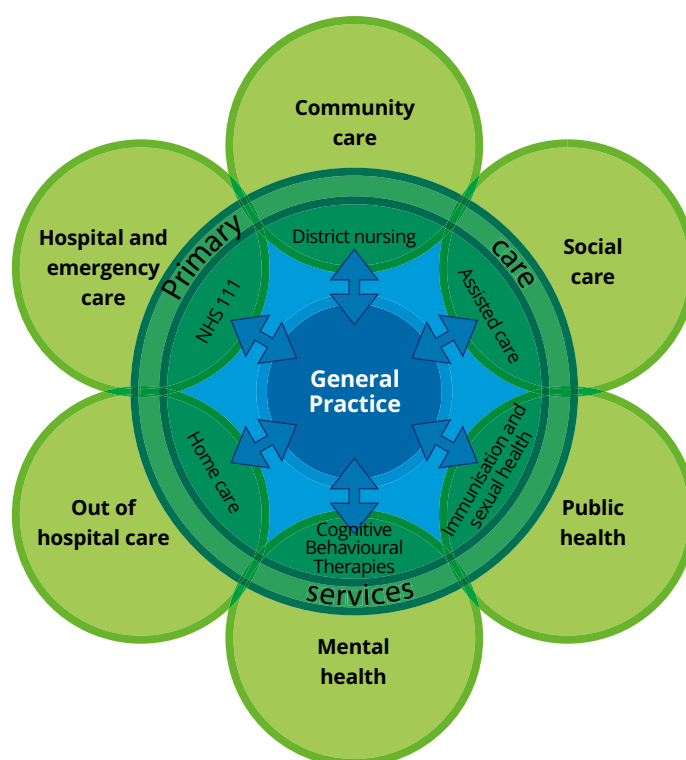
Sir Bruce Keogh, National Medical Director, NHS England on general practice¹

In the UK all residents are entitled by law to access primary care services with 90 per cent of all patient contacts occurring in primary care. Primary care includes the management of long-term chronic conditions, maternity, child and mental health services, and palliative care in patients’ homes. It also includes a range of public health interventions such as adult and child immunisation programmes, smoking-cessation clinics, and sexual health prevention (see Figure 1). The traditional approach is based on face-to-face interaction. The workforce across primary care services are mainly generalist professionals, treating a wide range of physical, mental and social problems.

General practice is the focal point of primary care, responsible for the health of a registered lists of patients, including maintaining each patient’s primary medical record.² General practitioners (GPs), working alongside nurses and other staff, provide advice and treatment to patients on a wide range of health issues. GPs act as the gatekeeper to and navigator of health and care services. They provide a vital service in controlling healthcare spending, preventing misuse and overuse of the more expensive hospital care.

Becoming a GP requires significant investment of time and resources in academic and scientific medical education and training. GPs are responsible for the assessment and diagnosis of undifferentiated conditions. They provide continuity of care for patients needing episodic care and consistency in the ongoing management of long-term conditions (LTCs). GPs are responsible for identifying and referring patients needing specialist treatment, oversee the majority of care, for people with LTCs provide health education and preventative services and may also offer additional services such as minor surgery.³

Figure 1. General practice at the centre of an evolving mix of primary care services



Source: Deloitte Centre for Health Solutions, 2016

Our first report on primary care in 2012 highlighted:

- the increase of the demand challenges
- the changing nature and capacity of the general practice workforce
- the need to shift from treating episodic illness to working in partnership with patients and other health providers to deliver more cost-effective care in the community
- the significant reform challenges facing the NHS, including the introduction of the Health and Social Care Act (HSCA) 2012
- the regulatory and financial barriers that need to be addressed to implement and embed solutions more comprehensively across the NHS.

We also highlighted a number of solutions comprising:

- new ways of multidisciplinary working
- accelerated use of new technologies
- more effective use of financial and other incentives.⁴

Fast forward to 2016 and the demand and capacity challenges have escalated, with many patients struggling to access services in a timely manner. The solutions we identified have not been implemented with any degree of consistency or scale. Moreover, the financial situation facing the NHS is unprecedented with authoritative reviews concluding that unless things change the NHS England faces a £22 billion deficit by 2020-21.⁵

These financial challenges, combined with increasing patient expectations, and problems meeting targets and quality metrics have placed immense pressures on primary care. There are increasing concerns about levels of staff exhaustion and stress with consequences for recruitment and retention. As a result concerns over the sustainability of the current model of primary care are at an all-time high.

This report provides a synthesis of the numerous research reports, enquiries and other evidence generated since 2012, supplemented with discussions with stakeholders across primary care. It evaluates the:

- numerous policy changes that have been launched, particularly in the past two years
- escalating demand and supply challenges
- impact of the significant financial and reform challenges
- potential solutions that could help ensure that primary care is sustainable.

Due to the relative dearth of comprehensive financial and performance data across primary care, and the central role of general practice, we focus our analysis more on general practice. We also focus predominantly on the NHS in England. However, the suggested solutions should be relevant to the transformation of care across all four UK nations.

The main primary care policy changes since 2012

Figure 2 charts the primary care policy developments in England since the enactment of the HSCA in March 2012.⁶ The most relevant organisational changes are the:

- abolition of primary care trusts (PCTs) and strategic health authorities (SHAs), and the creation of GP-led clinical commissioning groups (CCGs) to replace PCTs as commissioners of local services
- establishment of NHS England responsible for central commissioning of specialised services and primary care.

This reorganisation was intended to increase GPs' influence over the design and delivery of local healthcare services, including responsibility for around two-thirds of the £113.6 billion 2015-16 NHS budget.⁷

The Five Year Forward View

The publication of the Five Year Forward View (FYFV) in October 2014, including the introduction of vanguards was a key development in the history of the NHS. In response, the government provided an additional £8 billion by 2020-21 to support its implementation. The FYFV highlighted the importance of public health and prevention, empowering patients and communities, strengthening primary care and making efficiencies within the health service. It confirmed the vision of universal healthcare, with list-based primary care supported by a 'new deal' for GPs at its foundations.

The FYFV emphasised the need to address capacity and access problems across the NHS, including investing more money in primary care and stabilising the core funding for general practice. It aimed to give CCGs more control over the NHS budget to enable a shift in investment from acute to primary and community services. However to date the scope for this has been limited due to the financial crisis in hospital services (with deficits £2.54 billion).

A key action was the plan to establish five new care model vanguards, three of which are focused on redesigning how primary care operates:

- multispecialty community providers (MCPs) – enabling extended group practices to form, either as federations, networks or single organisations
- primary and acute care systems (PACs) – a new variant of integrated care allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services
- enhanced health in care homes (EHCH) – offering older people better, joined up health care and rehabilitation services.⁸

Following a bidding process, NHS England chose 50 different local health communities to pilot vanguards.⁹ Of these, there were

14 MCPs and 9 PACs and 6 EHCHs. Since then, the vanguards have been working to pool budgets and integrate services more closely. Some are continuing to use informal partnerships, but others are opting for more formal governance arrangements. Eighteen months after their initial launch, commissioners are grappling with how to contract for these new systems, while providers are exploring how to work together, allocate funding and share risk and rewards.¹⁰ An analysis of 11 MCPs and PACs, who between them requested some £107 million transformation funding found that they had received only £41.9 million (39 per cent). This has required them to scale back their plans and reduced the speed of implementation.¹¹

The General Practice Forward View

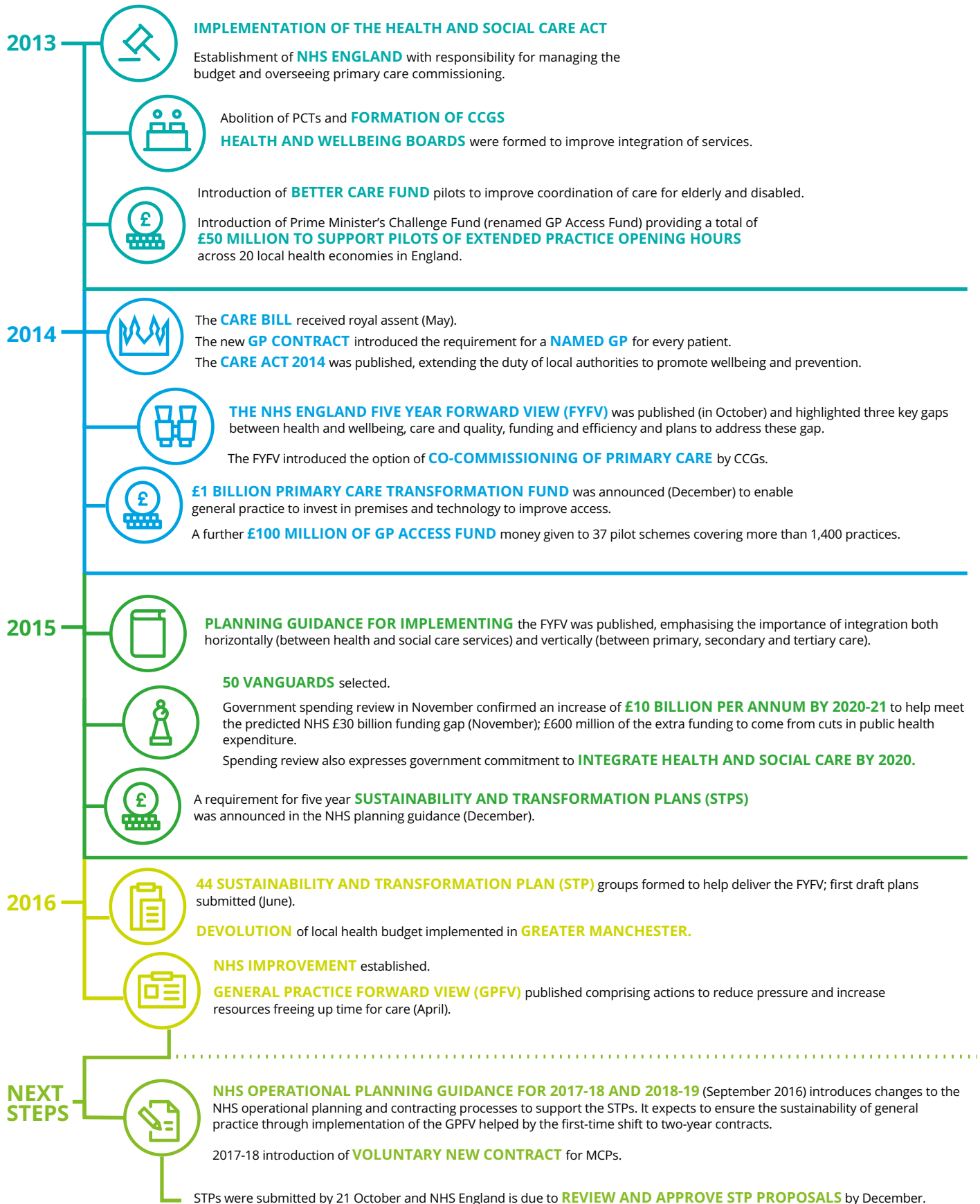
The second defining initiative was NHS England's publication in April 2016 of the General Practice Forward View (GPFV) which sets out a new direction for the wider primary care system. Developed by NHS England in partnership with the Royal College of General Practitioners (RCGP) and Health Education England (HEE), the GPFV recognises the need for a step change in the level of investment and support for general practice. It includes help for struggling practices, plans to reduce workload, expansion of the wider workforce, investment in technology and estates, and a national development programme to accelerate transformation of services. The GPFV is based on three main tenets:

- a deep-seated recognition that a strengthened general practice is essential to the sustainability of the NHS
- an acceptance of the need to reverse the historic underfunding
- the acknowledgement that practices are more open to new ways of working than ever before.

