PATIENTS, DOCTORS AND THE NHS IN 2022

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B. EXECUTIVE SUMMARY

The role of GPs and of general practice across the UK is evolving. In ten years’ time aspects of what GPs do will remain the same but there will also be significant differences.

The health and social care systems are undergoing major changes in the face of growing social and economic pressures. A vision is needed of how general practice can be a driving force in shaping and delivering these changes, to realise the goals of providing better care for patients and a healthier population.

It takes time and funding to deliver change across a profession which is why this is a call to action to seek a shared purpose and urgency to understand the evidence and to agree the steps to be taken to deliver the vision.

This document draws on an extensive body of evidence and will form the basis of a ten-year plan, setting out what needs to be done to make it a reality. It discusses the challenges faced by all health services in delivering high quality, accessible and fair health care in the 21st century and how these challenges impact on general practice in particular. It also provides evidence for the value of investing in primary care, now and in the future and how, with this investment, the GP of the future will be able to adapt to meet patients’ needs, and at the same time retain what works.

In 2000 the RCGP called for the government to increase the GP workforce by 30%. Measures were put in place that helped address the then workforce and workload crisis. New demands on GP services mean that the pressures have returned and the current workforce cannot meet demands on their time and expectations from policy makers, politicians and the public. To ensure that general practice continues to be effective in the future it is important that we again address the workforce, workload and training issues – and in particular the barriers that prevent GPs from delivering excellent care to patients.

The implementation needs to be championed and resourced by a number of organisations working together with shared goals:

- the political parties and ministries of health across the UK
- bodies with responsibility for the funding and delivery of training, education and research
- the professional and representational bodies whose members work alongside general practice in the primary care arena
- patient organisations
- the new organisations emerging in England to commission and regulate the provision of health and social care, and to drive improvements in public health
C. INTRODUCTION

“Primary health care offers the best way of coping with the ills of life in the 21st century: the globalization of unhealthy lifestyles, rapid unplanned urbanization, and the ageing of populations.”

Margaret Chan, Director General, World Health Organization, 2008

A major concern for all health services is how to develop local, practicable, sustainable and affordable systems of care. There is clearly no simple solution. However, there is significant evidence that investing in general practitioners and primary care will help address these issues and lead to solutions to fragmented, inconsistent and expensive health care.

“More GPs, with longer training, spending more time with their patients”—these are imperatives for RCGP 2022 Primary Care.

More GPs so we can continue to meet the demand, take on the extended clinical and leadership roles that the NHS requires, support patients in making decisions about their health and give GPs room to do their jobs well, improve the well-being of our communities and help reduce health inequalities.

Longer training, so our GPs have the enhanced knowledge and skills required to manage new complexity and confidently tackle problems in a range of areas, such as paediatric, geriatric and mental health issues.

Longer with patients to deliver evidence-based, effective health interventions, to prescribe safely, and to allow those patients with multiple-morbidities who need more, time to have it.

“A world where excellent person-centred care in general practice is at the heart of health care.”

RCGP Vision
D. THE CHALLENGES OF 21ST CENTURY HEALTH CARE

Governments across the world are trying to address the increasing demand for health care against diminishing resources and rising real-term costs.

The challenges faced by all health services include:

- Increase in patients with long-term conditions, multiple morbidity and ageing populations
- Fragmented and fragmenting care
- Delivering integrated care
- Public health pressures and greater need for disease prevention
- Widening health inequalities
- Financial constraints.

Below we look at these challenges in more detail.

LONG-TERM CONDITIONS, MULTIPLE MORBIDITY AND AGEING POPULATIONS

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

If there is a typical user of the NHS it is likely to be a patient like Mary: elderly, suffering from many long-term conditions, on multiple medications and requiring monitoring and coordination from a number of health, housing and social care agencies. The success of our health and social care system is manifested in our longevity, living longer with more illnesses and disabilities. There are currently 15.4 million people in England with a long-term condition (LTC). By 2025 the number of people in England with at least one LTC will rise by 3 million to 18 million. The picture elsewhere in the UK is similar. In Northern Ireland, the prevalence of hypertension, coronary heart disease, stroke and diabetes is predicted to rise by 30% between 2007 and 2020. In Wales in 2003/4, one third of adults (an estimated 800 thousand) reported having at least one chronic condition, and in Scotland in 2007 there were 2 million people with long-term conditions.
Though patients with long-term conditions account for around 29% of the population, they make up 50% of all GP appointments, 64% of all outpatient appointments and 70% of all inpatient bed days as well as 70% of the total health and social care spend in England. That means 30% of the population account for 70% of spend.5

