

Overview

1. Mr Wanless makes a convincing and coherent case that funding of the NHS through general taxation is both fair and efficient. We welcome his finding that there has been thirty years of cumulative underinvestment which explains much of the difference in health outcomes between the UK and similar European countries.
2. There are many things about this report that we welcome. The process of open debate, both about funding methods and about the type of NHS that we may expect, is very welcome. In particular the recognition that the NHS suffers from short-termism and year on year funding is particularly valuable and the variability in resources in the current arrangements is well shown. We would go further, and urge the review to investigate the problems caused by political interference in a service such as the NHS that needs long-term planning. Undergoing at least three major restructurings in little more than a decade has obvious negative repercussions for patient care.
3. We were impressed by the huge amount of data and information the report has brought together. It is written in a clear and thoughtful way. The report is clearly of profound significance to all of us.
4. We were pleased to see that, in general, the document highlights the importance of general practice and primary care to the NHS. It makes the point that the public are satisfied with what we provide and that other countries continue to look to British general practice as a useful model. The holistic approach taken by British GPs, traditionally called the 'gatekeeper' role, is particularly admired internationally.
5. We are disappointed, however, that this thinking is not reflected in the report as it effectively suggests diminishing this role. The IPPR study, commissioned by the Review itself, found that one of the things that patients want in terms of quality, is longer, good quality relationships with health professionals. General Practitioners provide such a relationship for the majority of patients; it makes no sense, therefore, to diminish this relationship which would happen if nurses were used to triage all patients visiting their GP. We have included more information on continuity of care and patient satisfaction at Appendix 1.
6. We feel that the Review shows a real lack of understanding about general practice and what we do. We are, therefore, attaching, a document which we recently produced, entitled "*Valuing General Practice*" (this document is also on our website at: http://www.rcgp.org.uk/rcgp/corporate/response/nhs_plan/valuing_gp/index.asp), which demonstrates the importance of the generalist both within primary care and the wider NHS. The Review needs to recognise that generalism is as much about training; skill set; inclination; and mind set as it is about job description.
7. The report states that GPs will become more specialist, this is probably not the case. If anything, there is a case for saying that specialists will become more specialised in smaller areas. It is possible there will be more community physicians, paediatricians, geriatricians and psychiatrists working in community based settings, but a far more appropriate response would be for there to be a larger number of generalists.
8. The concept of GPs with special interests accepting referrals from colleagues, has gained credence recently. It must, however, be noted that removing these GPs from their generalist role has obvious negative consequences on an already over-stretched workforce. We are attaching two papers which contain more detail on the issues surround GPs with special interests, both of which are on our website at: http://www.rcgp.org.uk/rcgp/corporate/response/nhs_plan/nhs_plan_menu.asp.

9. The report seems to view primary care as supporting the secondary and tertiary sector, whereas the opposite is true, the secondary and tertiary sector support primary care services, which provide the vast majority of medical and nursing input to patients. General Practitioners' holistic approach to patient care enables them to care for the vast majority of their patients' illnesses within general practice. There is clear evidence that between 85 and 90% of all consultations with patients take place in primary care rather than in the hospital setting.
10. We disagree with the view that most primary care can be provided by nurses and other healthcare professionals in a range of community based settings. Firstly, the nature of the work involved is becoming more complex and it will not be possible for a major shift to occur to nursed based services. Secondly, there are not the nurses available and the training of the nurses would be significantly prolonged if they were to undertake this role. Also, more highly trained nurse practitioners will want and deserve higher pay.
11. The report also needs to consider that many of the highly trained nurse practitioners may wish to retrain as doctors in short courses. There is a case for significant shifts of responsibilities, such as nurses undertaking increased activities in primary care which would be appropriate. Also, there will be a greater shift of care from hospital to the community, a large amount of which will be done by general practitioners, and this will require a significant increase in the numbers of general practitioners.
12. There is good evidence that general practitioners are effective in managing undifferentiated illness and also in dealing with complex often multi-system problems. These skills are however dependent on their continuing to deal with the whole range of patients' problems and it is partly because of this likely de-skilling of GPs, that we would argue against excessive reliance on nurses as the point of first contact.
13. While we believe that there is a case for some skill-mix in primary care, as can be seen from Appendix 2 there is insufficient evidence to show that it is cost effective, safe and satisfactory for both users and providers of healthcare.
14. We also consider it unfortunate that the Review has chosen as it's starting point the NHS Plan rather than the NHS as it is. It then seems to have gone on to state how working practices could be changed to make the likely future workforce fit rather than to look at the actual needs and see whether they could be achieved.
15. We believe that it is worth exploring the need for more and better primary care staff instead of consultants in order to make better use of the overall medical workforce. In particular, the Report is silent on possibly different types of roles for consultants. For example, a case can be made that most consultants should act as consultants to General Practitioners rather than to patients. With better information technology, it may be that patients do not have to see consultants; information could be provided to the consultant by the General Practitioner and returned to the General Practitioner by the consultant, without the patient being directly involved. The high level of patient satisfaction with primary care mentioned in more detail in our response to Chapter 11, would support this view as would the ease of access to primary care compared to secondary care.
16. We discuss other aspects of workforce later in our response to Chapter 11.
17. The other areas which concern us are:
 - Links between medicine and social care
 - Lack of regard for preventive care

- The disease/NSF-based approach

Links between medicine and social care

18. There does not seem to be any real recognition of the inter-dependence of health and social care, although the links are acknowledged. There is little recognition of the need to examine funding of these two aspects of care together, nor of the momentum being built up for so doing.

Lack of regard for preventative care

19. In keeping with the lack of emphasis on primary care, there is only passing reference to prevention and the debate about funding this as opposed to curative medicine. It is realistic not to hark back to an excessively Utopian view of the potential for prevention to eliminate the need for investment in curative medicine and indeed this is clearly flawed. Equally however, it seems to be wrong not to put more emphasis in the area of prevention considering the potential return from it. This is especially the case in conditions where there is a strong evidence base for preventative care, e.g. Coronary Heart Disease.

The disease/NSF-based approach

20. This lack of emphasis on prevention is another aspect of the apparent lack of regard for primary care. While the NSFs do emphasise the need for preventative care, only those parts which relate to secondary care seem to have been highlighted as major cost pressures. While we would not suggest for one moment that secondary and tertiary care issues do not provide cost pressures, they need to be seen alongside those of primary care. The disease/NSF-based approach risks a reductionist view of health and health care. Although this is an important perspective, it should only provide one stream of evidence for the long term view. It is also wise to take a more holistic view of patients rather than chopping them up into different diseases, this holistic approach is one that has been taken by GPs for many, many years.
21. We comment further on this approach later in our response to Chapter 8.

Co-morbidity

22. Except for one brief mention on page 142, the Report does not adequately deal with the challenge of co-morbidity. It is highly likely that co-morbidity will constitute an increasingly important aspect of health services challenges in the next two decades, and it needs more discussion in the report, both in the context of risk factors for ill health as well as for co-ordination of services across types of providers. It is also probable that more technologies will lead to more co-morbidity and therefore onto polypharmacy. The whole area of polypharmacy also needs more discussion in the report.

General comments

23. Most of the data is based on the white population. Caring for an ageing ethnic population is likely to present a huge challenge and add to costs. More data on specifically the south Asian population needs to be included and analysed. For example, diabetes and heart disease is up to four times as common in ethnic populations than in the white population.
24. We regret that the whole of England is considered as a single unit. We would suggest that, within this country there would be areas of greater disparity than there are between UK countries. London, in particular, has areas of great affluence and great poverty, and it is an error to consider it to be homogeneous. England also has ten times as large a

population as Scotland, which introduces peculiar problems of communication and diversity.

25. The Review does not consider two of the three elements of the cost of delivering a high quality service: the cost of changing processes e.g. training, altering buildings or equipment, and motivating change; and the cost of monitoring the change e.g. audits. The Review instead focuses on the third element: the cost of the process itself e.g. the cost of the drugs or the workforce. The other two elements need consideration.
26. We are also concerned that the Review does not mention pharmacists and their future role in health care. We would suggest that, in particular their role in self-care should be investigated. We discuss the concept of self-care further in our response to Chapter 11.

Comments on specific chapters

Chapter 7: Expectations for the health service

27. We are pleased to see that the Review acknowledges the high level of patient satisfaction with their General Practitioner. We also note that access to general practice is not cited as a major problem but rather access to consultants and A&E. This leads us to question, as we have since it was announced, the target of access to a General Practitioner within forty-eight hours as announced in the NHS Plan. We believe that only patients with urgent problems require such fast access, for others a slightly longer wait is acceptable. Forty-eight hour access has placed an unnecessary burden on an already over-worked profession whilst not significantly benefiting patient care.
28. In our view there is a mismatch between expectations of the general public and expectations of patients; these two are often interchanged indiscriminately, but they are not the same thing. In general, the public wants fast access and a free service. Patients want the best quality care when they need it - without having to fight for it, pay for it, or wait for it.
29. Changes to the way that services are delivered are inevitable. Advances in medicine will mean that patients can have minor operations or other procedures carried out in GP surgeries. Funding for these services should follow the patient to ensure adequate resources are directed to areas where treatment is being delivered.