NHS England acknowledged that GP-led CCGs are central to transforming local care systems. The expected increase of investment in support of general practice over the next five years, includes:

- a commitment to invest a minimum of £2.4 billion a year by 2020 in general practice services
- a non-recurrent sustainability and transformation package of more than £500 million including £40 million for practice resilience and £206 million investing in growing the general practice workforce; £246 million to support service redesign and £30 million for improving uptake of new technologies in patient care
- continuous support for the vanguards
- new rules to allow up to 100 per cent reimbursement of premises developments, alongside direct practice investment in technology to support better online tools and appointment, consultation and workload management systems
- changes to the Care Quality Commission (CQC) inspection scheme to reduce bureaucracy without risking safety and quality of care.¹²

Figure 2. Key reforms impacting primary care since 2012



Sustainability and Transformation Plans

Since January 2016, NHS organisations have also been focussed on producing STPs, based on 44 geographical footprints. STPs represent a radical shift in the way that the NHS in England plans its services. The aim is to improve health and social care services and finances over the next five years. The scale and speed of the process is large and ambitious and the focus has been predominantly on closing the funding gap. STPs are not legal entities, and the organisations that make up an STP have very different challenges, funding models and accountabilities, which will affect their chances of achieving greater vertical and horizontal integration of services.¹³

To date, despite the rhetoric that primary care and, in particular, clinical engagement are key components of the STP process, GPs and other primary care professionals have had limited input and influence over the process. Moreover, each of the above initiatives are being implemented concurrently but with different governance structures.

Primary care developments in the other UK nations

Since 1997, Northern Ireland, Scotland and Wales have had devolved responsibility for health and social care. Although there are variations in funding, organisation of services and health outcomes between the devolved nations, all have faced similar challenges in relation to a growing gap between demand and supply and have launched initiatives intended to address these challenges (see Figure 3).

The challenges that primary care has faced since 2012 have generated a huge amount of media debate and qualitative and quantitative research, with over 100 reports and reviews since 2012. All identify a gap between supply and demand as the main driver of the pressures facing primary care. Most provide examples of good practice with a large number of recommendations for change, including the FYFV and the GPFV which detail widespread proposals for change.

The rest of this report synthesise the available research, supplemented with discussions with senior stakeholders and our experience working across health and social care to:

- provide insight into the supply and demand challenges facing primary care today (Part 2)
- identify potential solutions that could make a difference today (Part 3)
- consider what primary care tomorrow could look like including future enablers to help secure provision of a high quality, safe and sustainable healthcare service for UK patients (Part 4).

Figure 3. Policy developments in Northern Ireland, Scotland and Wales



Part 2. The provider challenges facing primary care today

“If anyone 10 years ago had said: ‘Here’s what the NHS should now do – cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs, they’d have been laughed out of court. But looking back over a decade, that’s exactly what’s happened.”

Simon Stevens, Chief Executive, NHS England¹⁸

The same challenges identified in 2012 exist today

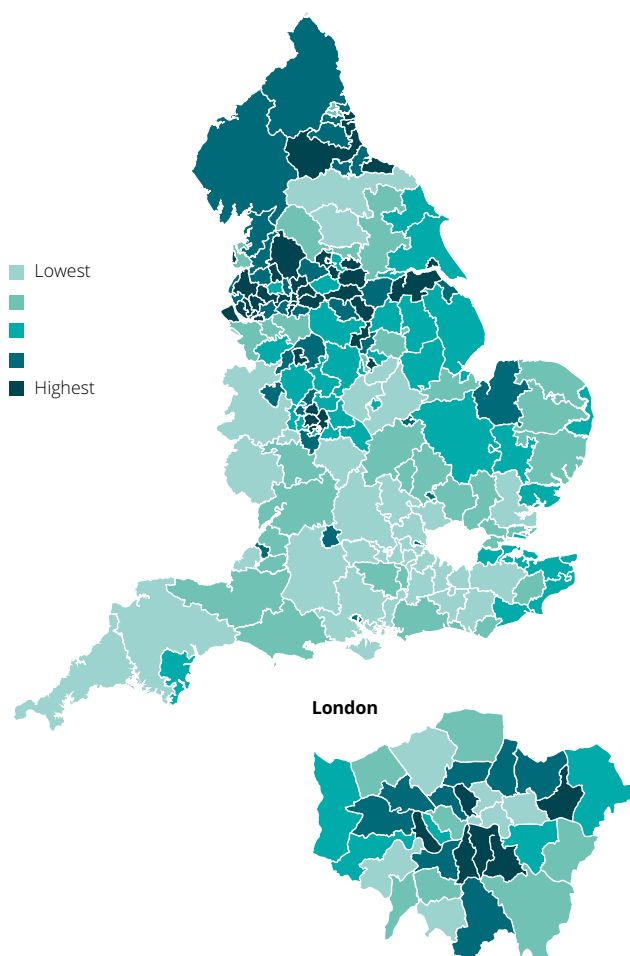
The challenges highlighted in our 2012 report are still evident today. Escalating austerity pressures have led to a lack of investment in general practice and primary care. Demographic and societal changes, medical advancements and developments in preventative health have combined to increase demand for primary care. Furthermore, initiatives to move care from hospitals to the community, combined with rising public expectations and major reductions in funding for social care, are placing primary care under unrelenting pressure.

A report by the National Audit Office (NAO) in 2015 on access to general practice in England noted that good access to general practice matters for patients and reduces pressure on other parts of the NHS, particularly hospital accident and emergency (A&E) departments. It estimated that in 2012-13, 5.8 million patients attended A&E or walk-in centres because they were unable to get an appointment or a convenient appointment in general practice; a figure that is believed to have increased still further in the past few years. Given that a typical consultation in general practice costs £21, whereas hospitals are paid £124 for an A&E visit this adds to the increasing financial burden of running the NHS.¹⁹

The NAO noted that more than a million patients consult their general practice every day and that pressures continue to rise faster than capacity, impacting negatively on health equalities.²⁰

Data from the NHS Atlas of Variation in Healthcare 2015 show an 8.6-fold variation in rates of avoidable hospital admissions for ambulatory care-sensitive conditions (see Figure 4). A key reason for this is the variation in the extent of collaborative working across different care sectors and the capacity and availability of community-based services.²¹

Figure 4. Emergency admissions to hospital for ambulatory care-sensitive conditions vary across England



Source: The NHS Atlas of Variation in Healthcare, NHS RightCare, 2015

Demand for healthcare services is influenced by age and health status

While there are many external influences on demand for primary care, the fact that people are living longer with more complex long-term conditions (LTCs) appears to have the largest impact.²² The number and proportion of older people continue to rise, with over 9.7 million (17.7 per cent of the population) aged 65 and over in mid-2015, up from 9.5 million in 2014. The Office for National Statistics (ONS) predicts that by mid-2025 more than 19.9 per cent of the UK population will be over 65 years old (see Figure 5).²³

Advancements in diagnosing and treating acute and chronic diseases have increased longevity without necessarily increasing overall health.²⁴ Additionally, research shows that patients in the most socioeconomically deprived groups experience long-term conditions and multiple morbidity much earlier in life and tend to have more mental as well as physical health problems. Meanwhile, shifts in culture have eroded traditional models of care within families, leading to more people, especially the elderly, living alone (approximately 4.3 million or one in five middle aged and older people).²⁵

Additional changes putting pressure on primary care include:

- patients with multiple long-term conditions increasing from 1.9 million in 2008 to 2.9 million by 2018²⁶
- long-term conditions accounting for 50 per cent of GP appointments while consuming around 70 per cent of NHS spending²⁷
- increased prescribing, particularly repeat prescribing (for example, a 46 per cent increase in antidepressant prescribing, 93 per cent increase in chronic obstructive pulmonary disease (COPD) drugs, 34 per cent increase in diabetes drugs)
- increased numbers of vaccines added to the immunisation programme, increasing demand for vaccinations.²⁸

Figure 5. Predicted changes in the age distribution of the UK population, 2015-25



Source: Principle Projection – England Population in Age Group, ONS, 2015

Demand for consultations continues to increase year-on-year

There is a scarcity of up-to-date data on the number of patient consultations in general practice and virtually no comparative data on wider primary care activities. There is no routine public reporting of GP or primary care activity data and no standardised national dataset(s). The only data available are based on secondary analysis of various GP patient record systems.

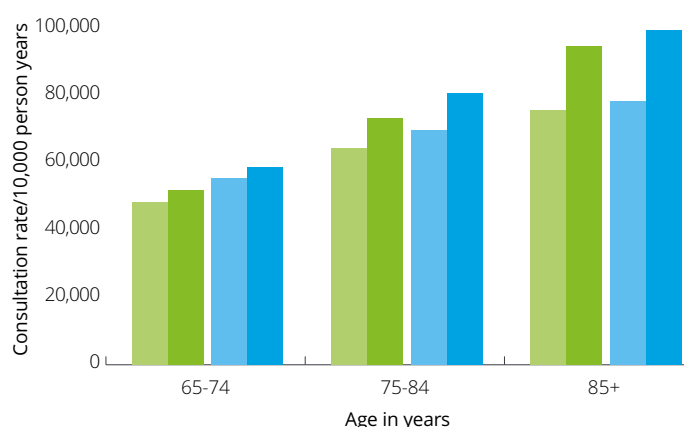
Views on changes in the numbers of patient consultations have largely been informed by a longitudinal study of trends in general practice consultations between 1995-96 and 2008-09, using the QResearch® database.^{29,30} The final dataset and report on this research was based on 122 general practices (one million patients and 3.7 million consultations) in 1995-96 and 496 practices (4.3 million registered patients' 21.7 million consultations) in 2008-09. This analysis estimated that the total number of consultations increased year-on-year from 224.5 million patients, on average, in 1995-96 to 303.9 million in 2008-09 (an overall 35 per cent increase). This meant a rise in consultations from 3.9 consultations per person each year in 1995-96 to 5.5 by 2008-09.³¹

Until recently views on activity have been informed by extrapolations of the Q RESEARCH database. For example, a Deloitte report, commissioned by the RCGP in 2014, estimated that between 2008-09 and 2013-14 the number of consultations had increased by 19 per cent. It also noted that the benefits of general practice are particularly relevant for those with more than one long term condition, with the average annual number of GP consultations per person for those with multimorbidities at 9.35 compared to 3.75 for those without multimorbidity.³²

In 2016, new research was published based on a retrospective analysis of over 100 million GP and nurse consultations that occurred between April 2007 and March 2014 in 398 English general practices. The analysis found that there had been an increase of 10.51 per cent in the average annual consultation rates per person from 4.67 in 2007-08 to 5.16 in 2013-14. Notably, telephone consultations doubled. Consultation rates stratified by age show that consultations per person increased for each of the older age group (Figure 6). The findings indicated a substantial increase in practice consultation rates, average consultation duration, and total patient-facing clinical workload in English general practice; and that English primary care as currently delivered could be reaching saturation point.³³