While the total number of people in England with one or more long-term condition is expected to remain stable over the next ten years at around 15.4 million, the number with two or more long-term conditions is projected to increase from 5 million today to about 6.5 million. Those with multi-morbidity are also the people who are most expensive to treat: on average someone with three or more long-term conditions in England costs £8000 a year, compared to £3000 a year for someone with one.6

Alongside long-term conditions, the prevalence and complexity of disease increases with age. The number of those aged over 80 years is expected to double between 2010 and 2030. Older patients aged over 80 years consult more frequently: between 12 and 14 times a year in 2008/2009 compared with between 6 and 7 in 1995. It is estimated that by 2025 there will be 42% more people in England aged 65 or over; and between 2010 and 2035 the number of people of pensionable age is projected to increase by 26% in Scotland, and the number of people aged 65 or over by 55% in Wales. In England, people over 65 years comprise 46% of spend in acute care, 37% in primary care, 60% in social care, 60% of all admissions and 70% of bed days in hospital.7 An increasing group amongst our aging population is that defined as ‘frail’, characterised by poor functional reserve, weight loss, muscle weakness, slow walking speed and fragility. This group of people are high users of health and social care, in particular with problems associated with falls, immobility, delirium or incontinence.8

Multi-morbidity is not simply a problem of chronological aging or randomly distributed in the population. For example the Scottish School of Primary Care has shown that people living in more deprived areas develop multi-morbidity 10–15 years before those in more affluent areas.8,10 A recent analysis of nearly 200,000 patients registered with over 300 GP practices in Scotland has shown that multi-morbidity is the norm for people with chronic disease and although its prevalence increases with age, more than half of all people with multi-morbidity are younger than 65 years.11

The most socioeconomically deprived young and middle-aged people have substantially more multi-morbidity than do their most affluent peers. Moreover, a greater mix of mental and physical health problems is seen as deprivation increases. This illustrates the need for holistic person centred care, taking into account social as well as physical factors.12
FRAGMENTED AND FRAGMENTING CARE

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

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

There are many causes of fragmentation, which vary across the world depending on funding mechanisms and organisation of health care. In the NHS, multiple competing providers, the emphasis on choice, short term contracts, reimbursement and payment systems, direct access to specialist services and the narrowing focus of treatment services all result in multiple providers caring for parts rather than the whole patient. This fuels fragmentation.13

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

At general practice level fragmentation results in the loss of continuity of care, something that is a vital component of generalist care. The evidence shows that continuity of care – especially for those who are older, have long-term disease or have multi-morbidity – improves health outcomes and reduces the need for hospital care. Patients at the end of their life are more often enabled to die in the place of their choice (often their own home), than when continuity is not provided. Continuity of care is highly valued by patients and is a key process through which therapeutic relationships are built and maintained over time. It is an essential prerequisite for effective generalist care.

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

There is significant evidence that many of the strengths attributable to primary care (in terms of health outcomes and use of resources) depend on an effective and long-term therapeutic relationship with a freely chosen primary care doctor. Together with communication skills, continuity of care is one of the most important tools of general practice.

Continuity of care is important clinically as well as financially and plays a major role in reducing hospital admission as well as improving quality of care. A study examining the impact of continuity found that a 1% increase in the proportion of patients able to see a particular doctor was associated with a reduction of 7.6 elective admissions per year in the average-sized practice for 2006–07 and 3.1 elective admissions for 2007–08. This equates to considerable cost savings across a whole practice of £20,000 per year for a 1% increase in continuity and a saving of £2,641 per hospital admission.