Q7.1

30. There may be a move towards a general acceptance that some services will require to be paid for in future. Many patients already pay for treatments like Chiropody and Dentistry privately. If this becomes the case then patients will expect a better service than that currently delivered by the NHS.

Q7.2

31. The public will demand better and more services as a result of the increasing information on health issues supplied by national and international providers. It is understandable that their expectations will be high as long as patients themselves, or their relatives or friends, receive care which is less than satisfactory. As long as where it is evident from experience in other countries that it is possible to receive better care, patients will remain dissatisfied.

Q7.3

32. Universal and fair needs to be included in the list.

Q7.4

33. This is the most poignant question asked in this section and the answer is a resounding yes, of course.

Chapter 8 Delivering High Quality

34. This chapter is devoted primarily to the diseases featured in the report. If these diseases are to be the focus of quality efforts, Chapter 5 should make some effort to provide evidence that the UK performs poorer in these disease areas than the other comparison countries. We understand the reasoning why these conditions were chosen, but the underlying rationale of the report is that the UK lags in performance in international comparisons and yet no evidence is provided that these five conditions account for the poorer performance.

Q8.1

35. The extent to which the five bullets are aligned with the health needs of the UK is unclear. Is there any evidence to suggest that they will improve the position of the UK relative to other countries, or are they to be defended on their own merits? The answer to this query depends on the answer to these questions.

36. **NSFs:** The report looks at costs of introducing the treatments/therapies required by the NSFs. It examines the costs of extending the treatments to those who are not receiving them at the moment, but seems to assume that these patients are not currently receiving *any* treatment. There may be some savings to be made by cutting out inappropriate treatment and these estimated savings should be subtracted from the estimated costs of introducing NSFs.

37. The economic benefits and/or health gain of preventative care are discussed in the overview to the Report, but they do not seem to be taken into the calculations of the impact of NSFs except in the case of the mental health NSF.

38. There is no reference to the costs of managing the implementation of the NSFs, and of continually updating clinical practice as the NSFs are updated. These may include costs of professional development and also the management costs of reviewing and changing the patterns of service delivery to enable the new treatments/therapies to be delivered. There is an assumption that the same patterns of service delivery will be appropriate for the new clinical practices.

39. The costs of the structures for developing and updating NSFs, guidelines and audit tools are not mentioned – i.e. the costs of NICE at a national level and the costs of local adaptation and implementation of guidelines. The ambitious programme of guideline development and technology appraisal which will need regular updating, is not referred to.

40. **Clinical governance:** although there is a brief mention that all staff will need protected time for clinical governance, there is no analysis of the numbers of new management posts associated with clinical governance. The need for protected time for staff who are not directly employed within the NHS e.g. practice nurses, must be taken into account.

41. We note that the Report assumes that General Practitioners, and some other health professionals, currently spend 5% of their time on clinical governance activities. We

would like to point out that this is not protected time. We also believe that the timescale of 2010 for all health professionals to have 10% of their time protected for clinical governance activities is too long.

42. Despite this lack of protected time, we would like to point out the enthusiasm with which General Practitioners have taken up the College quality awards. Uptake of Quality Team Development and the Quality Practice Award, both launched within the last few years, has been high. This coupled with the steadily increasing uptake of our more challenging quality markers; Fellowship by Assessment and Membership by Assessment proves that General Practitioners are committed to quality practice. More information on these quality awards is attached at Appendix 3.
43. It may be beyond the remit of the Report to consider the appropriateness of the models of quality which are beginning to dominate the health service. However, investing in ensuring compliance with targets and performance indicators is not inevitably beneficial to health. Some aspects of clinical governance may introduce inefficiencies and a concern with paperwork rather than real quality improvement.
44. **NHS Estates:** renewal of the estate is certainly important, but a higher level of investment in cleaning and maintenance is probably needed across much of the estate - new as well as old. It is not clear if the different financial arrangements for estate in primary care have been included in the calculations. Increased activity in primary care will increase the need for buildings as well as for staff.
45. **ICT.** Throughout the document much comment is made about the poor level of investment in ICT. The emphasis in the report is on how better ICT will help people take more responsibility for their own care. We would not wish to quarrel with that but there needs to be rather more emphasis on how better ICT would help NHS staff, including health professionals to deliver a better service.

Q8.2

46. The chapter seems at times to confuse choice with quality - they are not necessarily the same thing. The priority must be to provide accessible services which are fit for purpose to the whole population. If there is acceptable quality available to all, the issue of choice becomes less important. Where choice is directly related to improved health outcomes, e.g. through greater compliance, then it is appropriate to invest in choice. Equally where it leads to greater efficiencies, e.g. by reducing wasteful non-attendance. However, some types of choice may be more to do with political ideology than health care. It may be more important to make it clear that some limitations on choice are necessary in order to use resources to provide a universal fit-for-purpose service.
47. The report does not consider that there may be a tension between increasing patient choice and implementing guidance such as NSFs.

Chapter 9: Changing healthcare needs

48. Issues relating to the elderly seem to lack depth and breadth. The emphasis on patient expectations and the removal of age discrimination is welcome. However we believe that this report really does not address the issues faced by the elderly or by the NHS in dealing with them. It may be that this is beyond a report on funding, but it does have very serious implications for funding.
49. Many patients would seem to want to make choices for their care which relate as much to their comfort and convenience as to technical quality and longevity. Increasingly we feel

that a distinction must be drawn between making decisions purely based on grounds of age and making decisions based on a holistic approach to patients problems including the existence of multi-system disease and general frailty. These are clearly very significant ethical issues, but will have important consequences.

50. We question the assumption that fitness into old age implies that health problems up until that time will be of a minor nature. It seems perfectly possible that the problems that occur on the route to old age may still be major and therefore expensive even though they become increasingly survivable.
51. We would also question the assumption that there will be “a greater affluence of the next generation of older people” (para 2.54). We are not convinced that this is pre-determined, especially as the State pension system appears to be being dismantled. We are more likely to have an underclass of impoverished older people. We are not convinced that the elderly, who will be the heaviest users of the NHS in twenty years time, will possess any of the attributes listed in Box 2.1.
52. We were concerned at the Government’s refusal to accept the recommendation that elderly people should receive free personal care made by the Royal Commission on Care of the Elderly. We support the Commission’s recommendation which is based on considerations of both equity and efficiency. Whereas the state through the NHS pays for all the care needs of sufferers from, for example, cancer and heart disease, people who suffer from Alzheimer’s disease may get little or no help with the cost of comparable care needs. We would, therefore, strongly advocate that this is considered in the final Review.

9.1

53. Most of the data is based on the white population. Caring for an ageing ethnic population is likely to present a huge challenge and add to costs. More data on specifically the south Asian population needs to be included and analysed. For example, diabetes and heart disease is up to four times as common in ethnic populations than in the white population.
54. There needs to be explicit consideration of co-morbidity as a changing demand on the organisation of health services.

9.2

55. In ethnic populations age related illness occur earlier i.e. late sixties rather than seventies.
56. Consumerism and demand are likely to continue to increase.
57. If the trend to family disintegration continues, as the numbers of older people increase so will the need for more sheltered housing and care home places. Hospitals bed numbers are likely to continue to decrease as more treatments and surgery are done on an out patient basis. It is likely therefore that social care costs will significantly increase.

9.4

58. Morbidity in the elderly is unlikely to decrease as patients live longer but are vulnerable to more age related diseases.

9.5

59. There need to be interventions in obesity reduction and increasing exercise. These could have an impact on CHD and diabetes morbidity and mortality. Inequalities are often

based on factors of socio-economic deprivation. Disease prevention initiatives usually do not work in the presence of poverty.

60. We are concerned that the Review does not consider what the situation will be if the Government does not meet its targets on inequalities. Indeed, an analysis of the existing Government targets are valid and credible would have added weight to this comprehensive analysis.

9.6

61. Demands will clearly increase. Current elderly by and large are not excessively demanding, but future elderly will demand in line with increasing consumerism.
62. Good health will become the expectation of all. People will expect to be able to have major interventions such as coronary bypass surgery if this is indicated, regardless of age.

9.7

63. People who seek always continue to seek help throughout their lives. Accepting telephone advice and telephone consultations are a step forward.