A King's Fund analysis, published in April 2016 and based on 30 million patient contacts from 177 practices and a qualitative survey of GP trainees, found consultations had increased by more than 15 per cent between 2010-11 and 2014-15, with a 63 per cent growth in telephone consultations. The report noted that while there are contrasting views on the benefits in managing increased numbers of contacts by telephone, most experts agree that the need to record and act on clinical decisions, such as follow-ups, prescription or further investigations needs to be taken into account when considering the overall workload.³⁴

Figure 6. Changes in consultation rates for people over the age of 65, 2007-13



Source: Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007-14, The Lancet, 2016

Note: Consultations rates/10,000 person years are calculated based on time spent with GP and frequency (rate) of visit for each stratum

While the above analyses of general practice consultations are impacted by differences in the number and size of practices, the location of the practices, the software used to log consultations and staff included within the underlying analysis, they all confirm that there have been year-on-year increases in the number of consultations. Differences in the assumptions made, and limitations in extrapolating to the whole population at a time of extensive changes in the expectations being placed on general practices, add significant weight to the NAO's 2015 report on access to general practice. The NAO strongly recommended that NHS England needs to improve the real-time data it collects on demand and supply. Importantly, without a centralised effort to measure the full extent of the rising demand and availability of staff resources cannot be allocated effectively.³⁵

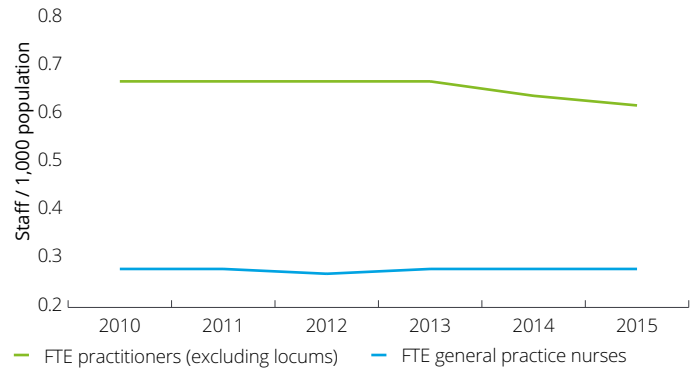
General practice capacity has not increased in line with demand

GP practice size varies widely. The average number of patients per practice has grown steadily from 6,610 in 2010 to 7,580 in 2016, reflecting the move towards larger practices. The number of single-handed practices is now only 843 (10.7 per cent), a 30 per cent fall since 2010. Twenty-six per cent of practices in 2016 have more than 10,000 patients. The increase in the size of practices is largely in response to growing demand and due to the merger of smaller practices.

There has been a decrease in total numbers of fulltime equivalent (FTE) GPs (excluding locums) from 35,243 in 2010 to 34,055 in 2015 (-3.3 per cent) and an increase in the FTE number of all nurses in GP practice from 14,644 to 15,398 (5.15 per cent).³⁶ Increases in population numbers mean the ratios of GPs to the population have declined from 0.67 per 1,000 population in 2010 to 0.62 in 2015, whilst the ratio of practice nurses is stagnant (see Figure 7).

The decline in the number of GPs per head of population reflects, in part, major problems in recruitment and retention. It is also increasing the annual number of consultations per GP and per practice nurse.

Figure 7. Numbers of GPs per population are decreasing while numbers of nurses are stagnant



Note: Methodology for gathering workforce numbers changed in 2014.

Source: General and Personal Medical Services in England 2005-2015, HSCIC, 2016; UK population estimates, 1838-2015, ONS, 2016

Changing career choices of the current and future GP workforce

To date, most GPs are independent contractors. However, there is an increasing trend for GPs to work in salaried and locum roles rather than taking on partnerships, with a number of GPs giving up partnerships in favour of locum or salaried roles. The proportion of salaried GPs has increased over time to around 27 per cent in 2014. This is despite the fact that GP partners' average income across general and personal medical services contracts is £100,867 on average in the UK, compared with £54,467 for salaried GPs in 2013. On average GP salaries have been in decline (Figure 8).³⁷

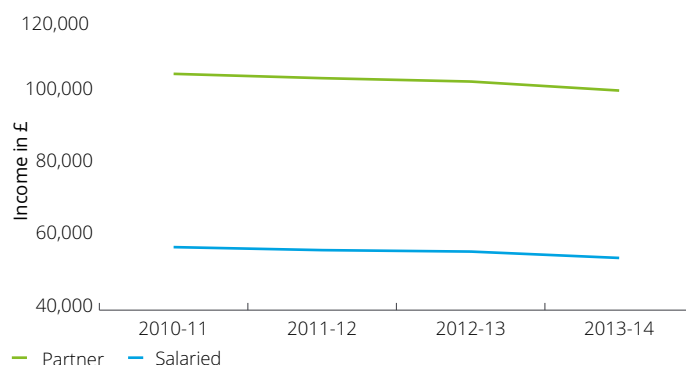
Evidence from workforce surveys shows a shift towards a preference for portfolio careers that allow flexibility of working hours (part-time versus full-time), geographic location (both national and international) and type of work (e.g. primary versus secondary care as well as clinical versus academic work). Specifically, fewer GPs are choosing to undertake full-time clinical work with increasing numbers opting for portfolio careers or working part-time. This is true for both male and female GPs.³⁸

Currently, just over half of the current GP workforce is female.³⁹ Importantly, 79 per cent of salaried GPs are women and 72 per cent of GP trainees are women.⁴⁰

A large proportion of the existing GP workforce plans to leave general practice

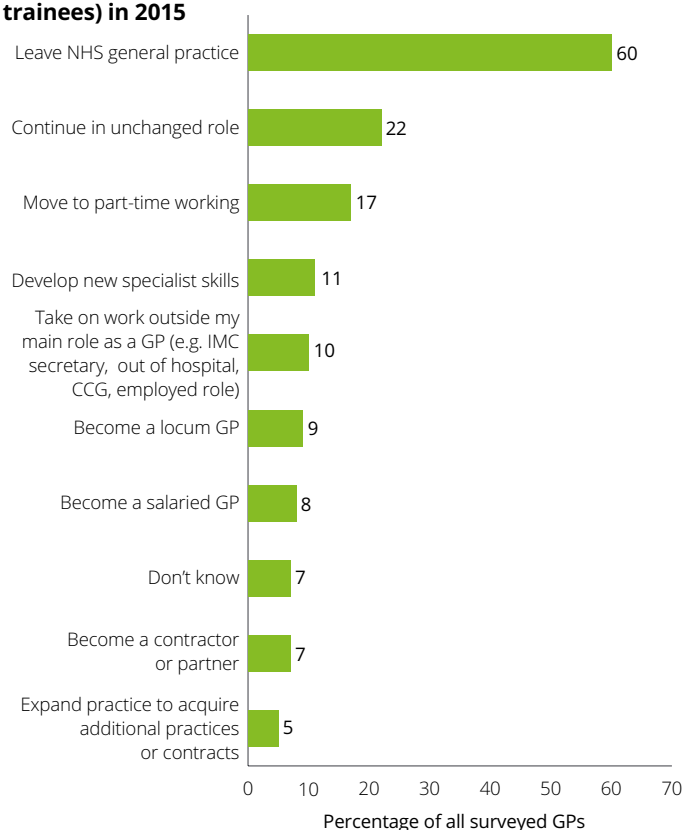
Findings from the BMA GP survey 2015 show that up to 60 per cent of all GPs surveyed report plans to leave general practice within the next five years (45 per cent of respondents were aged 50 or over). The reported reasons for leaving are diverse, with 34 per cent of all GPs planning to retire from general practice and 9 per cent planning to leave the UK to work overseas (see Figure 9).⁴¹

Figure 8. Income gap between salaried versus partner GPs in the UK



Source: GP Earnings and Expenses 2002-2014, HSCIC, 2015

Figure 9: Career intentions among GP workforce (including trainees) in 2015



Source: Future of general practice survey, BMA, 2015

Career intentions of GP trainees

The career intention of GP trainees complicates workforce planning and suggests that simply increasing the number of training places will not stop the outflow of GPs in the future workforce. Up to 19 per cent reported plans to leave the UK to work overseas with 35 per cent planning to move to part-time working (see Figure 10).⁴²

A King's Fund survey of trainees in 2015 also found that partnership is no longer seen as an attractive option for many. Five years after qualifying 48 per cent of respondents reported an intention to be a salaried GP, 25 per cent a locum and just 25 per cent a partner. Ten years after qualifying, fewer than half of respondents (45 per cent) intend to be a partner at this stage of their career; a proportion that would traditionally have been much higher.⁴³

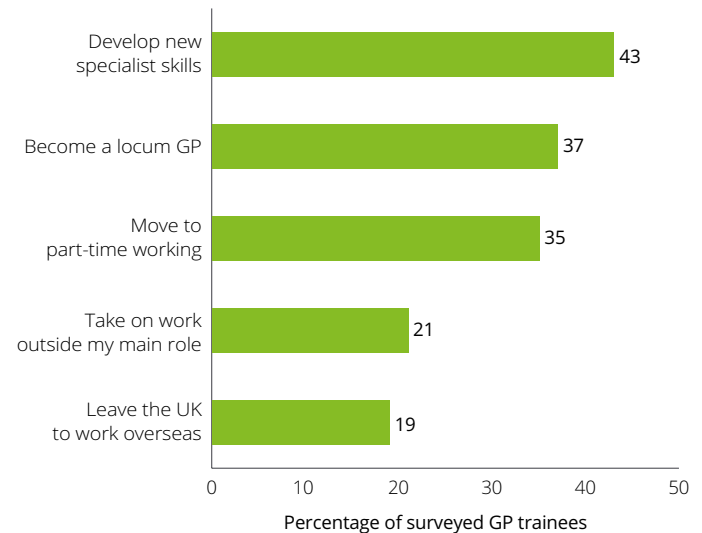
Workforce developments of other healthcare professions

The workforce strains facing GPs are mirrored in the wider primary care workforce. However, there is no centrally held data on other health professionals employed in primary care, an omission that makes planning increasingly challenging.^{44, 45, 46} Surveys by nursing organisations show that primary care nursing is facing significant capacity challenges with an ageing workforce across practice nurses, community and district nursing and problems in recruitment and retention. For example:

- research by the Queen's Nursing Institute (QNI) found that 33.4 per cent of current general practice nurses are due to retire by 2020⁴⁷
- King's Fund research shows a growing gap between capacity and demand in district nursing services that risks adding to pressures across the whole care sector since this predominantly affects vulnerable populations that are already high users of care.⁴⁸

Despite the rhetoric of more care in the community and increasing demand for community care from the rising numbers of frail older people still living at home, community nurses and other community staff are in decline. Indeed, between 2001 and 2011, the number of community nurses decreased by 38 per cent.⁴⁹ However, there is no comprehensive updated national activity data to assess the impact of these changes in nurse numbers and workload, although anecdotal evidence suggests eligibility criteria for care packages have tightened.