The trend towards larger general practices and public demand for access has led to a decline of personal care by GPs. This loss of continuity, such that a patient can see ‘my doctor’ is one of the most important victims of the modern health service. The pressure to offer increased access, loss of personalised GP lists, the multiplicity of providers and skill mix, the increased workload and overstretched workforce and working less than full-time are all part of the causes of this loss of continuity of care.
The opening of general practice boundaries in England, due to be implemented in the near future, will mean that patients can register with any GP irrespective of place of residence, breaking the bond between the GP, their patient and their local community. This policy initiative will also widen health inequalities as patients able to register with GPs in more affluent areas will do so, meaning that resources will be removed from areas that most need them.¹⁸

Continuity of care leads to:

- Better health outcomes
- More satisfied patients
- Better cost control
- More personalised decisions on appropriate care
- More effective care outside hospital
- Earlier diagnosis¹⁹
- Better targeting of expensive interventions to those most likely to benefit
- Limited use of interventions that have a significant harm rate
- Better acceptance of self-limiting illness
- Better medicine usage and adherence²⁰
- Uptake of screening programmes and of immunisations
- Cost savings in investigation, prescribing, hospital referral, admissions, use of A&E and overall cost of health care.
Continuity does not mean continuous face-to-face consultations. Quite the contrary. A trusting relationship with a GP facilitates the use of non face-to-face contact such as email, text and telephone, with the GP and the patient more readily able to trust decisions not made through the intimacy of face-to-face contact in an individual consultation. New approaches to care, such as telephone, email, SMS and social media work best as an adjunct to care, rather than as a replacement for the traditional model of face-to-face contact with 'my GP'. Consider for example:

*Peter, a 35-year old patient with schizophrenia – who is currently stable and living with his parents. The family have been registered with their local practice for 30 years and Peter is well known to the practice and a trusting relationship has been built up between him and his GP over the course of his life. He more often than not maintains contact with his GP via text messages and appointments are arranged as and when they are needed, with an annual face-to-face review carried out by the practice nurse.*

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

**DELIVERING INTEGRATED CARE**

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

Integrated care\(^1\) is a fuzzy ‘wicked’ issue with nearly 40 definitions and models and the simple concept of joint working, within and across different professional groups, is at risk of being drowned in complexity\(^2\) affecting its promise to deliver utopian care.\(^{22,23}\) The Nuffield Trust\(^24\) uses the term integrated care as an umbrella term, encompassing diverse initiatives that seek to address fragmentation but that differ in underlying scope and values. Integration is a continuation of health policy that began with multidisciplinary working in the 1960s,

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\(^{1}\) Integrated care has several meanings and in this context could be considered to be similar in shared-care, intermediate care, disease management (UK), managed care (US) also referred to as continuous care, comprehensive care, transmural care, transition care.
followed by shared planning and coordinated working in the 1980s, disease management in the 1990s and patient centred care in the 2000s.
There is no one ‘right’ model of integration. Different approaches will be appropriate depending for example on patient needs, geographical factors and organisational characteristics.

For example, it can refer to:

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

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

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

The prerequisites of integrated care must include:

- Continuity of care which is an essential component to achieving high quality care
- Cooperation between different parts of the health and social care system
- Coherence and common vision for the patient at the centre of the service
- Communication and information exchange
- Collaboration that goes beyond the simple exchange of letters
- Coordination at different levels of the system (strategic, management and clinical levels).

The Deep End study in Scotland identified the following criteria for integrated care as illustrated in Figure 2.

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2 The Deep End study (GPs at the Deep End) identified 100 general practices that served the most severely deprived populations in Scotland and examined differences between these practices and others in less deprived areas.
This report and recommendations draw on research evidence, previous Deep End reports and discussion groups at the second national Deep End conference at Erskine on 15 May 2012.

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

“General Practitioners at the Deep End” work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners, the Scottish Government Health Department, and the Department of General Practice and Primary Care at the University of Glasgow.

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Full report available at http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend
Integration will require redesign of services around the needs of the patient and development of care pathways for patients that can deliver real benefits. The RCP, RCGP, RCPCH joint paper, *Teams without Walls* set out a vision for a health system in which clinicians would work together in ways that transcend the traditional boundaries between primary and secondary care. The publication provides many examples from across the NHS of integrated care in a number of different clinical areas. The three Colleges called for an aspiration to create an NHS that puts the patient at the centre of everything we do, involved, empowered and enabled to achieve the very best outcomes for their health.

Under this model:

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

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

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

*Mr Jones, a 78 year old widower with diabetes, hypertension, prostate cancer, depression, incontinence of urine, poor eye sight and limited mobility, currently on 12 different tablets per day administered through a ‘dossett’ box, delivered weekly by the local pharmacist. He is 'under' the care of 4 hospital specialists and 2 community-nursing teams. He attends a local authority day centre once a week, requiring an ambulance to transport him back and forth. His daughter lives 100 miles away.*

Such patients frequently receive care from multiple sets of providers and decision-making concerning their treatment is often complicated by the potential for interaction between conditions. This is why it is vital that the leadership of service redesign, care pathways and integrated care is undertaken by GPs, trained to take a population health perspective on care, with time to consult with key stakeholders and to deliver and lead the services.