Chapter 10: Technology and medical advance

10.1

64. It is very difficult to predict the correct answer to this question. On balance, we believe that it is correct to assume that the aggregate effect of new technologies and medical advances will increase expenditure. History shows us that new technologies do tend to cost more than old ones (but perhaps with better outcomes) and tend to allow intervention in situations where none was previously available. In addition to this, we believe that a key factor is that much future innovation is likely to come from outside the NHS/academic research and may be driven by the need to make a profit.
65. Pharmaceutical and biotechnology companies are investing large sums of money in genomics and will require a return on this investment if they are to remain viable businesses. NHS and academia therefore need to invest in health services research (HSR) to act as a counter balance to ensure that any new technologies are fully evaluated prior to introduction into clinical practice. This is of course true for all new technologies but is particularly important for genetics as there is a tendency to view it as a "special case". Because of the vast investment in the human genome project and in genomics by biotechnology/pharmaceutical industries, there is the assumption that genetics will inevitably improve practice and offer more cost-effective options than the status quo. This is not necessarily the case and proper HSR is required.

10.2

66. Information technology is certainly going to be a major driver for two reasons. Firstly, in facilitating the public's access to medical information (now the commonest reason for use of the internet) and secondly in facilitating the medical profession's use of other technologies as outlined above.
67. Education of both the public and the professions will be important, in order to ensure appropriate and informed use of new technologies. This is one of a number of barriers that prevents evidence-based medicine from becoming routine practice.

68. Perhaps one of the major drivers, and a surprising omission from the report, is the pharmaceutical and biotechnology industry. This industry has already invested millions in genomics and requires a return from the investment. Therefore new technologies will have to result from the investment if companies are to remain viable concerns. If the NHS does not adopt the new technologies, then the companies are likely to seek other avenues into the health market place.
69. Having the facilities and staff to provide the service is also, we agree, key. Current practice is already limited by lack of both resources. Genetic technologies currently available are under-utilised, partly due to lack of public and professional awareness, but also through lack of resources to cope with the demand should awareness be increased. There is a lack of clinical and laboratory staff; for example the Joint Committee on Medical Genetics recently discussed the lack of funding for training of clinical scientists to work in laboratories.

10.3

70. The top-down approach is probably the most pragmatic way of estimating the historical impact of technology growth. However, for new technologies in general and especially for genetics, as the Review points out, the estimates do not provide any information on whether past spending on technology has been adequate. We believe it has not been adequate and therefore, if we aspire to providing an adequate genetics service, past behaviour of the health economy is not a good guide to future health spending required.

10.4

71. This is a very difficult question to answer. As the Review points out, there is much uncertainty over what the next 10-20 years will bring. In terms of genetics, costs are likely to increase in the next 10 years - not for any revolutionary reason but simply as the UK catches up with technology that already exists.
72. As risk reduction evidence becomes available for conditions where the genetics has been defined (e.g. BRCA1 or BRCA2 forms of breast cancer) then services will be required. There are three large scale trials of breast cancer risk reduction currently running, one in the USA, one in the UK and one in Italy. We are quite likely to have some evidence to put into practice within the next 10 years. There are 47,000 women per million at moderate risk of breast cancer as a result of their genetic makeup. This could be a significant cost.

10.5

73. We agree with the Review that pharmacogenetics has great potential benefit. If it proves to cost-effectively reduce the use of ineffective drugs, to identify the best product for a patient faster, and to reduce adverse drug reactions (ADRs), then it could revolutionise the way doctors prescribe and patients take drugs. It needs, however, to be assessed by health services researchers to ensure that it achieves these aims.
74. As well as assessing new technologies as they appear from industry, the academic community requires funding to develop and research its own innovations. This is likely to be key in the area of pharmacogenetics, as the agendas for use of pharmacogenetics in medical academia as opposed to the pharmaceutical industry have some differences. Lack of funding for empirical pharmacogenetics research outwith industry may lead to an imbalance in overall costs of using the new technologies.

75. The report indicates the UK's slow uptake of new technologies including new drugs. We believe there is a balance to be struck. Just as slow uptake can withhold effective treatment from a population, so rapid uptake can lead to use of a technology before the long term effects of that intervention are apparent.

Chapter 11: Workforce

76. Overall the chapter contains substantial inconsistencies, mostly caused by a failure to take a whole systems approach. The vision of how health care will be delivered is predicated on two areas that are the report's major weaknesses.

77. On the one hand the gatekeeper role of GPs is praised and the objective of making sure specialist services are used appropriately is emphasised. At the same time it is suggested that many GPs should be replaced by nurses and those that remain will become increasingly specialised. Specialists will, at the same time, become more generalist. In the introduction to our response we have argued further against this assumption.

78. The report suggests that patients will become increasingly able to care for themselves although it gives no evidence for this and the statement appears contrary to current experience in both the primary care and A&E environments. It also suggests that nurses will be able to deal with much of the minor illness. It has missed the point that NHS Direct, Walk-in centres and 48 hour access for all will make patients more dependant and not less so. The consumption of over the counter (OTC) medicines is not entirely self managed: health professionals, particularly General Practitioners, provide a safety net for patients who take OTC medicines.

79. We suggest that the Review analyses the impact on workforce of General Practitioners involvement in teaching and research.

80. Between 10-20% of the undergraduate medical curriculum is now being taught outside hospitals, in general practice. This huge change has taken place over the last 10 years, and represents a welcome addition to the working patterns of general practitioners but also has implications for workforce planning and for the consideration of job descriptions. The reasons for this shift in teaching are complex, but include much shorter hospital stays, so that fewer patients are available for teaching purposes in university hospitals, and a general transfer of the care of chronic illness from the hospital sector to general practice and primary care.

81. Research and development in primary care also need to be considered as part of the job descriptions of many general practitioners and these, like teaching, also have workforce implications job description implications. In a primary care led NHS, the importance of primary care-based research to provide robust evidence for clinical effectiveness in primary care, is essential, and has been recognised as such by both the NHS and the Medical Research Council. The involvement of many general practitioners in research practices and research networks should not be forgotten, because of the resource implications mentioned above.

82. We are attaching a recent document that we produced outlining the workforce problems that we in general practice currently face. This document is also on our website at: <http://www.rcgp.org.uk/rcgp/corporate/position/careupdate/index.asp>.

Comments on specific sections

83. Although 11.3 makes the point about graduates it fails to comment on the effect of graduate nursing as a career and its possible effect on medical recruitment as both

professions will increasingly be looking for recruits in the same and diminishing pool. The same paragraph refers to the high number of women in the NHS without making any comment about participation rates. Indeed the whole document appears to deal with headcount although this is not made explicit.

84. In para 11.5 the figures for both training time and cost appear to be inaccurate as no definitions are given. The time to train a consultant from scratch is nearer 15 years and the cost excludes undergraduate training.
85. In 11.7 the increase of numbers of medical staff is headcount and disguises the position in primary care.
86. 11.8 is accurate in its statement of the major changes in primary care. However it fails to say how this change can continue to be supported with fewer doctors and with increasing specialisation. The figures in 11.9 are headcounts, the whole time equivalent (WTE) in 1995 was around 10,000.
87. Discussions on pay in 11.15 could have made more of the fact that doctors in London and the South East are proportionally disadvantaged by a national pay structure.
88. The conclusion in para 11.20 is wrong when related to GPs. The majority of the additional GP numbers by 2004 will be achieved by counting non-principals. It is unlikely that there will be real increase in numbers of this scale. Even if it were so, it would be totally inadequate. Again headcount is a particularly poor proxy for participation in the highly feminised GP workforce. Apparent increase in GP registrar numbers is largely spurious and caused by double counting since the change in funding arrangements has allowed innovative posts to be created. This may improve recruitment and conversion in the longer term but currently the figures are disappointing. Further increases in training places will, in the short term, lead to an increase in vacancies.
89. The extra doctors in 11.21 are speculative and will be almost completely used up meeting the Working Time Directive in employed settings and the reducing participation rates across all sectors. Much of the NHS Plan increases, even if achieved, would only go towards reducing current vacancies in medical and nursing staff. Even if all this were not true, chart 11.6 shows clearly that by 2024 the UK will not even have reached the EU 1997 figures.
90. Although the proposed increase in qualified (as opposed to in training) doctors is welcome (11.23) working practices in secondary care will need to radically change if this is to be cost effective. Recent increases in consultant numbers have increased the demand on doctors in training rather than reducing it.
91. 11.29 underlines the short term and short sighted nature of the current drive to recruit doctors from abroad. Although colleagues from over-producing countries are welcome, and the cost to the NHS of recruitment is relatively small (around £15k per head in the case of the current GP recruits from Spain) the effort expended to ensure quality and to support these doctors is huge. The fact that overproduction is largely in secondary care is emphasised.
92. 11.34 raises the opportunity costs of administration and record keeping. This burden is increasing exponentially and is a huge cause of dissatisfaction in front line health care staff. The paradox of patients taking more responsibility for their own care and yet wanting more time with their carers needs further exploration.