Figure 10. Career intentions of GP trainees in 2015



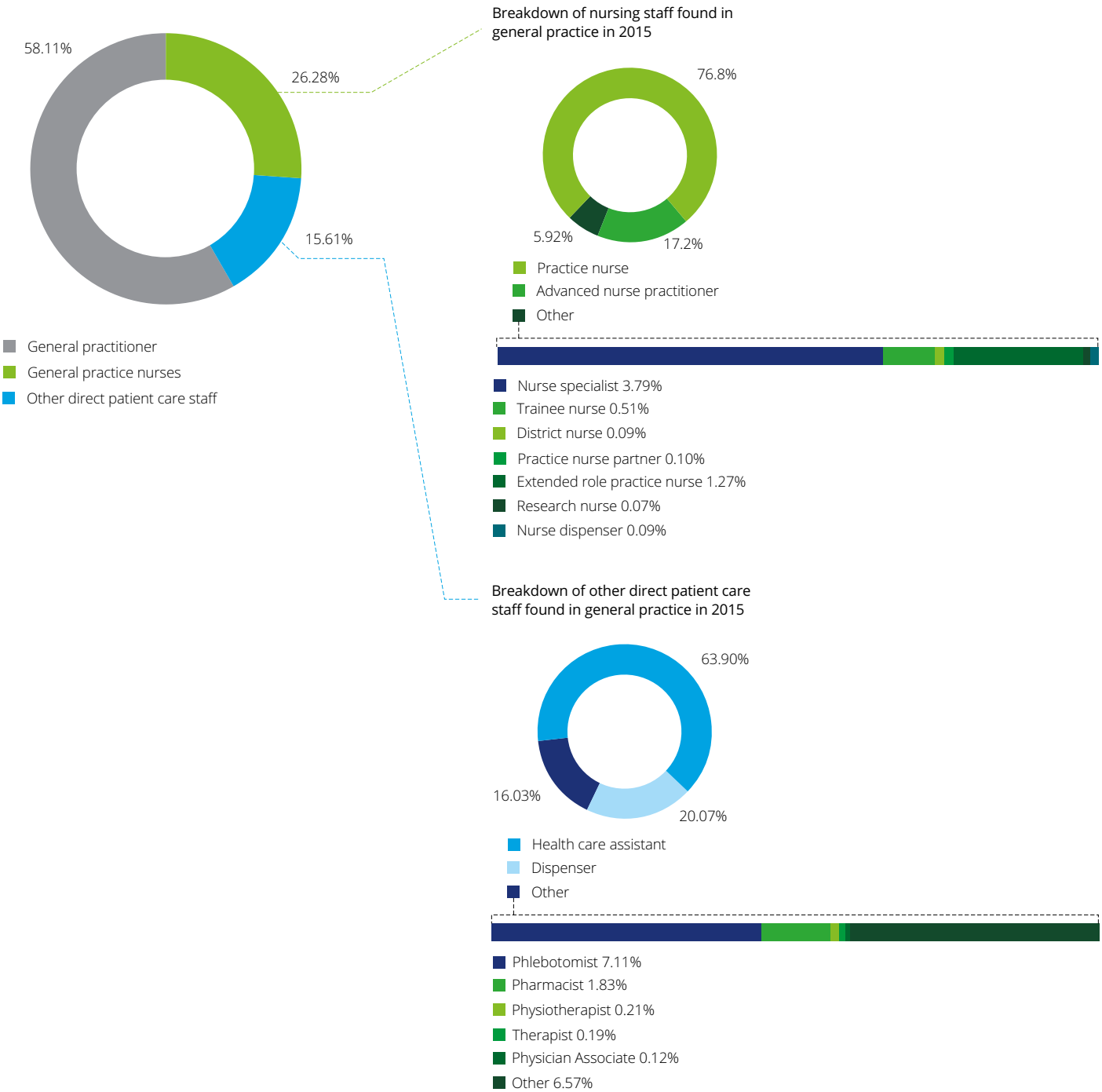
Source: Future of general practice survey, BMA, 2015

Surveys among nurses point to a vicious cycle of overwhelming demand that results in people leaving district and community nursing, extending the gap between demand and supply. A Royal College of Nursing survey of district nursing staff found that 83 per cent of respondents reported insufficient nurses to get the work done.⁵⁰ A QNI survey found that 60 per cent of staff were concerned about the availability of appropriately skilled staff to deliver appropriate patient care.⁵¹

NHS England in 2015 reported vacancy rates of more than 40 per cent in some community nursing teams, with the King's Fund estimating a 15 to 20 per cent vacancy rate in district nursing across the country in 2014.⁵²

Overall, these capacity challenges have resulted in general practice deploying a much more diverse nursing workforce in direct patient care (see Figure 11).⁵³

Figure 11. Diversity of general practice workforce



Source: General and Personal Medical Services in England 2005-2015, HSCIC, 2016

Recruitment and training issues that impact the healthcare workforce

The government has acknowledged that the UK needs to increase efforts to train its own future workforce.⁵⁴ However, the planned 25 per cent increase in medical students from 2018 onwards, won't have an impact for at least eight years. Specialist recruitment for postgraduate general practice training positions, starting in August 2016, had the second lowest fill rate (82.8 per cent) with only psychiatry showing a lower fill rate (80.71 per cent). In comparison the fill rate for core surgical training and anaesthetics remains high at 99.8 per cent and 99.18 per cent respectively.⁵⁵ Moreover, wide variations in uptake of GP training posts across English regions persist. The first recruitment rounds in 2016 led to 54 per cent of places being filled in the North East deanery whereas in London 99 per cent of GP trainee posts were filled.⁵⁶ GP leaders suggest that the government target of 5,000 more GPs by 2020 looks unlikely to be realised.⁵⁷

Nursing faces similar problems. A 2016 QNI survey shows that only a small number of practices provide placements for pre-registration nursing students.⁵⁸ This limits the opportunity to expose nursing students to the work in a GP practice, negatively impacting the future workforce. There is similar evidence regarding training places for district nursing.⁵⁹ According to the QNI report, Health Education England reduced the number of commissions for specialist District Nurse programmes by 0.8 per cent from 2015-16 to 2016-17.⁶⁰ Pressures on the nursing workforce are expected to increase still further as a result of the removal of student bursaries from 2017 onwards.^{61, 62}

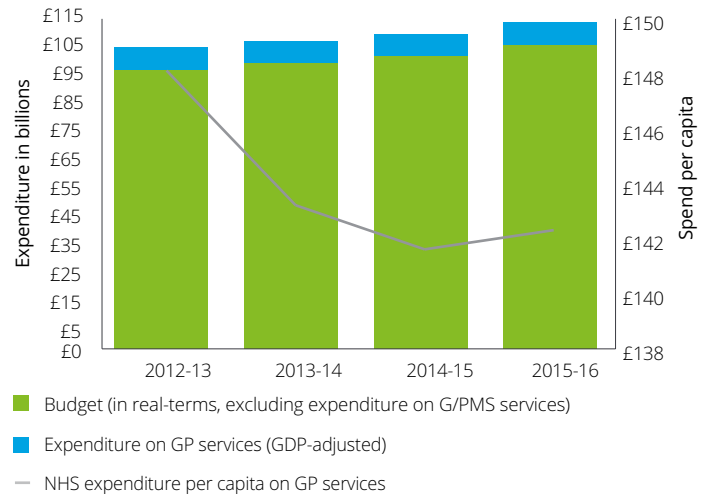
Reduced primary care funding is a barrier to reform

Comparable data on government funding of primary care in England are not available. Indeed, funding streams within primary care and between primary, community and secondary care are very fragmented.⁶³ The most comprehensive data available is for general practice. Data show funding has declined by 1.6 per cent in real-terms since 2012-13 despite a real-term rise in total NHS spending of 8.22 per cent over the same period. Since the large injection of funding into general practice in 2004-05 and 2005-06, following the introduction of the new GP contract, the share of NHS spending allocated to general practice has fallen year-on-year. In 2012-13 it was 7.54 per cent and by 2015-16 the share (6.86 per cent) was the lowest in ten years (see Figure 12).⁶⁴ These levels of under-funding threaten the necessary reform, particularly with regard to workforce development.⁶⁵ Although the GPFV recognises the need to increase funding to ten per cent, it will take time and reform of incentive structures to enable primary care to recover from years of under-funding.

Decreasing number of GP surgeries

Data show a rise in the number of general practices vulnerable to closure. In March 2016, NHS England identified up to 20 per cent of GP practices as in need of emergency support funding, with an average of 10 per cent of practices at risk of closure.⁶⁶ Some 201 practices closed in 2015-16. Though some reduction in surgery numbers is due to practices merging in new models of cooperation, across country practices are increasingly closing due to failure to recruit new GPs on list-holder retirement.^{67, 68}

Figure 12. Funding allocations in GP services



Source: Public Expenditure, Statistical Analyses, HM Treasury, 2016; Department of Health Annual Report and Accounts, Department of Health, 2013, 2014 and 2016; Deloitte Centre for Health Solutions research and analysis

The current primary care estate is not fit for purpose

Over the past 15 years there have been a number of initiatives aimed at improving the primary care estate, including the £2 billion NHS Local Improvement Finance Trust (LIFT) scheme, established in 2000 as a public private partnership initiative. To date, LIFT companies have provided some 339 purpose built facilities aimed at delivering integrated primary community and social care.⁶⁹ Other improvement initiatives included the £250 million GP Access fund to develop at least 100 new GP practices in the 25 per cent of areas with the poorest provision. Despite these initiatives, modernising the entire general practice estate remains a major challenge, only one quarter of GP practices across the country currently occupy modern purpose-built premises. The CQC found that 24 per cent of the premises they inspected failed the safety and suitability criteria when they commenced inspecting GP surgeries in 2013-14.⁷⁰

A BMA survey of GPs in 2014 found that four in ten practices in England were inadequate for patient care. Almost 70 per cent of GPs said their facilities were too small to deliver additional services, and more than half have had no premises investment or refurbishment for a decade.⁷¹ In 2015, NHS England announced a multi-year £1 billion Estates and Technology Transformation Fund for 2015-16 and 2016-17.⁷² However less than £200 million was allocated in 2015, while applications for 2016 were four to eight times oversubscribed.

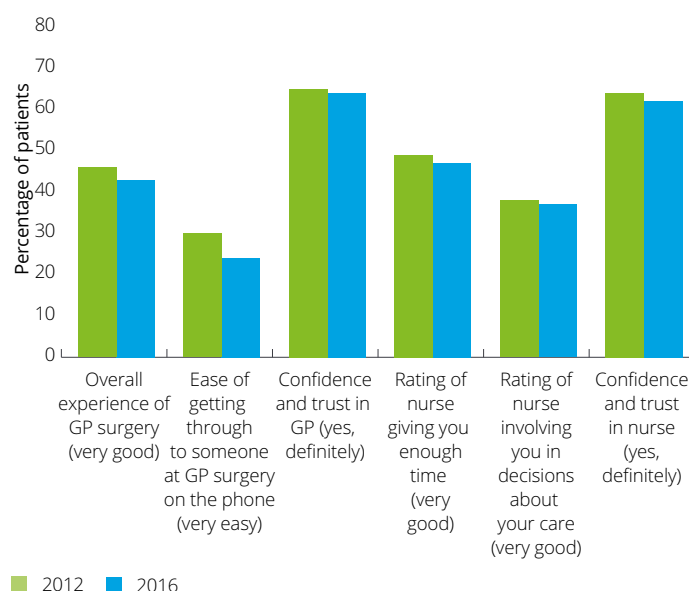
Current indemnity and pensions schemes are a barrier for innovation

The GPFV suggests that rising indemnity costs are one of the reasons for GPs to decide to leave the profession. Unlike hospital doctors, GPs have individual responsibility for their clinical liabilities.⁷³ In July 2016 NHS England published the GP indemnity review, which showed that up to 72 per cent of GPs are deterred from taking on more out-of-hours sessions due to rising indemnity costs.⁷⁴ Average payment for indemnity for in-hours and scheduled care rose by more than 50 per cent between 2010 and 2016 from £5,200 to £7,900 per GP. Data for out-of-hours care are patchy. However, the GP indemnity review calculates it is rising by about 20 per cent per year. Uncertainty surrounding appropriate approaches to indemnity under new models of care poses a significant barrier to workforce and service reform.⁷⁵

Patient satisfaction with general practice is declining

Primary care is valued highly by the general public. However, according to the British Social Attitudes survey, in 2015 overall satisfaction with GP services was 69 per cent, the lowest since it started reporting in 1983.⁷⁶ Likewise, the annual national GP patient survey, carried out by Ipsos MORI, shows a decline in satisfaction since 2012. The number of patients rating their experience as very good fell from 46 per cent in 2012 to 43 per cent in 2016. Satisfaction with opening times of GP surgeries has also fallen: 81 per cent of patients said they were very satisfied or fairly satisfied with opening hours in 2012, but in 2016 the figure has fallen to 75.9 per cent. Trust in GPs and nurses decreased from 65 per cent to 64 per cent and 64 per cent to 62 per cent respectively (see Figure 13).