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

**INCREASING PUBLIC HEALTH PRESSURES**

The aetiology of important 21st century health problems, such as obesity, child health, mental health and co-morbidity, are highly complex and are increasing in numbers, putting a greater burden on health services. There is a continuing challenge of non-communicable diseases such as cardiovascular disease, cancer and liver disease, alongside the new lifestyle related challenges of obesity, alcohol dependence and type 2 diabetes.\(^{28}\)

**CHALLENGE OF ADDRESSING HEALTH INEQUALITIES AND INVERSE CARE LAW**

Many of the problems associated with patient access, quality of care, fragmentation of care and so forth are disproportionately found in areas of high deprivation, the so-called inverse care law.\(^3\) These areas manifest themselves in having patients with high levels of physical and mental illness (commencing at a younger age than more affluent areas), more multi-morbidities and greater problems with being able to self-care.

For example, if everyone in England had the same death rates as the most socially advantaged:

- People dying prematurely would enjoy 1.3–2.5 million extra years of life
- People dying prematurely would be more likely to be living disability-free by retirement age, having 2.8 million additional years free of limiting illness and disability
- Every year, the economy would save £31-33 billion in productivity losses, £20-32 billion in lost taxes and welfare payments, and in excess of £5.5 billion per year in healthcare costs.

*Source: \(^{29,30}\)*

Health inequalities in the UK are getting worse.\(^{31}\)

As described in the Marmot Review, health inequalities arise from a complex interaction of factors including housing, income, education, social isolation and disability.\(^{32}\) Marmot described the social determinants of ill health in his WHO report: poverty, exploitation, oppression and injustice. It is these determinants that result in health inequalities and many of the new (and not so new) health problems we see today. However, as Marmot

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\(^3\) The inverse care law is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served. Proposed by Julian Tudor Hart in 1971 [http://en.wikipedia.org/wiki/Julian_Tudor_Hart](http://en.wikipedia.org/wiki/Julian_Tudor_Hart); the term has since been widely adopted. The law states that: ‘The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.’ (Hart, 1971)
said, “Simply telling people to behave more responsibly is no more likely to be effective than telling someone with depression to pull his socks up.....smoking, obesity and heavy drinking are causes of ill-health, but what are the causes of these behaviours?”33 It is the determinants of ill health that result in the variation of life expectancy that we see across London and across most other major cities in the UK. People with less money and less education are likely to have less control over their lives and their health behaviour.34 For example, in Scotland in 2008/09, the rate of alcohol related discharges was 9 times higher for patients living in the most deprived areas than in the least deprived areas.35

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

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

The inverse care law has a powerful effect on the ability of a GP to offer adequate time to patients and continuity of care. Patients with such complex problems are more common in areas of high deprivation, where patients often receive shorter consultations compared with more affluent areas, despite greater need and more multi-morbidity. The doctors also feel more stressed after consultations.

The maps below show how the areas in England where life expectancy is lowest for men (red, map 1) – concentrated in London, the Midlands, Yorkshire, North West and North East – broadly match the areas with fewer GPs per head (red, map 2). The picture is the same for women. Mid Devon PCT, for example, has over twice as many GPs per head of weighted population as Oldham PCT. The current GP system has actually led to a larger inequality in the distribution of GPs across the country over the past two decades even as the overall number of GPs has increased.36
The Deep End study found that on independent health measures there is a steep social gradient with a greater than 2.5 fold variation across deciles of the Scottish population from the most affluent to the most deprived. On average, the most deprived 10% of the Scottish population has 70% more male and female deaths under the age of 70 than the most affluent 10%37. The total number of whole-time-equivalent general practitioners favour more affluent areas, with 11% more GPs in the more affluent half of the population than in the more deprived half.38

Consequent to this mismatch of need and resource, consultations in general practices serving very deprived areas are characterised by:

- Multi-morbidity and social complexity
- Shortage of time
- Less patient enablement, especially of patients with mental health problems
- Practitioner stress.