93. Of course, if tasks are taken in isolation and assessed, they can be delegated (11.39) but the effect on the care of the patient has not been assessed in this approach. A similar argument for replacing 10,000 GPs with nurse practitioners appears in 11.42. HCAs will inevitably come but as with many substitution arguments they will actually be doing tasks that nurses are no longer doing and that are often not done rather than further freeing up nurses to undertake medical tasks.
94. Although there is clearly a place for some of the new workers in 11.40, increasing fragmentation of care will bring its own problems. We already see continuity of care decreasing with consequent reduction in patient satisfaction and increase in risk. Increasing specialisation also brings its own bottle necks into the system. One of the current blocks to increasing the amount of CABGs for example is the number of trained technicians available to work in cardio-thoracic theatres.
95. Skill mix has been increasing in primary care over the recent past and nurse practitioners have taken on many tasks previously done by GPs, this has freed GPs to care for those patients who need more skilled care. We would, however, question the assumption that between 20 and 32 per cent of GPs could be replaced by nurse practitioners. It must be noted that this study was carried out in Canada in 1985 and therefore cannot be assumed to relate directly to the UK or be relevant today. Appendix 2 sets out our concerns about the evidence for skill-mix in primary care.
96. As mentioned above, there is no evidence for bullet 1 in 11.50. This is a major weakness of the report as it predicated much of its vision on increasing self-care by patients without supporting evidence. The final bullet states that specialists will have a strong general background. This is probably desirable but would require a major change in both attitude and training.

Q11.1

97. Earlier in our response, we have set out our views about a number of these points, but would like to add the following points.
98. There is clearly scope for a significant expansion in the services provided by nurses, but the further development of triage and the substitution arguments set out in the report give a simplistic view that results in greatest “efficiency” but ignores the complexity of care in the real world. Firstly it may make care more “expensive” for users and the NHS – a person might be assessed several times before seeing a GP who can effectively manage their condition – a consultation that the GP might have recognised that a patient when the patient first presented. With an increasing consumerist society and patients who know more about their health, patient demands are likely to continue to increase. They will, therefore, be less likely to tolerate obstacles to accessing a GP if that is what they deem necessary and/or desirable.
99. Second, many problems have aspects that require nurse, GP or hospital care. Problems are often not simple ones with single simple solutions. Linear care, rather than team care, will often be disruptive. Also, there is no mention of co-morbidity (we have discussed this issue in more detail earlier in our response) which, in a task-oriented workforce, increases the need for co-ordination. Currently, with GPs taking a holistic approach to patients, co-morbidity is managed effectively.
100. We do recognise that there is scope for more nurse led services. There is particular need for this in secondary care to release PRHOs and SHOs to concentrate on training.

101. The use of Health Care Assistants (HCAs) seems to be increasing and is likely to increase rapidly. This increase is desirable to free up skilled nursing time and for the individual personal development of people who could undertake this role. HCAs already do phlebotomy, take blood pressures and carry out registration health checks in many practices. This trend should be encouraged and the range of work done by health care assistants is likely to increase to include other investigations such as audiometry, pulmonary function tests and electro-cardiography etc and simple dressings. It should also be noted that current pay and conditions are unlikely to attract an appropriate quality of recruit. Also, it is important that their use does not block the access for patients to the most skilled personnel for diagnosis and discussion of management.
102. The partnership with other professionals is important and has not been sufficiently exploited. However, this is largely due to the absence of organisational support and the poor resourcing of other professions as well as those in the NHS. Social work is clearly the most important area and we have already argued that the liaison with social work receives insufficient attention in this report. The aspiration should be to reduce the overlap between the work of different agencies, reduce the need for hospital and perhaps other institutional admissions and empower patients and their families. However, this will need an up front investment and there can be no guarantee that domiciliary care will be a cheaper option than institutional care.

Q11.2

103. The current training places will not give the UK the number of health care professionals it needs. The College and the JCPTGP have argued that the current provision is woefully inadequate and that even with the numbers promised (and we see no immediate chance of achieving these) it will not be possible to address the government's agendas which include an increased reliance on primary care, higher quality of provision and a less stressed but more skilled workforce. Work has already been done by the College to try to quantify the shortfall and the Joint Committee would wish to argue for investment in training to ensure that general practitioners are fit for purpose and are equipped for lifelong service, thereby increasing the chances of retention.

104. Work by the College estimates that 10,000 GPs are needed to match current exceptions, retirements etc. A conservative estimate is that 150 GPs currently need to be trained for 100 that currently retire.

105. There has been poor investment in practice nurse training and primary care trusts need to be enabled to develop proper training and support programmes for practice nurses. Many PCTs are experiencing difficulties in practice nurse recruitment, training and retention. Likewise, training opportunities for health care assistants and training as a whole needs to be seen as an integral part of provision and not as an add on.

106. The immediate and medium term looks concerning. The numbers of nurses planned is grossly insufficient. Not only do we need nurses to fulfil the roles above, but we need a return to nurses who *care* for patients who are ill – physical hands-on caring. Future GP demands will significantly increase as GPs take on more complex care, management roles, national service frameworks, and various quality improvements. Intermediate care will add further to GP's workload and so add to pressure to increase GP numbers.

107. Q11.3

108. There are two extremes, both flawed and a pragmatic middle road. The "free market" approach of open numbers for medical schools (as in Italy or Spain) results in reduced standards of training and medical unemployment on a significant scale. This represents poor

value for the investment (state or private) in education and training for medicine. At the other extreme the state determines future demand and fine tunes medical school places in anticipation of needs in ten or more years time. This has resulted in a chronic shortage and Britain being a net importer of doctors (often from poorer countries who can ill afford to lose such expensive human resources).

109. This mismatch between demand and supply needs to be addressed on several levels. The supply needs to be increased, particularly for GP's and practice nurses. However, in the long run primary care and secondary care are interdependent and one should not be developed at the expense of the other. Selection processes need to ensure the best possible fit between those selected for training and the jobs as they evolve and training needs to be made relevant. Retention has received insufficient attention both for doctors, especially in the later parts of their career, and for nursing staff. The provision of effective CPD and of time to benefit from it is important. The mismatch can to some extent be corrected by opportunities for re-training and by enhanced flexibility within the workforce. While we have reservations about skill mix as a panacea, the ability to deploy staff as flexibly as possible will be seen as an important part of the management of this mismatch.

110. Q11.4

111. The concept of productivity is difficult, particularly in general practice and in a service which should be increasingly driven by quality. Patient expectations, job satisfaction, retention of the workforce and risk management all seem to point towards an imperative to allow more time for patients.

112. The face-to-face time of NHS GPs is substantially less than that of doctors working in a fee-for-consultation service in, for example, Australia. If GPs involvement in paperwork was reduced (a move that has occurred in many practices already) then their time can be further freed for more clinical contact or more involvement in health strategy and management.

113. If General Practitioners only saw more complex cases (and then mostly as part of team care) or those that specifically requested access to them, then the reduction in workload might be balanced by longer consultations and movement of work from other settings (especially secondary care). Again, it seems inevitable, that productivity gains are more likely to improve quality and outcomes rather than to reduce costs and improve efficiency.

11.5

114. Once again the question about the appropriateness of productivity as a concept arises. However, if this is defined predominantly in terms of the improvement of quality and outcomes, it is possible to comment with more or less precision. The principal barrier is probably time, but not as seems to be implied in this report. Contact time here seems to be regarded as patient throughput. Of equal importance from the quality point of view is the amount of time available to spend with each individual patient. However, this in turn is related to all the other factors mentioned. Thus better use of skill mix and clarity about roles may enable higher quality care to be provided on the basis of longer contact with smaller numbers of patients. Again, if part of the role of the general practitioner is in the management of the care of individual patients, time spent on related paper and office work may contribute directly to productivity. For example, if GPs were more clearly responsible for the ongoing care of patients, including preventive aspects, they might well need to spend more time reviewing patients' records on a regular basis and planning their care. This may require a major reduction in list size or in better exploitation of skill mix and other devices. In addition, the application of information and computer technology will be an important factor.

Easy access to information on a regular basis and practice systems that facilitate the pursuit of quality in the care of individuals in practice populations will be an important factor.

115. The next question also addresses the involvement of patients and this too should help drive productivity again and overcome potential barriers. For primary care, improvements in secondary care are also a potentially significant factor. Some of the difficulties in primary care and the disaffection of GPs relate to the need to deal with the consequences of long waiting lists and difficulties in dealing with hospitals. Improvement in the secondary care sector would therefore drive "productivity gains" while the perpetuation of the status quo would be a significant potential barrier.