Figure 13. Patient views of general practices

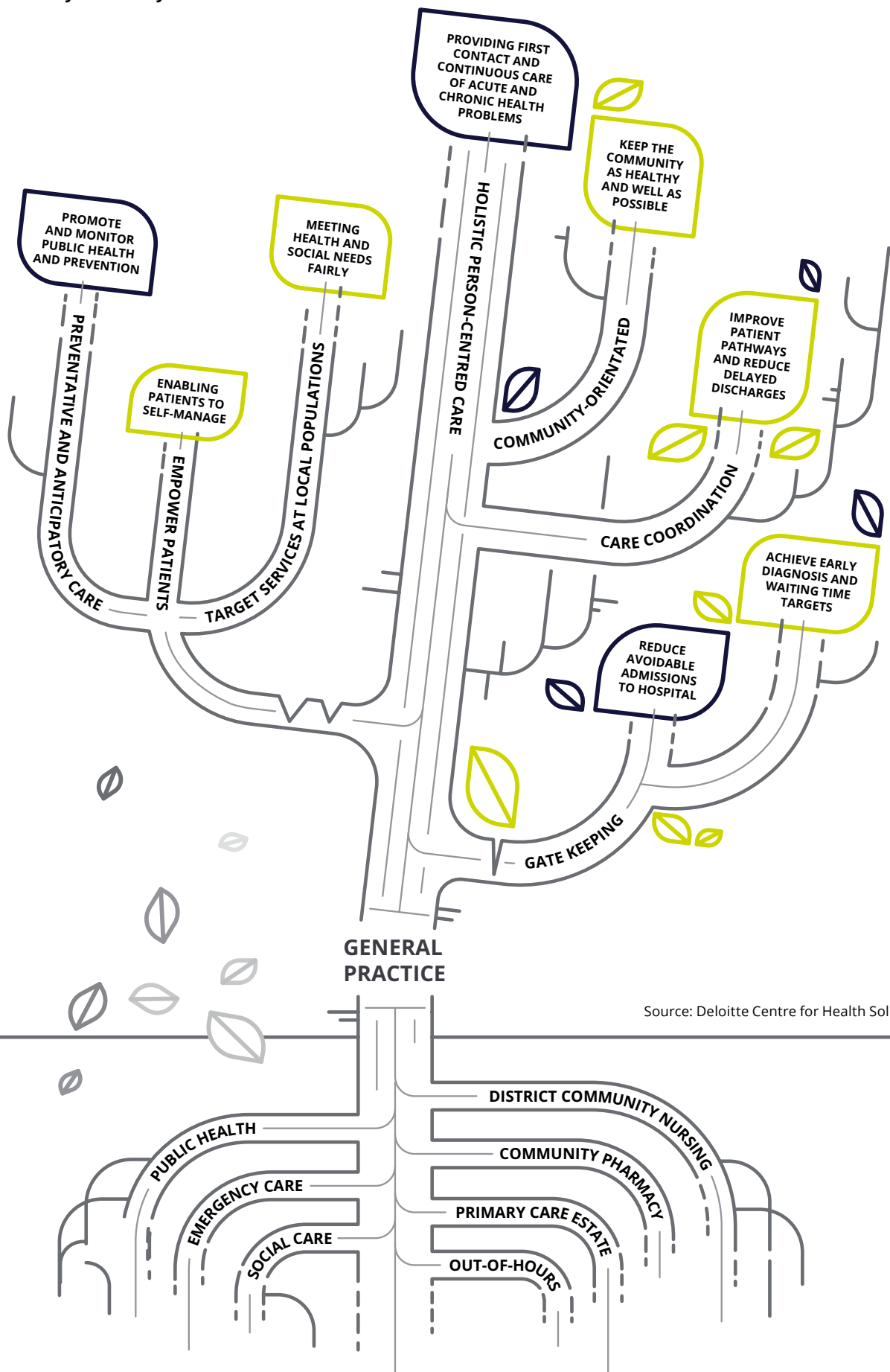


Source: GP patient survey, NHS England/Ipsos MORI, 2012 and 2016

Primary care is at a tipping point

Primary care today is fragmented and disjointed with general practice looking very much like an overladen tree with weakened roots (see Figure 14). Indeed, general practice is increasingly unable to support the growing weight of demands placed upon it. Nor is it able to work cost-effectively with the other parts of the primary care system due to organisational and funding silos and misalignment of incentives.

Figure 14. Primary care today



Source: Deloitte Centre for Health Solutions, 2016

Part 3. Today's solutions: Adapting to new ways of working

This part of the report considers progress against the suggestions in our 2012 report, many of which have since been trialled across different parts of the UK (Figure 15). It also examines the impact of the policy initiatives and other developments launched since 2012 (see Part 1) and the extent to which these are helping to improve service delivery today. Despite reform efforts over the last four years, the key enablers that might support primary care staff to work differently, including the adoption of technology, have not yet been adopted at scale.

Figure 15. Good practice examples of implementation today of strategies highlighted in our 2012 report

Strategies highlighted in 2012 report	Good practice examples today
Using new nursing skills mix for administering and providing care Practice nurses have become an integral part of the primary care team, undertaking an increasing proportion of consultations. More recently advance nurse practitioners, have become more widely deployed (now 17 per cent of the nursing workforce).	Cuckoo Lane Surgery, London was established as a social enterprise in 2005. In 2015 the nurse-led general practice was awarded an 'outstanding' rating by CQC inspectors. The report praised 'clear leadership structure' and 'strong team working' leading to outstanding care especially for vulnerable populations of patients with complex, long-term conditions. The practice runs four nurse practitioner sessions alongside one GP session. 80 per cent of patients are primarily cared for by nursing staff. Patient satisfaction is high and the patient list has grown from 4,400 in January 2015 to 5,500 in February 2016. ⁷⁸
Pharmacist-led care Enhancing the role of pharmacists in general practice and community-based primary care is as yet underutilised. ⁷⁹ While there is a new initiative to encourage practices to employ pharmacists the Department of Health has proposed a six per cent reduction in funding for community pharmacy for 2016-17. ⁸⁰	<p>The NHS Pilot Programme of Pharmacists in General Practice launched in July 2015, with a £31 million budget, currently part-funds new clinical pharmacist posts. To date 435 FTE pharmacists have been integrated into general practice across 658 practices in 89 pilot sites.⁸¹ The programme builds on the experience of practices with patient facing roles. Evidence shows a significant reduction in medication errors and increased efficiency of prescribing and dispensing medication. Medicines adherence improved by around 10 per cent and support for asthma patients reduced GP appointments by 32 per cent and hospital admissions by 40 per cent.^{82, 83, 84, 85}</p> <p>Under the NHS Pharmacy First scheme 37 community pharmacies in Bradford City freed an estimated 900 hours of GP time across 27 practices by promoting self-care and pharmacist consultation before contacting the GP surgery. Community pharmacies contributed an estimated net value of £3 billion to the NHS in 2015.^{86, 87, 88}</p>
Group visits for people with the same condition Group visits can prove useful in public health and education, and supporting people with LTCs. Their effectiveness in regulating demand pressures in general practice is still little understood.	<p>Creating capacity and improving outcomes through group consultations Group consultations offer efficiency gains, reduce repetition, activate patients and support them to take control. They also improve patient experience through extending the time patients get to spend with primary care clinicians. They have been shown to be especially useful for routine follow up and planned reviews. Currently specialists, GPs, practice nurses, early-years practitioners and clinical pharmacists are all testing group consultations to increase their impact.</p> <p>International evidence shows that group consultations improve clinical markers in diabetes, reduce unplanned hospital admissions and A&E visits, and improve patient satisfaction.</p> <p>Evidence for the UK is emerging:</p> <ul style="list-style-type: none"> • GP practices in Smethwick attribute group consultations with supporting delivery of £2.5 million of quantifiable savings • GP practices in Slough report that group consultations have reduced frequent attendance, restored the joy to clinical practice and have worked well with their diverse community • mental health specialists in Croydon saw a 30% reduction in hospital days amongst people with severe mental health issues supported with group consultations. <p>Further evaluation is underway in UK primary care.⁸⁹</p>

“The NHS has historically assumed that it can implement changes in half the time and with a quarter of the resource used elsewhere.”

Nigel Edwards, Chief Executive, Nuffield Trust⁷⁷

Figure 15 (continued). Good practice examples of implementation today of strategies highlighted in our 2012 report

Strategies highlighted in 2012 report	Good practice examples today
<p>Productive general practice</p> <p>The evidence for general practice productivity is limited and is largely around demand management and new models of access. Since 2012 the use of telephone triaging has grown with emerging evidence that around one- third of demand can be handled over the phone reducing A&E attendance by up to 20 per cent.^{90, 91}</p>	<p>Patient demand for help from the healthcare system is highly predictable, and a GP surgery can effectively plan to meet it and offer same-day access for patients. Organising the resources of the practice and GP time can be oriented to meet these predictions as precisely and appropriately as possible. Capacity is generated since a large proportion of patient needs can be managed through phone consultations (averaging 5 minutes). Further efficiency is enabled by technology solutions such as askmyGP.</p> <p>For example the demand led model and askmyGP were piloted by four practices in Northern Ireland since May 2016. Patients email their GP practice via askmyGP at their own convenience, enter their details and symptoms online and answer a set of simple structured questions with one-click answers, creating a medical history. They also see self-care information relating to their symptoms, and may decide that is all the help they need. A doctor at the surgery takes seconds to scan the report and respond quickly with the best course of action, e.g. calling the patient in or organising referral. Evidence shows that two thirds of patients can be dealt with remotely, yet clinical quality is improved as many more questions can be asked by the askmyGP system than most GPs have time for. Given the evidence of the four pilot sites (including a reduction of face-to-face consultations by up to 50 per cent) the Northern Ireland health board has requested a larger scale rollout with 10% of the population to be covered by the end of 2016.^{92, 93}</p>
<p>Integrating pathway hubs – to commission whole patient pathways</p> <p>Despite the recognition of problems resulting from fragmentation of delivery of care, to date, integration of commissioning and provision have not been implemented at significant scale.</p>	<p>Symphony Integrated Healthcare</p> <p>The south Somerset Symphony Programme is one of 50 vanguards across the country, looking to devise new innovative ways to deliver healthcare against the challenges of growing patient list sizes, an ageing demographic and increasing numbers of patients with a number of long-term complex health conditions.</p> <p>The Symphony Programme is a collaboration between Yeovil District Hospital NHS Foundation Trust, south Somerset GP practices, Somerset CCG, Somerset Partnership and Somerset County Council aimed at integrating health and social care services to enable patients to access the right care in the right place. The partnership between primary care and the hospital is beginning to shift resources so that more specialist services can be accessed within primary care and focussing more on prevention and education to help patients to better manage existing health conditions, to reduce unnecessary admission or re-admission to hospital.</p> <p>New strategies of care include the implementation of the Enhanced Primary Care model that has introduced the role of nominated Health Coaches to provide support for patients currently across 19 GP practices in south Somerset, supporting the role of the GP. Over 3,500 patients have had interactions with a Health Coach to date, with positive results described by both patients and GPs.</p> <p>In addition, the creation of a Complex Care Hub model currently provides care to around 330 patients with the most complex health conditions, with early indications showing a positive impact on hospital admissions. Patient participation is enhanced by a partnership of Symphony with Patient Know Best®, providing patients with access to their own care records, a bespoke and detailed care plan and support to reach individual health and wellbeing goals.</p> <p>Symphony Healthcare Services Ltd (SHS) was set up as a subsidiary of Yeovil Hospital in April 2016, as an operating company for local GP practices to integrate with if they choose, where they are able to benefit from the additional support that a larger NHS healthcare organisation can bring – such as back office functions, support with recruitment of GPs and healthcare teams as well as IT and quality. SHS has currently integrated with 3 practices, with more currently considering integration.^{94, 95}</p>

Figure 15 (continued). Good practice examples of implementation today of strategies highlighted in our 2012 report

Strategies highlighted in 2012 report	Good practice examples today
<p>Primary care-led specialist clinics or rapid access and treatment centres</p> <p>A number of geographies have adopted the idea of Primary care led musculoskeletal (MSK) clinics following the success of the initial project in Oldham during the 2000s.</p>	<p>Pennine MSK partnership Ltd is a clinically owned business commissioned by NHS Oldham. It has a standard NHS community contract and provides a single point of contact and care for all musculoskeletal conditions. It provides a full range of services including non-admitted care in elective care pathways in orthopaedics, rheumatology and chronic pain. The service has four clinical leaders and an accountant who also own the business including, a nurse consultant in rheumatology, a consultant rheumatologist and two GPs with a special interest in rheumatology. Pennine MSK Partnership uses clinical judgment and skills to improve and where necessary redesign services to achieve better value. Patients are supported in direct access to the right specialist and a range of psychological support services. The service is funded through payment by results, offering a reduction up to 90 per cent of the national tariff for some elements of the pathway and a range of local tariffs that improve and reward efficiency. Local GP referral times are shorter than the national average. The second national Rheumatoid Arthritis (RA) audit found that 40 per cent of patients were referred within 3 days of presentation, compared with 20 per cent nationally. Effective triage and workforce planning ensured that across the 2 years period of the RA audit between 72 per cent and 58 per cent of patients (compared to 37 per cent nationally) are seen and treated in accordance with NICE Quality standards within 3 weeks of referral.⁹⁶</p>
<p>Home-based, self-management, involving collaborative working</p> <p>Implementation has been hindered by delays in implementation, licensing and funding for technological solutions. However, some examples have been implemented in the context of chronic conditions and especially in care homes.</p>	<p>NHS Health Call</p> <p>Health Call is a joint partnership between County Durham and Darlington NHS Foundation Trust (CDDFT) and Inhealthcare Limited, established in 2013. It aims to redesign care pathways across the UK enabling patients and health professionals to manage International Normalised Ratio (INR)-monitoring, nutrition, chronic pain and obesity at home. The service is designed around easy to use digital technology involving automated phone calls, internet portals and medical devices.</p> <p>For example, patients on warfarin require regular blood tests which traditionally requires time consuming clinic attendance. Health Call means they can self-monitor, submitting home-readings through an automated phone call or an on-line portal. The data and the current dosage of warfarin to be used is calculated by specialist nurses in the clinic and the patient then receives a second automated phone call to inform them about their next dose of warfarin and when their next INR test required – always at a time to suit the patient. Evidence shows that self-testing INR at home is found to be 17 per cent cheaper than in clinics and 25 per cent cheaper than home visits. Patient satisfaction is high and clinical outcomes improved. In addition, a study involving 100 patients at risk or suffering from malnutrition showed cost savings of £21,550, resulting from the impact on clinic appointments, dietician visits and optimisation of prescription of nutritional supplements.⁹⁷</p>
<p>Extending GP Access</p> <p>Since 2013 a number of providers have been trialling longer opening hours and new ways of accessing primary care using funding from the prime minister's GP Access Fund. However, evidence regarding the effectiveness of these programmes in balancing costs and managing demand remains mixed.</p>	<p>A study carried out in 2014 in Greater Manchester showed a 26 per cent reduction in patient-initiated emergency department visits (11,933 fewer visits) across practices with increased access (opening times) compared to practices with standard opening times. However, the increase in out-of-hours GP appointments (33,159 additional visits) was greater than the reduction in visits. Over the study period the reduction in A&E attendance generated hospital savings of £767,976 after allowing for the funding of out-of-hours services of £3.1 million. Evidence regarding the health outcomes for patients resulting from extended hours was not included in the study. The evaluation of cost-effectiveness is further limited since set-up costs could not be separated from the running costs of extended hours.⁹⁸</p>
<p>New non-NHS models of GP access</p> <p>The last four years have seen an increase in the private provision of services both online-based and private GP services. However, these new services are largely concentrated in densely populated and affluent areas.</p>	<p>For example, Babylon Health is a digital-based health company offering services that range from symptom checking, health monitoring, text-based e-consultations and same day face to face video consultations that in some areas are offered in partnership with NHS surgeries. It is prescription-based and currently has 350,000 registered users in the UK. Babylon contracts with individuals, employers and some NHS commissioners and providers to improve access to primary care services. An independent evaluation of its algorithm-based triage system found its 'Check a Symptom' feature to be safe, accurate and significantly faster in diagnosing than unassisted clinicians.^{99, 100}</p>

Different models of collaboration in general practice are emerging

Since 2012 there has been an increase in collaboration and partnership working in many parts of the UK with nearly three-quarters of general practices in England now working as part of a federation or in another form of collaboration (Figure 16).

This change recognises the fact that larger scale general practices have the potential to achieve operational efficiency, standardise processes, maximise income, strengthen the workforce and deploy health technology more effectively. This in turn, enables more effective integration of care. However, a study by the Nuffield Trust on large scale general practice also cautions against unrealistic expectations regarding the pace of service transformation through these new organisations.¹⁰¹

Implementation of new care models aimed at more integrated ways of working

Despite a plethora of research evidence on the benefits of integrated care, whether between primary and secondary or health and social care, there has been limited success in integrating services in the NHS in England. However, the foundations are now in place to enable things to change. The devolved health economies in Northern Ireland, Scotland and Wales, as well as current plans for Greater Manchester, are now well on their way to supporting a more integrated approach.¹⁰² This is partially due to the removal of institutional and organisational divides between health and social care providers.

Integration is central to the reform efforts being implemented across the NHS, including the NHS vanguards, yet progress made by the 50 vanguards established since 2015, has been variable. While all share a high level of enthusiasm and commitment in trying to develop new ways of working, progress has been faster in some areas than others. There is a clear recognition of the need to do things differently and not just deliver more of the same. Some of the biggest challenges in setting up a vanguard have been establishing the governance framework, the need for new types of system leadership, aligning the different organisational cultures, and overcoming the difficulties in sharing health data, including the need for interoperable electronic health records. There is also a recognition that it will take several years to realise the benefits of transforming care.

The vanguard programme is being supported by a system of facilitated learning and in 2015-16 NHS England allocated around £132 million of funding to the 50 vanguards, who contributed over £110 million themselves; with some £112 million allocated for 2016-17. While it is too early to tell how the models will evolve or the potential scale of wider adoption, Figure 17 (overleaf) highlights emerging benefits from one example of each primary care vanguards.¹⁰³

Figure 16. New organisational forms of collaborative working



Source: Is bigger better? Lessons for large scale general practice, Nuffield Trust, 2016

Figure 17. Emerging evidence from a number of the primary care vanguards

Integrated primary and acute care system	<p>Northumberland Accountable Care Organisation</p> <p>A new specialist emergency care hospital provides A&E consultants 24/7 and specialty consultants 7 days, 12 hours a day. It is complemented by 3 urgent care centres based in 3 local district general hospitals, staffed by a mix of hospital doctors, GPs and emergency nurse practitioners. Early evaluation has shown the model has reduced emergency admission rates by 30 per cent in 2015-16 compared to 2014-15 with estimated £6.64 million of savings. Northumberland's care model is being supported by the formation of an accountable care organisation (ACO), which brings together all providers in Northumberland to focus on health outcomes. A CCG/Local Authority partnership acts as strategic commissioner, applying a single contract and allocating a capitated budget to the ACO.</p>
Multi speciality community provider	<p>Stockport together</p> <p>Using 'Consultant Connect', GPs in Stockport can access real-time specialist advice from consultants at the local hospital, during patient appointments if appropriate. Consultant Connect was initially launched with haematology and endocrinology specialists, but was later extended to paediatrics, cardiology, elderly medicine and gastroenterology. It also provides GPs with direct access to a specialist IBD nurse practitioner. Introducing the service has led to a reduction in access times for GPs to consultants, from 3-4 weeks to instant telephone access, and as a result has led to the provision of more timely care and advice as well as the avoidance of unnecessary referrals and admissions for patients.</p> <p>In addition to Consultant Connect, Stockport Together MCP has also introduced 'enhanced services' allocating named GP practices to all care homes across the borough. Services include a weekly ward round and reassessment of care plans, facilitated through a multi-disciplinary team operating at a neighbourhood level.</p>
Enhanced health in care homes	<p>Airedale and partners</p> <p>The vanguard comprises local CCGs and their associated general practices, NHS providers, care home providers, social services and the third sector with further support from technology partners and the University of Bradford. The partners have a success record of innovative enhanced care delivery for the group of vulnerable, frail elderly people, many with multiple LTCs. By using enabling technologies, nursing and care home residents and their carers benefit from being able to access expert advice remotely 24/7. The vanguard and its partners support over 7,000 nursing and care home residents living in 248 homes across Yorkshire and Lancashire. Care homes have reported a reduction in hospital as place of death for palliative care patients, reductions in A&E admissions and non-elective hospital admissions, and reduction in inappropriate GP call-out.</p>

Another new model of primary care – the Primary Care Home

The National Association of Primary Care (NAPC) has advocated the concepts behind their 'Primary Care Home' (PCH) programme for a number of years. The main features have been promoted in the recently published MCP framework document. Both involve a unified budget, a single integrated workforce and an alignment of clinical and financial drivers to ensure a collective approach to risks and rewards. In October 2015, the NAPC, supported by NHS England, requested expressions of interest to be a PCH 'Rapid Test Site (RTS)'. Around 100 networks comprising GPs, health and social care staff responded and, following a rigorous evaluation process, 15 RTS were selected in December 2015. Several sites have already reported seeing a positive impact on care and services, including one with a step change in recruitment of clinical staff and using new approaches to deal with capacity issues.