Q11.6

116. There is good evidence that involving patients in their own care improves outcomes in a number of situations, particularly those involving the management of chronic illness and behaviour change. Having said that however, as we have said previously, the assumption in the report that patients will be better educated and better informed in the new climate, with the implication that patient involvement will follow naturally is not well argued; no strong evidence is given.

117. It is also clear that for many situations and for some patients a more traditional style of care may be appropriate. The tailoring of care to individuals is a very important and sensitive issue and skills for doing this need to underpin the movement towards the involvement of patients.

118. Over time the involvement of patients should result in improvements in quality and outcomes, but this coupled with availability of treatments is likely to increase demand. Patient awareness does not necessarily drive cost down; increasing consumerism may well push costs higher. The cost of new pharmaceutical agents especially for lifestyle problems e.g. weight loss is another key cost driver. This will also require the investment of professional time, both in face to face contact with individuals and also in educational and organisational initiatives.

119. Much of the information currently available to patients, for example on the internet, is of dubious quality and the education of patients in the discriminating use of information is a long term project. This requires greater time in face to face consultations and also greater time in practice and information management.

Chapter 12: Difference within the UK

120. If the future health service is truly to become patient centred then it will inevitably become more locally focused and differences across the UK will follow. As there are different central systems managing the health service in their part of the UK, the worry is that there will be a series of health migrations; of health care workers to where pay and terms of service are better and of affluent patients to where 'better' service can be bought. This will lead to an impoverished underclass of patients being cared for by an impoverished, substandard health service.

121. An important but unmentioned question is the extent to which the differences within the UK are associated with differences in the mix of types of personnel as well as differences in information as well as other technology.

122. Turning to expenditure in Para.12.17, which compares England with Scotland. At present, expenditure per head in Scotland is £1,000, rising to £1,400. In

England it is £800 per head rising to £1,180 - still a vast deficiency, which is not being redressed.

123. Para.12.23 cites areas of remoteness as a cause for special consideration. There is more evidence that congestion and high levels of housing density is an indication for more resources.

Q12.1

124. There are a number of differences between the four countries which will affect the provision of health care in the future. The Review will need to take account of these – highlighting different health needs and, so, priorities.

125. The population of Scotland is predicted to fall over the next twenty years at a time when the UK population is set to increase. This will presumably have an effect on current funding patterns – heralding change in the Barnett formula, for example.

126. In Scotland there is a higher proportion of the population living in remote and rural communities – and the proportion of “old” elderly is increasing in such settings. This will have a profound effect on the way in which services are delivered (not least by primary care).

127. The high levels of immigration, particularly asylum seekers, is mainly concentrated in England, especially the Home Counties and London. The peculiar health trends and needs of these people should be considered.

Q12.2

128. Absolute social deprivation, especially real poverty and social isolation, is a major source of ill health. However, relative deprivation is also associated with worse health and outcomes. There is a gradient across social classes well beyond the poverty line. Societies with greater differences between upper and lower quartiles have lower life expectancy and worse outcomes.

129. If any of the countries in the UK either reduce their absolute poverty or change their relative poverty we would expect these changes to be reflected in health needs, status and outcomes.

Q12.3

130. CHD and cancer are particularly important issues for Scotland. The nature of these conditions means that they consume considerable resources – and that will make funding considerations more complex. Within general practice we need to consider more thoughtfully our current and future role in tackling these issues.

Q12.4

131. The complexity and very size of the health management structure in England precludes efficiency when compared to the simple unitary structures of the other countries. Given the differing needs and priorities, it does make sense for each of the four countries to develop different systems when necessary. However, there does need to be equity across the UK with regard to the principles underpinning the NHS. Such issues as access to different levels of care, standards of care, etc should be broadly the same.

Q12.5

132. The diverging population trends are less important than other factors and do not need to be approached differently.

Q12.6

133. Devolved responsibility may facilitate technology diffusion if resources are also devolved. This is less conclusive in workforce development and may lead to competition between adjacent health economies in the search for scarce human resources.

Q12.7

134. We regret that the whole of England is considered as a single unit and would suggest that, within this country there would be areas of greater disparity than there are between UK countries. London, in particular, has areas of great affluence and great poverty, and it is an error to consider it to be homogeneous.

135. England also has ten times as large a population as Scotland, which introduces peculiar problems of communication and diversity.

136. There are well-established differences in health needs between English regions at present and the distribution of health resources does not reflect those needs – the inverse care law applies. We do not know how those differences will change with time, but in relative deprivation is to be addressed, then future investment must go to areas of highest health need.

Appendix 1

Evidence on continuity of care and patient satisfaction

It is important to recognise that only a limited amount of good quality evidence is available about the impact of different levels and types of continuity of primary care on outcomes. Interest in this field is growing, and it is likely that better evidence will become available in the next five to ten years. Therefore, any assumptions that we make now about the organisation of services, the provision of continuity, and the consequent outcomes must be regarded as tentative at best.

The report refers to three trials of nurse practitioners in primary care,^{1,2,3} and notes that patient satisfaction was 'just as high with nurse practitioner services' (para 11.42). The developer of the satisfaction instrument^{4,5} that was used in two of the trials,^{1,2} who is a member of our College, has informed us that some qualifications about the interpretation of the findings must be made. The same qualifications also apply to the third trial that used a different instrument. The trials measured satisfaction with consultations, not with primary care services as a whole. Thus, although we can say that consultations with nurses were satisfactory to the patients included in the studies, we can say nothing about the consequences of such consultations for patients' experiences of, or views about, continuity or fragmentation of services. It is possible that patients could be satisfied with their consultation, but dissatisfied with the service in general.

There is consistent evidence that patients generally prefer continuity of provider.^{6,7,8} There are, however, occasions when patients place a higher priority on quick access, or even prefer to see someone they do not know (for example, to ensure choice of gender of the doctor for certain complaints). Practice organisation and size of practice are key factors in determining satisfaction with general practice services.⁹

Although the consequences of lower levels of continuity are largely unknown, there is some evidence that should give rise to caution in assuming that offering primary care services through a team of providers would be more cost-efficient. Patients who feel they know their doctor well report being more likely to comply with treatment.¹⁰ If the GP has better knowledge of their patients, fewer tests and prescriptions may be ordered, but expectant management, use of sickness certificates and referral may be more likely.^{11,12} In recent work, patients' trust in their doctors has been shown to be associated with continuity.¹³ Lack of continuity is associated with non-attendances for consultations and patients who settle for lack of continuity may be a vulnerable group, with increased morbidity and relationship problems.¹⁴ Evidence from the US indicates that patients who experience continuity of provider have a lower likelihood of future hospitalisation.^{15,16} Furthermore, in another US study, people with diabetes who had a regular primary care provider were more likely to receive most recommended elements of diabetes care.¹⁷

Thus, the available evidence suggests that the provision of primary care services in a way that reduces continuity would be associated with lower levels of patient satisfaction, lower levels of trust (the consequences of lower trust have not been fully investigated), changes in the care provided (for example, in prescribing or admission to hospital), and in adherence to recommendations about best practice. Therefore, it is not possible to judge whether primary care provided by a mix of staff that includes care assistants, nurse practitioners and more or less specialised doctors would lead to reduced or increased costs.

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Appendix 2

Skill mix in primary care - implications for the future

1. Executive summary

1.1 The increased use of skill mix within primary care brings with it the theoretical possibilities of increasing the variety of health care professionals offering a service to a given population, and reducing the number of any one set of professionals within that team.

1.2 With the advent of NHS Workforce Development Confederations and a financial allocation formula for allocation of GPs, the need for robust evidence to support far-reaching decisions becomes ever more urgent.

1.3 Despite the large number of pilot projects incorporating various patterns of skill mix, there is as yet a dearth of evidence as to the feasibility and the implications (both in terms of financial and human resource allocation) of the increased use of skill mix.

1.4 For skill mix to be acceptable, there needs to be proof that it is:

- cost effective
- safe
- satisfactory for both users and providers of health care

1.5 It is not enough to consider any one of these criteria in isolation, since variation in one may have implications for others.

1.6 Studies have been done on cost effectiveness, safety and patient satisfaction in a variety of models of skill mix, but there has been no examination of the effect on the other two variables if one of the three is altered.

1.7 There is some evidence that increased use of skill mix in areas of nursing has resulted in de-skilling and reduced morale among staff involved.

1.8 Researchers into patterns of skill mix have concluded that “There is no straightforward association between structural characteristics of the practices and either the pattern of activities or the process of delegation referral between members of the primary health care team.” This conclusion suggests that simple financial allocations formulae may be difficult to translate into practical equity of workload.

1.9 Patients’ enablement and satisfaction correlate closely with continuity of care.

1.10 The dilution of the GP’s role as independent patient advocate has led in other countries to both public displeasure and professional disillusion.

1.11 The use of NHS Direct has had some impact on demand for GP out of hours services but not on use of Accident and Emergency departments or ambulances. The relative cost effectiveness of NHS Direct, GP co-operatives and other models of out of hours care has not been assessed.

1.12 In short, a study of the available evidence suggests that considerable research needs to be directed at answering questions which may have major implications for both financial and human resources under the new workforce arrangements.

2. Suggestions for future work

2.1 In order to inform the debate, there needs to be more information on the following:

- Can skill mix provide consistently safe care for the patient when other variables, such as consultation times, are altered?
- Is the use of less highly trained staff cost effective if they take longer to perform roles traditionally taken on by more highly trained professionals?
- Is the workload of highly trained professionals reduced in practice by the increased use of skill mix?
- To what degree will duplication of workload offset the potential savings offered by increased skill mix?
- Do patients find care provided under skill mix models as satisfactory as that provided by traditional models?
- Will deviation from the GP's traditional role as independent patient advocate affect public and professional perceptions?
- There is some evidence that increased use of skill mix in the nursing profession has had an adverse effect on morale. What are the underlying causes for this?
- What are the longer term implications of increasing regulation on the innovation offered by PMS pilots as they become more widespread?
- What are the direct financial implications of moving away from traditional models of 24 hour care towards cover by GP co-operatives and NHS Direct?
- Is inter-practice variation great enough to prevent any implications being drawn from models of skill mix in a different practice setting?
- Are the same conclusions applicable for large and small practices?
- What safeguards and organisational structure need to be in place to ensure that skill mix provides safe, cost effective and satisfactory care?
- Does the primary health care team still need a "leader", and if so, who is best placed to carry out this task?
- Is the use of skill mix to solve problems of short supply of GPs simply moving the problem of human resource supply further down the professional chain?
- What changes to the training of GPs and nurses will be necessary in the future to ensure that they make the most of the potential benefits of increased skill mix?

3. Introduction - What is skill mix?

3.1 In its simplest terms, skill mix is the use of a variety of professionals, with varying qualities and expertise, to carry out roles traditionally performed by one health care professional. Carried to its extreme, the theory is that all staff should be working to their maximum potential at all times, carrying out only those tasks which cannot be delegated to less highly trained professionals (who, by definition, are available to carry out those tasks). In principle, this could have two main benefits:

- maximising cost effectiveness, ensuring that all tasks are carried out by the "cheapest" person who can perform them;
- maximising human resources, by making the most of the relatively small number of highly trained professionals available to carry out highly skilled tasks. This in turn should ensure that all team members are always working to their maximum professional capacity, reducing under-usage of training resources and maximising efficiency of working patterns.

3. Background

4.1 Following the inception of the NHS in 1949, the role of the GP within the primary health care team remained largely unchanged for several decades. The traditional model was a strictly hierarchical one, with the GP at the head of a small team of receptionists and practice nurses whose roles were largely reactive and determined by the GPs.

4.2 In the early 1960's, a widescale disillusionment among doctors with life in general practice led to acute shortages of GPs. The government's response was to draft in large numbers of overseas trained doctors, who took up positions in general practice, often in small inner city practices.

4.3 As many of these doctors now approach retirement, it has been suggested that there is a real prospect of further problems with GP recruitment. Anecdotal evidence of recruitment problems led the Medical Practices Committee (MPC) to pilot its recruitment survey in 1994. This has been followed by an annual recruitment survey from 1995-1999(1). The main findings of the surveys can be summarised as follows:

- the overall average number of applications per vacancy has been fairly constant at about 8 since 1996, down from 10.7 in 1995;
- the proportion of practices filling a vacancy within 12 months has been relatively stable at 86-90% since 1997, up from 80% in 1996 but down from 97% in 1995;
- the male-female split on applications for full time vacancies has remained fairly constant, although the 1999 survey shows an increase in the number of men applying for part-time posts, particularly as job-sharers;
- the overall balance of male/female recruitment has shown no significant trends over the five years the survey has been carried out;
- in 1999, about 20% of practices reported that it was easier to recruit than the last time they recruited, about 40% reported that it was harder and about 40% reported no difference. The proportion reporting that it was easier to recruit has risen from a low point of about 5% in 1997, and those reporting it as harder has fallen from a peak of about 85% in 1997.

4.4 At the same time, traditional models of primary care provision have undergone gradual evolution, the rate of which has increased exponentially since the inception of the New GP contract in 1990 (2). Factors influencing this evolution include:

4.4.1 Financial factors

- financial incentives of 1990 GP contract were followed by rapid increase in the number of partnerships and the development of practice premises;
- further financial incentives from the same contract provided significant incentive for increased employment of other professional staff by GPs;
- introduction of target and health promotion payments encouraged GPs to participate in primary prevention, whose activities were relatively easily delegated to practice nurses;
- change in pension regulations in 1995 removed disincentive for staff moving from secondary care to primary care employment.

4.4.2 Organisational factors

- increasingly clearly defined roles for GPs;
- increased accountability for GPs, bringing with it the need for measurable outcomes;
- increased use of audit to determine quality of care;
- increased emphasis on proactive and preventative measures;

- a move away from traditional hierarchical models of provision of primary care towards collaborative team working;
- an increasing trend towards partnership working, with the opportunity for provision of more diverse practice teams;
- increased bureaucracy to police outcome measures, with the widespread introduction of computer records.

4.4.3 Consumer factors

- increasing consumer expectations;
- increasing awareness among patients of their rights;
- changing attitudes towards the traditional doctor-patient relationship, with the patient expecting an increased participation in determining their management;
- increased convenience of opening hours of other “consumer services” (supermarkets, banking, internet).

4.4.4 GP Workforce factors

- changing GP expectations towards 24 hour responsibility (largely related to the advent of GP co-operatives);
- increasing feminisation of the GP workforce, with an attendant trend towards part-time working and increasing focus on the conflict between home and work issues;
- increasing trend towards part time working by both sexes;
- workforce implications of the large cohort of overseas trained doctors drafted into the UK (largely into inner cities) in the 1960s, who will almost all become eligible for retirement in the same ten year period

4.4.5 Changing role of other health care providers

- restructuring of the role of district nurses following the NHS Value For Money Unit’s report;
- trends towards specialist training of practice nurses;
- development of nurse practitioner models;
- role of paramedics;
- development of role of pharmacists, encouraged by change in status of some drugs from prescription only medicines (POMs) to pharmacy available (P) and the development of prescribing formularies;
- increased popularity of complementary practitioners;
- increased consumer demand for “healthy living” products.

4.4.6 Trends in complaints

- increase in the number of complaints brought against GPs, which acted as an impetus for a restructuring of GP complaints procedures;
- increase in the number of claims for medical negligence;
- a resultant perceived need for more guidelines and protocols to inform, standardise and justify clinical decisions;

4 Structural changes within the NHS

5.1 The New GP contract was the first of many fundamental changes affecting primary care in the last decade. The introduction of the “internal market” within the NHS relied on the concept of money following the patient, and paved the way for the introduction of

fundholding. This latter brought with it the prospect of increased autonomy for GPs to use savings in one area to increase provision of facilities in others. Efficiency in human and financial resources became much more important to a profession which until now had placed financial considerations way down its list of priorities. GPs became increasingly closely involved in the planning and implementation of services for their patients, both in the primary/community and the secondary care sectors.

5.2 For practices unwilling or unable to commit to fundholding, multifunds and locality commissioning provided the opportunity for limited involvement in planning and pooling of resources. By 1999, these were all superseded by Primary Care Groups (PCGs) in England and Health Care Groups in Wales. While the underlying concepts of direct involvement of health care providers in the planning of services remains, the make-up of the PCG board aims to ensure much wider involvement of stakeholders in primary care, including nurses, social workers and lay representatives.

5.3 At the same time as many PCGs prepare for Primary Care Trust status, with increased direct influence over provision of services and budgets, a variety of other initiatives have been introduced. These include:

- widespread provision of out-of-hours co-operatives, the development of which has been encouraged by changes in patterns of GP remuneration designed to encourage collaboration between larger groups of GPs in provision of out-of-hours services;
- Personal medical services (PMS) pilots, which encourage the development of alternatives to traditional models of primary care provision;
- salaried options, aimed at increasing retention of doctors for whom traditional models of GP partnership are unattractive or not feasible;
- NHS Direct, a centralised service for provision of round the clock telephone advice by trained nurses;
- Walk-In Centres.