The features of both the MCP and PCH models include:

- an optimal population size of not less than 30,000, and normally not more than 50,000 people
- the provision of care by one provider to a registered population balancing personalised care with population health planning and provision
- workforce planning matched to the needs of the registered population
- dismantling historical organisational boundaries while working collectively through networked arrangements within modernised community healthcare premises, with access to on-site diagnostics and an integrated IT system
- a whole population budgets for the registered population taking delegated accountability to improve NHS resource utilisation
- urgent, same day and pre-bookable appointments for the registered population (consistent with the concept of 'the never full' practice).^{104, 105}

Part 4. A sustainable model of primary care for tomorrow

“There is a continual risk that either we, or those who are watching and commenting on us immediately defer to discussing new models of organisation rather than new forms of care.”

Paul Maubach, CEO of Dudley CCG, 2016¹⁰⁶

Participatory, proactive and adaptable

Good primary care involves collaboration and integration at scale and alternative ways of accessing services. It includes more effective use of technology and supported self-care models. A sustainable system of primary care should be firmly rooted in multiprofessional, multiservice, delivery models, with general practice acting as the primary care management centre or ‘control tower’ ensuring that patients receive the right care in the right place at the right time.

Figure 18 (overleaf), shows what a healthy, proactive and adaptable primary care system could look like. It comprises a fully integrated primary care system with strong foundations and a managed approach to demand pressures. It involves new, evidence-based funding models deployed as part of population health management; technology as an enabler accepted as a normal way of working; and multiprofessional teams with shared accountability for the health of the local population. Central tenants of this model of care include: policies that support self-directed care, the physical and mental health of the population and prevention. The workforce is motivated and highly skilled performing their day-to-day responsibilities for primary care while also providing strong system leadership. This part of the report considers how best to achieve this vision.

General Practice Forward View implementation is critical to the future sustainability of primary care

The promised investment of £2.4 billion as part of the GPFV is not part of core funding for practices, but rather attached to specific schemes and initiatives. More importantly it is not new money but is included in the increase in NHS funding announced in the 2015 Autumn Statement.¹⁰⁷

The sustainability of primary care depends on this funding being allocated quickly and transparently. It is also important that measures to monitor its use and impact are put in place. NHS England suggests that this additional funding will increase general practice funding to over 10 per cent of the NHS budget. However, with demand outstripping supply of primary care resources, there will still be a need to deliver more services for less resources.

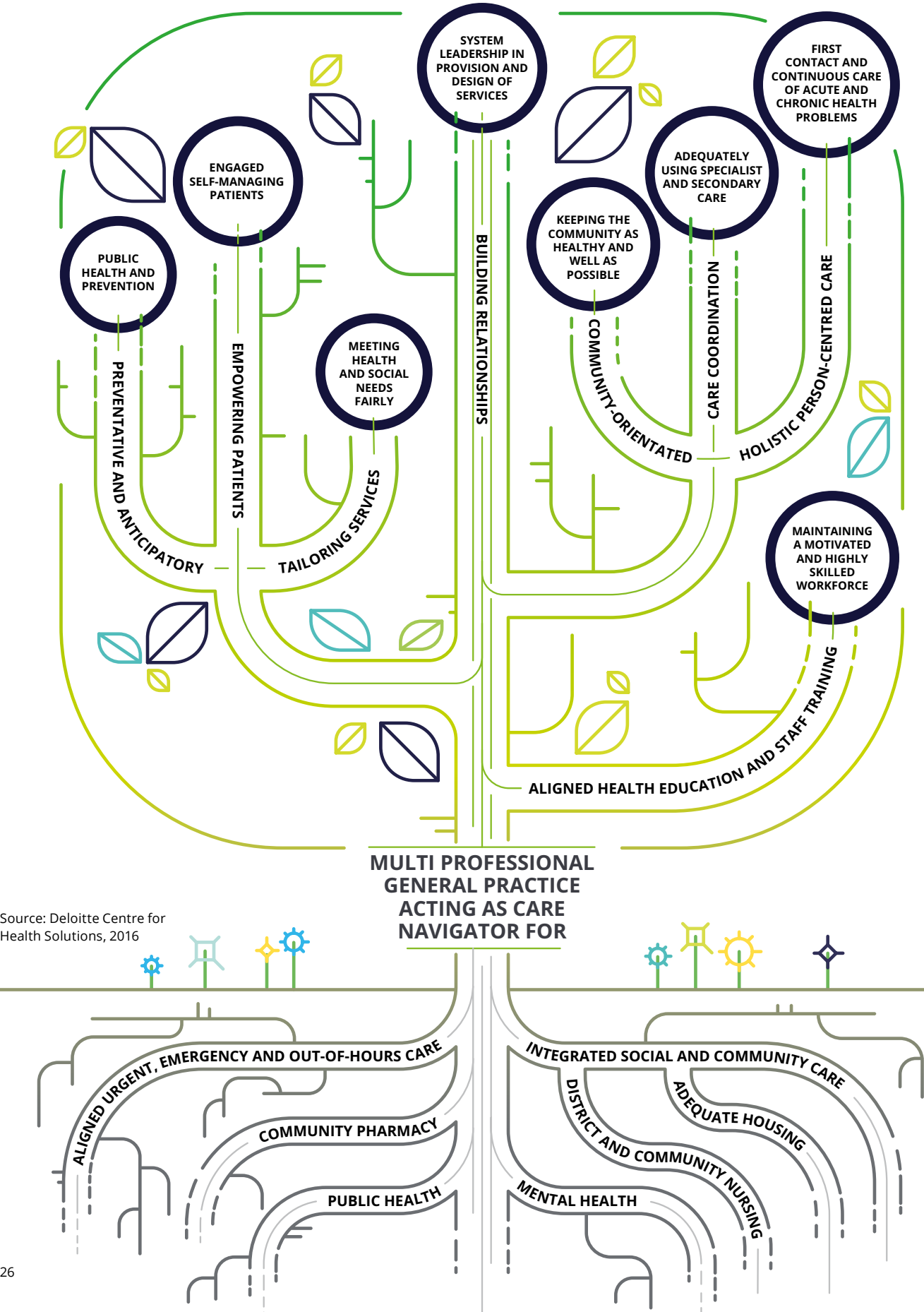
More evidence is needed on the appropriate levels of funding and workforce numbers needed to implement, effectively, the new models of care.

While NHS England’s promise of 5,000 extra GPs, 3,000 mental health workers and a further 1,500 clinical pharmacists working in practices could potentially alleviate the pressures in the short term, it is vital that these workforce commitments are delivered by 2020. However, more effective workforce planning based on transparent evidence of current and planned levels of activity are urgently needed.

The establishment of a new national service to provide GPs with free access to mental health and support from December 2016 is long overdue. However, it needs to be prioritised so that the soaring levels of stress and burn-out that successive surveys demonstrated as adversely affecting the workforce, can, as far as possible, be alleviated.

A key initiative in the GPFV is the commitment to provide an automated appointment-measuring system for every practice in 2017-18 to help practices understand, measure and manage appointments and match supply to demand. While improving information about service use and targeting of services is essential for helping to alleviate many of the immediate pressures facing GPs, obligatory data collection on access and use is needed to improve transparency of demand for care.

Figure 18. Primary care tomorrow: the centre of the health ecosystem



Improving the primary care estate

The recognition of the need to improve general practice premises is arguably the second most important factor, after the workforce, in ensuring a sustainable future for primary care. However, the multi-year Estates and Technology Transformation Fund is unlikely to meet the full extent of modernisations that is needed. Other ways of funding improvements in the estate will be required. Again, this needs to be underpinned by accurate assessments of the state of the primary care estate, its location and the extent to which it meets current and future patterns of demand. This will need to take into account plans for increasing the number of technology assisted consultations. Capital projects also take time to get through the design, financial and legal processes. In addition, the new law on energy efficiency from April 2018 and the concerns expressed by the CQC over the number of premises that are not fit for purpose mean that time is of the essence.

Indeed, while the GPFV has much to commend it, it remains to be seen how accessible the additional funding will be to practices. Accessing the money will likely require funding bids and requests. Some decisions will depend on how CCGs decide to allocate the funds they receive, while other funding streams will only be available if the practice signs up to the new MCP contract. Importantly, primary care leaders will need to have full voting rights in the implementation of the STPs.

The role of the STPs for primary care sustainability

Of all of the initiatives and programmes aimed at incentivising new care models, the initiative with the most disruptive potential is the development of the 44 STPs.¹⁰⁸ While these plans have the potential to make fundamental changes in the shape and nature of health and care services, they also need to improve services and achieve financial stability by 2020. NHS England's advice on STPs indicates that the aims and ambition of the GPFV should be reflected fully in local plans.

However, the speed with which organisations have had to come together to develop the plans has been unprecedented. Many local organisations have to develop new relationships and ways of working in the absence of previous experience, while others have been able to build on work already underway. As a result, current progress varies across England. Expert commentators have raised concerns about the speed of development and the large and ambitious scale of the STP process. Specific concerns include the fact that initial indications suggest that the plans are insufficient to close the funding gap.¹⁰⁹

Implementing the STPs is challenged by the difficult financial situation and the requirement to continue a seamless provision of care. Further risks surround the implementation process itself, especially the absence of clear mechanisms of accountability for delivery, concerns over managerial competencies across all organisations and a lack of stakeholder buy-in, most notably from the majority of GPs.¹¹⁰

To date, general practice has not had much influence over the process, a concern reflected in new guidance from the RCGP: *10 actions to help implement the GPFV locally*. The RCGP has also appointed 32 clinical ambassadors across England to try and ensure that local plans pay sufficient attention to addressing the crisis in general practice.¹¹¹

The proposals for primary care in the STPs will need to obtain the buy-in of the clinicians who will be implementing these new models, and be supported by patients, who will be the end-users.¹¹² Furthermore, with the above developments happening at a time of intense change and churn, the fact that CCGs will be focused on achieving financial balance increases the risk that insufficient priority will be given to transforming primary care.

Enablers to future-proof and transform primary care

Sustainable primary care requires new models of care in which general practice acts as the management centre of coordinated and integrated care. As highlighted in our recent report *Vital signs – How to deliver better healthcare across Europe*, the one-size fits all model of primary care is unlikely to be effective in the future given the wide variation in needs of different patient groups.¹¹³ Key enablers include:

Improved systems and processes

- single patient identifier and registered population lists for each primary care organisation or network that enable economies of scale and population health management (PHM)
- appropriate levels of funding for general practice (around 10 and 11 per cent of healthcare spending) accompanied by increased investment in prevention (international comparisons suggest at least five per cent of healthcare spending) and access to funding to address the non-medical, social care needs of the population
- access to agreed levels of healthcare, free at the point of delivery, and which may include an agreed and transparent level of cost-sharing with patients for specific items, such as charging for prescriptions
- value-based payment models, including bundled payments for chronic conditions
- standardised guidelines, treatment protocols and clinical pathways
- bringing together community-based services across general practice, hospitals, urgent care, NHS 111 and specialist services to improve extended opening times, and an efficient and effective system for providing out-of-hours services
- an agreed set of performance metrics for real-time assessment of activity and resource deployment across all primary care providers
- publicly available assessments of the effectiveness of different primary care providers and a national register of approved primary care providers.