5.4 In July 2000, the Secretary of State for Health announced the abolition of the Medical Practices Committee (MPC). This abolition will be brought into effect through the Health and Social Care Bill 2001. In April 2001, 24 NHS Workforce Development Confederations will be established, with a wide remit which includes "review and aggregation of the workforce development plans of the full range of local employers in that health economy."

5.5 Allocation of GPs and other primary care professionals will be based on a financial allocations formula, devolved to Health Authorities and PCTs.

5 The evidence

6.1 For skill mix to be a realistic way forward for the NHS (and for primary care in particular), the net advantages for patients, Health Authorities, PCGs/PCTs and primary health care teams need to outweigh the disadvantages. This means that there needs to be proof that skill mix is cost effective, safe and satisfactory for both users and providers.

6.2 The increased investment in primary care, reflected in the growth of staff directly employed by GPs since the 1990 GP Contract, has been measured largely in terms of activity rather than in terms of health outcomes or best value. In part, this has been due to studies which suggest that increasing levels of certain activities (such as primary prevention measures) show a positive correlation with long term health measures. Perhaps more important is the relative difficulty in finding measurable short term outcomes from primary care.

6.2 It has proved similarly difficult to measure either the cost effectiveness or the relative quality of primary care when provided by the traditional hierarchical model or by the increased utilisation of skill mix. The most debated models centre on reallocation of specific tasks from GPs to practice nurses or nurse practitioners, and from district nurses and health visitors to health care assistants.

6.3 When attempts have been made to reduce any element of primary care to a series of mechanised tasks that could be counted and reallocated, as in the NHS Value For Money Unit's report Skill Mix in District Nursing (3), the results have been viewed as dangerously simplistic. In this model, skilled district nursing professionals were expected to delegate the core of their work to relatively unskilled workers, leaving themselves with a supervisory or managerial role. While the general concept has now been embraced by large elements of the district nursing profession - and with some success from the point of view of financial savings - there is significant concern that the narrowing of experience of the more senior professionals runs the risk of "de-skilling" them and reducing their clinical ability as well as the risk of lowering morale (4).

6.4 Other studies have concentrated on one element of skill mix, omitting other elements that allow direct comparison of effectiveness. Lattimer et al in 1998 and 1999 published the results of two randomised controlled trials of a nurse telephone consultation service in primary care out of hours (5,6). Both showed that the service significantly reduced GPs' workload and the first that the service was at least as safe as the existing out of hours service. While the second touched briefly on cost effectiveness, neither compared the costs of the combined GP/telephone advice line service with the GP service alone, or looked at relative levels of patient satisfaction. Another series of trials comparing GPs and nurse practitioners dealing with requests for same day consultations(7,8,9) showed patients to be just as satisfied with consultations with the nurse practitioner as with a GP. The same series revealed that nurses were able to deal just as safely as GPs with these consultations – but no comparisons were made for safety or patient satisfaction with consultations of the same length. Interestingly, evaluation of a GP-staffed direct access telephone line in an inner London practice showed it to be valued by users, but the impact on surgery consultations was considered too small for it to be advocated as an alternative to emergency consultations (10).

6.5 Likewise, the added costs of devising and updating protocols, as well as the duplication of workload resulting from internal referral from nurses to GPs, have not been addressed.

6.6 In its first year of operation, NHS Direct received about 68,500 calls from a population of 1.3 million. This resulted in a relative reduction of 2.9% in use of GP co-operatives in areas covered by NHS Direct compared with areas not covered. It did not have any significant trend on either the use of accident and emergency departments or ambulances. The cost of producing this reduction was not calculated (11).

6.7 Once NHS Direct has been extended nationwide, of course, the relative impact on GPs' workload should be fairly consistent across the country, and should affect primary care workforce planning in one locality no more than in another. Far more relevant for workforce planning and skill mix implications are local factors such as relative numbers of practice nurses and nurse practitioners.

6.8 The PMS pilot scheme was designed to allow experimental schemes to test alternative models for delivery of primary and community care (12). As it enters its third wave, however, clinicians are finding that the contract is becoming increasingly regulated, and the scope for innovation is declining (13). There is an urgent need for robust assessment of existing pilots – almost non-existent to date – if lessons are to be learnt about which forms of innovative working models work.

6.9 If a direct comparison between the “value” of GPs and nurses/nurse practitioners is to be made, there are a variety of factors which must be considered:

- 6.9.1 **Measuring workload and financial considerations.** It has been traditionally perceived that on an hour for hour basis it is cheaper to have 24 hour cover from GPs, who have included out of hours provision within their existing contracts, than from nurse working strict shifts. As GPs shed their 24 hour responsibility or organise it in different ways (notably through co-operatives) new costs - both start-up and ongoing - are introduced.
- 6.9.2 Within the practice setting, most of the comparison trials have been with trained nurses dealing with specific clinical problems at 20 minute intervals (14,15) - which, at over twice the length of the average GP consultation, makes them a more expensive option than GPs doing the same task. When dealing with minor illnesses, the clinical care and health service costs of nurse practitioners were similar (9). It is oversimplistic to state that “If nurse practitioners were able to maintain the benefits while reducing their return consultation rate or shortening consultation times, they could be more cost effective than general practitioners.” (9)
- 6.9.3 Likewise, while studies suggest that there are methods which should provide an accurate, reliable and valid picture of GP activity (16,17) the financial implications of increasing the range of work carried out by Primary Health Care Team (PHCT) members has not been fully assessed. This would need to include research on the number of hours worked by GPs, the length of GP and nurse consultations and the range of services offered by comparable PHCTs with and without a wide range of skill mix.
- 6.9.4 **Interpractice variation and its consequences.** It is well recognised that practices vary enormously in the services they provide, and Jenkins-Clarke et al conclude that “There is no straightforward association between structural characteristics of the practices and either the pattern of activities or the process of delegation referral between members of the PHCT”. They also conclude that “...Whilst a broad-brush or macro-examination might, for example, show that 20% of a doctor’s time could be substituted by a mix of other fractions of the manager and the practice nurse (and perhaps other members of the PHCT), the practicalities of weaving together such a collection of part-time workers into a coherent team may be insurmountable.” (17).
- 6.9.5 Depending on the workload generated per patient by standard models of skill mix, it is not known whether it will be financially feasible for smaller practices to employ the same models of delegation and skill mix as larger ones.
- 6.9.6 **Quality of care and safety.** Several trials confirm that nurses have no higher incidence than GPs of misdiagnosis and adverse outcomes (5,8, 14) - but again, there are no trials comparing the safety of nurses or nurse practitioners working at the same rate as GPs.
- 6.9.7 There is evidence, however, of significant unmet need, especially with respect to aspects of health promotion (18), and there needs to be research to confirm that delegation of GP tasks to other PHCT members does not reduce the provision of “soft” areas of care such as health promotion still further.
- 6.9.8 **Patient satisfaction.** While there is, once again, evidence that patient satisfaction with nurse/nurse practitioner consultations is just as high as it is with GPs (5,7, 9,

14), there have been suggestions that patient satisfaction is directly related to length of consultation, and no comparisons have been made of patient satisfaction in nurse consultations of different rates.

- 6.9.9 Similarly, there is a paucity of evidence about variation of patient satisfaction with length of GP consultation. In addition, the research that has looked at patient satisfaction has concentrated on individual encounters and not on long term satisfaction. The traditional model of continuing personal care by the GP, who has an intimate knowledge of the patient and their personal as well as medical history, is often cited as a main cornerstone of the primary care system.
- 6.9.10 While there is anecdotal evidence that patients' priorities have changed, and that for some, at least, having access to immediate care is as important as having continuity of care, large scale studies do not support this point of view. Most research suggests that a patients' enablement and satisfaction with a consultation is strongly associated with visiting the same doctor (19). It seems certain that as the number of alternative models of primary care increase, patients will become more accustomed to seeking medical care from a variety of sources. This may affect their view of the relative importance of continuity of care. There needs to be more formal evaluation of long term patient satisfaction, comparing traditional models with those incorporating skill mix.
- 6.9.11 In countries such as the USA, which have no equivalent of the United Kingdom GP, care tends to focus on the acute rather than the chronic, and long term, co-ordinated health care for patients is lacking. There is a risk that the trend towards cash-limited, unified budgets controlled by PCGs or PCTs, in combination with reduced co-ordination as a result of increased skill-mix, could threaten the GPs role as independent patient advocate. In the USA, this has led to both public displeasure and professional disillusion (20).
- 6.9.12 **Start-up costs (financial and human resource).** While the number of protocols (both national and local) is increasing, there is a suggestion that clinical staff are likely to be happier with, and more likely to adhere to, protocols into which they have had an input. Until the practice of delegating tasks to nurses and nurse practitioners becomes more widespread, there will continue to be a tendency for individual practices to "reinvent the wheel" (or at least the protocol).
- 6.9.13 **Duplication of workload.** Every time both a nurse and a GP see a patient for the same condition, there is duplication of workload which undermines potential savings. In 1994-6, the University of York carried out an extensive study of workload in general practice and the opportunities for spreading it more effectively among members of the PHCT (16, 17).
- 6.9.14 While they concluded that there is "some scope for safely and acceptably transferring some work away from (expensive) GPs towards (less expensive) nurses and other clinical workers", they found that in a high percentage of cases, only part of the GP consultation was delegatable. They also highlighted the fact that the triage function of GP has to be carried out by someone, and the difficulty of organising flexible pathways through care.
- 6.9.15 **Knock-on effects for recruitment.** Setting aside financial issues, an increase in the skill mix of the PHCT will require a supply of nurses, who appear to be an increasingly scarce commodity(4). Studies suggest further potential for practice nurses to delegate some of their workload to less qualified, or even unqualified, staff(21).

- 6.9.16 While at its best, careful consideration of skill mix has the potential to align local services much more closely to patient need, there are enormous dangers in setting up widescale models of skill mix without ensuring the prior provision of human resources at all levels.
- 6.9.17 Similar considerations apply when considering skill mix in other areas - for instance, the substitution of health care assistants for nurses, and the substitution of other health care professionals to carry out administrative and patient advocacy roles traditionally taken on by GPs. For these, the evidence seems even more scarce.

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RCGP Quality Awards

◆ Membership by Assessment of Performance (MAP)

MAP is a route to membership of the College which enables experienced GPs who can show evidence of good quality practice to become members through an assessment of their performance rather than through sitting the MRCGP exam. MAP is equivalent to membership by exam; the principal difference is that the exam is designed to be taken in the registrar year, whereas MAP is particularly appropriate for doctors who have been practising for several years.

Those GPs who wish to undertake the assessment are required to produce evidence that they can meet a set of criteria that include both clinical and organisational standards and require evidence of CPD. Candidates have to produce a portfolio of evidence which describes their practice, demonstrates audit, and includes surveys of, for example, accessibility and continuity of care. Candidates are assessed on their consultation skills and are visited in their practice by two trained assessors. They will also be asked to produce evidence of their competence in child health surveillance and CPR.

There are 36 essential MAP criteria and several optional ones under the headings: Accessibility and Continuity; Patient Records; Health Promotion; Management of Acute Illness; CPD; Practice Organisation and Team Working; Management of Chronic Illness; Ethical Standards; Prescribing and Referral; Consultation.

◆ Fellowship by Assessment (FBA)

FBA is a route to Fellowship of the College for members of not less than 5 years' standing and who have been in practice for at least 5 years. FBA is based entirely on the candidates' work as doctors with their patients in their own practices and it is based entirely on the quality of care provided to patients. The assessment process is based on a set of criteria which are under constant review and development.

When an application for FBA is submitted it is assessed by 3 assessors, who are all Fellows and who act as peers on behalf of the College. The assessors visit the applicants' workplace to check that the material submitted is an accurate reflection of the candidate and their practice and to assess those criteria that can only be assessed in discussion with the candidate. The assessors then make a recommendation to the Fellowship Committee, which considers all the relevant evidence. It then makes a recommendation to Council, who then announce the election of the applicant at the AGM.

Failure of the candidate to meet any one of the essential criteria will fail the candidate. The areas assessed in FBA include health promotion activities, consultation skills and out of hours emergency care arrangements.

◆ Quality Team Development (QTD)

QTD is an initiative which aims to help PCGs/Ts assess the performance of primary care teams. At present, the scheme is only available in England. The standards and criteria within QTD are aspirational, with the emphasis on the primary care teams developing over a number of years. It is not expected that the teams will meet all of their criteria at their first assessment visit but that they will use the criteria to assess themselves and highlight their development priorities. The local assessment team provide external validation of the teams' self assessment. QTD is awarded for three years and is reviewed annually.

The criteria for QTD have been produced by a national steering group representing the professions in primary care. Assessment methods based on the criteria are: practice self assessment questionnaire; practice profile; patient questionnaires; documentation review; and, a practice visit by a team of colleagues (usually a GP, nurse, and practice manager) who undertake direct observation, interviews and clinical record review. Feedback is provided on the team's strengths and weaknesses and help to create a practice development plan provided.

QTD is particularly useful as a tool for clinical governance as it is carried out through a PCG/T and there is scope to adapt the way it is implemented to meet local clinical governance strategies. The criteria can be prioritised and used to develop a picture of strengths and weaknesses within a PCG/T.

◆ **Quality Practice Award (QPA)**

QPA is a quality assurance process undertaken by practices which recognises a high standard of quality patient care delivered by every member of the Primary Care Team. Each practice is required to submit a portfolio of written evidence set against 19 sets of criteria, which include: communication; health promotion; medical records; information technology; staff development.

When a practice's written evidence is complete, a full day assessment visit is conducted by a panel of four, usually two GPs, a Practice Nurse and Practice Manager. The assessors interview the team and inspect the practice premises, systems and medical records. At the end of the visit, the assessors give feedback to the team on their achievement and make recommendations for continuing improvement.

Practices will normally take between one and two years to complete their submission. The criteria manual contains a step-by-step User Guide and a Local Adviser is appointed to provide advice and guidance through the process. Practices vary in the amount of support they require.

◆ **Practice Accreditation (Scotland only) (PracA)**

Practice Accreditation is designed to help practices meet the demands of the developing quality and clinical governance agendas. It is set at a fundamental level to allow the primary care team to demonstrate that they have in place the essential elements to provide good general practice. In June 2000, Practice Accreditation was endorsed by the Clinical Standards Board as its recommended method of accrediting standards in general practice in Scotland. The Scheme is delivered locally by Primary Care Trusts and Islands Health Boards and there is no cost to practices.

Practice Accreditation covers a wide range of clinical and service criteria applicable to both patients and the primary care team. The criteria are set in three categories - Essential, Good, and Quality, and there 127 in total. Practices must meet all 46 Essential criteria and must demonstrate that they can also meet a maximum of 20 Good and Quality criteria.

Practices complete a self-assessment checklist indicating which criteria they have met. This is then assessed by a multidisciplinary team of two, one of which is a GP, who will conduct a half-day visit to meet members of the practice team and verify the information provided on the checklist. On successful assessment, practices receive a Certificate which is valid for three years.

Work is currently underway to develop Version 2 of the criteria, which will be endorsed by the Clinical Standards Board for Scotland, Scottish General Practitioners Committee, Royal College of Nursing and Royal College of Midwives.

◆ **Primary Care Research Team Assessment (PCRTA)**

PCRTA is an assessment scheme for primary care research teams, which focuses on individual practices and their teams as the unit of assessment. The scheme provides both primary care teams and stakeholders with a mechanism for acknowledging the quality of research infrastructure within a practice and provides a way of assessing and recognising the quality of research infrastructure against professionally developed and tested standards.

Two levels of assessment are available: PCRTA Collaborator Research Practice or PCRTA Investigator Led Research Practice. PCRTA seeks to encourage individual practices to develop their research experience and to foster a wider culture of research while providing a reliable and professionally recognised kite-mark of quality. Standards for the assessment are grouped into 7 areas of activity: practice organisation; strategic planning; practice as a learning organisation; research resources and infrastructure; project funding and management; involvement of patients; dissemination of research. Candidates are required to complete an application form to help with the preparation and submission of written evidence. Additionally, practices have to compile a folder of documentary evidence relating to their application that is reviewed by assessors when they visit the practice. After the practice has been visited, the assessors prepare a feedback report, which announces whether the practice has been successful or not.

◆ **Accredited Professional Development (APD)**

APD offers ongoing support for GPs' continuing professional development as part of their everyday practice. The process will help GPs to collect all the information and evidence that is required for their annual appraisals and revalidation, over a five year period. That is, to plan their learning, demonstrate the quality of their practice and celebrate their achievements in looking after patients. Documentation for appraisal and revalidation is provided within the programme wherever possible.

The APD programme is all about learning in a way that is relevant to participants' everyday practice and individual needs. The programme incorporates 6 modules over 5 years: keeping up to date and improving care (an ongoing module); communication skills; record keeping; access and team-working; referrals and prescribing; complaints and removals.

At least once a year the participating GP will undergo a peer review with their APD facilitator of participation in all stages of the APD programme and their own standards matched against those set out for all aspects of practice in *Good Medical Practice for General Practitioners*.

Record sheets to demonstrate learning and progress are provided which comprise the core APD evidence but GPs will also attach other evidence in their APD portfolios such as the work they prepare for their full annual appraisals, clinical audits or significant event audit sheets, certificates of awards, tangible demonstrations of improvements in practice etc. First candidates for the APD programme are hoped to be registered in spring 2002.