A flexible well-trained workforce

- GPs acting as medical interpreter and health coach optimising their broad medical knowledge, strong consultation skills and understanding of the psychosocial aspects of illness
- establishment and deployment of multidisciplinary teams from across primary care that include doctors, nurses, physician assistants, specialist nurses, healthcare assistants, physiotherapists, pharmacists, social care staff and (where appropriate) volunteers

- locating mental health staff in primary care, to ensure that a patient's mental and behavioral health, are recognised and given parity of esteem with physical health, helping to reduce emergency attendances and admissions to hospital
- providing financial incentives to attract and retain staff in under-served areas, for example through one-off payments on appointment and recurrent supplementary payments or bonuses to aid retention
- managing demand by telephone triaging by a doctor and/or nurse, flexible appointment lengths, group appointments, primary care-led specialist clinics and rapid access centres as well as technology-enabled early access to specialist advice
- ensuring ownership for strategic planning amongst all providers of primary care services through NHS leadership programmes that acknowledge the diversity of the primary care workforce
- active engagement with patient advisory forums, patient-led innovation groups and the voluntary and charitable sectors
- fully engaged patients exercising patient choice, with access to own patient records, supported by services like NHS Choices and myNHS.^{114, 115}

Effective use of technology

- interoperable, integrated electronic health records (EHRs) that patients can access and interact with, which are shared with all staff who come into contact with the patient (but with patients having control over the information different people can access)
- improved diagnostic capability, including point-of-care diagnostic testing (for example digital blood testing, atrial fibrillation, and tests for bacterial or viral infections) and if appropriate direct referral to imaging, such as MRI and CT scans
- technology-enabled communication systems that enable patients to email staff, access online appointment booking and obtain e-prescriptions
- deployment of telehealth and telecare to monitor and support people in their own homes
- prescribing approved ('kite-marked') digital devices and health apps as an alternative to, or supplementary to, drug prescriptions, alongside technology to monitor compliance and adherence.

Whatever the far reaching changes proposed in the STPs, no one organisational model for primary care provision is likely to be advocated or prioritised. The nature and priorities of local populations will likely determine the organisational form and precise mix of functions of the new models of care.

Closing thoughts

Our research indicates that primary care will become even more important in the future. General practices are, and will remain, the central co-ordinators, coaches, and providers of treatment and support for their local populations. To realise the ambition for general practices to be the responsible and caring pivot in the system that evidence suggests they should be, the reforms need to be implemented as intended and the increased resources allocated as promised. Furthermore, we believe that the following measures could help stakeholders work together more effectively, across the health and social care system, to alleviate the immediate pressures and enhance future sustainability of care.

TAILORING SOLUTIONS TO TARGET LOCAL NEEDS

As services across primary care evolve and adapt they need to be closely aligned to local needs. This requires local conversations and an actuarial assessment that helps to segment the local population according to their needs and plan and align services accordingly. General practice is in a unique position to make more effective use of patient lists and the consistency and continuity of their doctor/patient relationships. General practice needs to act as the navigator for care across local networks to enable the right care with the right professional, at the right time and in the right place.

OPTIMISING THE TIMEFRAMES OF REFORM PROCESSES

Transforming primary care requires implementation timeframes to be more realistic and more aligned. Reform timeframes still tend to align to political timeframes when research evidence demonstrates that the extent of change requires longer planning horizons. The recent decision in the NHS planning guidance for two-year contracts and funding, instead of the traditional annual contracts, is a step in the right direction.¹¹⁶ However, the scale of system transformation needed to implement new models of primary care is likely to require secured funding over a longer timeframe.

GENERATING ALIGNED INCENTIVES THROUGH INTEGRATED FUNDING AND COMMISSIONING

The current models of funding pose a barrier to implementing reforms. New payment schemes need to be based on an improved understanding of primary care spending, and move away from activity-based funding to outcomes-based funding of integrated services. Across the country stakeholders have accepted individual solutions in shifting budgets and responsibility for commissioning primary care. In future these shifts need to be supported by changes in legal provisions. While some local variation will remain, transformation should build on current trends of joining up both budgets and responsibility for care in accountable care type organisations that coordinate physical and mental health and social care.

ENHANCING COLLABORATIVE WORKING ACROSS ORGANISATIONS AND INDIVIDUALS

Despite technological advances, people remain at the core of a sustainable health system. The planning and implementation of changes to service design and funding require collaboration and joint working between hospital specialists, community teams, primary care teams, pharmacists, social care, the voluntary sector and, importantly, patients. As indicated in NHS England's 2017-19 planning guidance, partnership behaviours between individuals and organisations need to become the norm.¹¹⁷ New models of accountability as well as adequate schemes of clinical and financial risk-sharing need to recognise and reward partnership. Most importantly, new care models need to focus on a convincing value proposition for GPs to shift from traditional contract-based partnership models towards collaborative models. The new care models need to include frameworks for developing sustainable relationships with third sector organisations, including optimising the use of social prescribing. Plans for service redesign need to provide more support for informal carers including financial support and access to technological solutions.

TRULY INNOVATIVE, PROACTIVE WORKFORCE STRATEGY

NHS England and Health Education England need to improve workforce planning for primary care, including refreshing their understanding of the competencies and skills needed, and matching these to new and more flexible roles, which reflect the demographic and social trends within the workforce and the population served. Integrated working across permeable boundaries requires an inclusive approach to health education and continuous training across all health and social care professions. This needs to be matched by regulatory re-design and licensing of care professionals.

HELPING PATIENTS UNDERSTAND AND ENHANCE THEIR ROLE IN HEALTH AND CARE

Service transformation needs to include a national strategy for patients and staff to 'co-produce' services. Including, harnessing technological solutions such as the use of wearables and the deployment of home monitoring devices and the adoption of tools to improve health literacy, such as the Patient Activation Measure®.¹¹⁸ Evidence shows that improving health literacy of the local population is crucial to the achievement of a sustainable and cost-effective health system. Providing different access routes to advice and support (such as online triaging) can enable better utilisation of the wider primary care workforce. Applying behavioural economics can help incentivise healthy behaviours and lead to more responsible service use, which in turn would reduce the numbers of unnecessary primary care consultations, do-not-attends, and use of urgent and emergency services.

EXTENDING THE ADOPTION OF HEALTH TECHNOLOGY THROUGH EFFECTIVE PARTNERSHIPS

Technology is a crucial enabler of the new care models and is central to the delivery of STPs, aiming to increase the reliability and ease of access to services. A key requirement for the adoption of health technology is being able to harness the power of connectivity, so that healthcare can be monitored and managed remotely in real-time. Primary care providers should work with patients and technology companies to maximise their cost-effectiveness and capability to meet patients' expectations and demand. Commissioners should develop partnerships with industry to develop new business models, including new ways of risk-sharing. Resolving regulatory concerns around privacy and data security needs to be tackled as a priority so as to allow telehealth and mhealth to be expanded. In addition, accessing care through online and video appointments will help to respond to growing patient demand for online services.

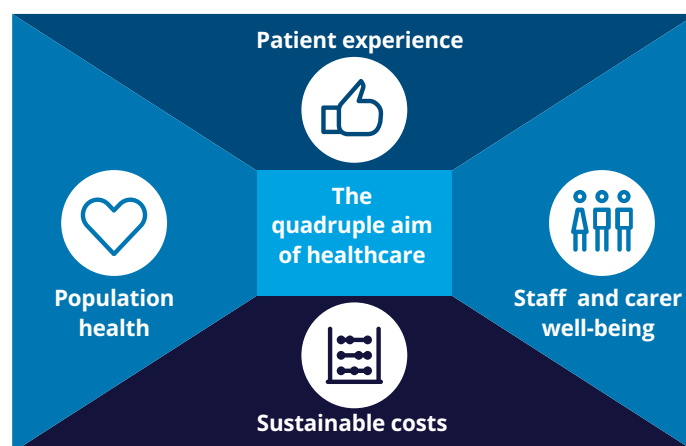
REVIEWING IMPLEMENTATION OF THE REFORM PROCESS REGULARLY

Using technology to measure the progress of planned reforms enables both frontline workers and policymakers to adjust strategies according to outcome. Real-time measurement should encompass up-to-date technological solutions such as RFID-enabled real-time activity measurement and tailored apps. However, models of care should focus on outcomes that are determined in conversations with commissioners, providers and service-users. There is scope for improved data collection and analysis across all segments of health and social care.

Deloitte believes that the solutions and enablers discussed in this report provide building blocks that all stakeholders can utilise in the further design and implementation of reform programmes such as the vanguard models of care and STPs.

Current improvement plans are still more rhetoric than reality and policymakers, commissioners and providers face significant challenges in achieving a sustainable primary care system. Addressing these challenges will require some unpopular decisions and a high level of transparency and engagement across all stakeholders. This in turn will allow primary care to fulfil its vital role in achieving the quadruple aim of healthcare across the UK health system (see Figure 19).¹¹⁶

Figure 19. From triple to quadruple aim: integrating staff well-being to optimise healthcare performance



Source: Deloitte Centre for Health Solutions, 2016; From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider, *Annals of Family Medicine*, 2014

Clinically-led and expertly-managed

Transformation of primary care is ongoing and the outcomes of current reforms remain uncertain. The success of reforms depends on having an open, honest, engaging and iterative process that utilises the energies of clinicians, patients, carers, citizens and local community partners, including the independent and voluntary sectors and local government health and wellbeing boards. A new social contract for health and social care is required, based on reaching an agreement on what levels and types of care are sustainable, at what cost.

Looking ahead to 2020, it is evident that general practice and how it operates will not look the same. The workforce, at the heart of the primary care delivery model, will look and feel different. It will comprise larger more agile and more coordinated multiprofessional staff groups, who will be making more effective use of new technologies and be co-located in purpose built or redesigned premises. Patients will be signposted more effectively to the services that best meet their needs with an increasing emphasis on care coordination, including supported self-care. GPs will be working as an integral part of a more joined up workforce and have an active role in service redesign, while devoting a greater amount of time to population health management, benefitting their patients and the wider local community.

Acronyms

A&E	Accident and Emergency
ACO	Accountable Care Organisation
APMS	Alternative Provider Medical Services Contract
BMA	British Medical Association
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DoH	Department of Health
EHCH	Enhanced Health in Care Homes
EHR	Electronic Health Record
FTE	Full-time equivalent
FYFV	Five Year Forward View
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
GPMS	General Personal Medical Services Contract
HC	Headcount
HSCA	Health and Social Care Act
INR	International Normalised Ratio
LIFT	Local Improvement Finance Trust

LTC	Long-Term Condition
MCP	Multispecialty Community Providers
NAPC	National Association of Primary Care
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIGPC	Northern Ireland General Practitioners Committee
NMC	National Midwifery Council
ONS	Office for National Statistics
PAC	Primary and Acute Care System
PCH	Primary Care Home
PCT	Primary Care Trust
PCTMS	Primary Care Trust Medical Services
PMS	Personal Medical Services Contract
QNI	Queen's Nursing Institute
QOF	Quality and Outcomes Framework
RA	Rheumatoid Arthritis
RCGP	Royal College of General Practitioners
SHA	Strategic Health Authorities
SHS	Symphony Health Services
STP	Sustainability and Transformation Plans

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