Providing continuity of care and integrating services around the patient can have a role in tackling health inequalities. Preliminary evidence in Glasgow suggested that targeted longer consultations for patients with complex needs in deprived areas led to greater patient enablement.39 In the long-term, the greatest impact of the
NHS on health inequalities should be by way of funding – with greater wealth equity and as Julian Tudor Hart has expressed on a number of occasions, funded through properly progressive taxation.\(^4^0\)

GPs provide care to the neediest groups and are crucial to tackling health inequalities. One of the objectives of the NHS plan 2000 and subsequent initiatives was to increase the number of GP in deprived areas. However, in 2008, 65% of primary care trusts in spearhead areas still had lower levels of GP coverage than the national average of 60 GPs per 100,000 population, when weighted for age and need.

**CHALLENGE OF ENGAGING PATIENTS IN THEIR OWN CARE**

**Shared decision making** (SDM) between doctors and their patients is important.

Shared Decision Making is a process in which patients, when they reach a decision crossroads in their health care, can review the treatment options available to them. With current, clinical information, relevant to their particular condition, patients will be helped to work through any questions they may have, explore the options available, and take a treatment route which best suits their needs and expectations.\(^4^1\)

The benefits of SDM include better consultations, clearer risk communication, improved health literacy, more appropriate decisions, fewer unwanted treatments, healthier lifestyles, improved confidence and self-efficacy, safer care, greater compliance with ethical standards, reduced costs and better health outcomes.\(^4^2\)

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

There is good evidence the patients want to be more involved in making decisions about their health and health care. The most recent national patient survey suggests that one in three patients in primary care, as well as one in two patients in hospital, would have liked greater involvement in care decisions. Patients who are active participants in managing their health and health care have better outcomes than patients who are passive recipients of care. However, although most clinicians claim that they involve patients in decisions, evidence suggests otherwise.\(^4^3\)

There is also a great deal of evidence on what works best in the care of people with long-term conditions. The Wagner Chronic Care Mode (see below),\(^4^4\) for example, shows that the best outcomes are achieved when three components of care are integrated: a prepared pro-active practice team, an informed engagement by people in their own care and partnership working between health professionals and people with LTCs.
Care planning is a means of supporting people to understand and confidently manage their own condition, as well as supporting them to manage the inevitable consequences of living with a long-term condition – consequences for the way they live their lives (roles and responsibilities) and the way they think and feel about themselves and their relationships. It involves the preparation of a care plan and coordinating care across a range of health, social care and other professionals to ensure the provision of support and services to address the patient’s needs. In 2011, the RCGP produced guidance for GPs on care planning for people with LTCs.45

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

A patient decision aid is an evidence-based tool designed to facilitate the process of arriving at an informed, evidence and value-based choice among two or more health care alternatives (including ‘watchful waiting’). A PDA systematically guides patients through their decision-making process by clarifying patients’ knowledge, values, decision certainty and roles using a series of questions. It presents the risks and benefits of each treatment option using best clinical evidence in a simple and accurate manner that can generally be understood.
by most patients (e.g. numbers, pictures). PDAs may be pamphlets, videos or web-based tools that describe the options available and help patients to understand these options as well as the possible benefits and harms. In 55 trials addressing 23 different screening or treatment decisions, use of patient decision aids led to: greater knowledge, more accurate risk perceptions, greater comfort with decisions, greater participation in decision making, fewer people remaining undecided about treatments and fewer patients choosing major surgery.46

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

However implementing these innovations would require more GPs, spending longer with their patients with enhanced training in care planning and the use of PDAs. The cost-benefit analysis shows that this would pay dividends.

The likely savings in national tariff costs if rates were reduced by a conservative figure of 10% as a result of using decision aids have been calculated for the most common elective surgical procedures and renal dialysis. The Cochrane review of decision aids46 suggests that reductions in the use of elective surgical procedures of somewhere in the region of 20–25% are possible, but since many of the studies have been carried out in North America where surgical rates are higher, a more conservative assumption of a 10% reduction can be used. There is evidence that the effective deployment of SDM tools will lead to savings of (at a conservative estimate) £100 million per annum.

In addition to these direct savings, indirect savings are also anticipated. As patient involvement increases in clinical decision-making, the potential for those individuals to better understand risks and benefits of procedures is increased, which may lead to a reduction in personal litigation against the NHS.

FINANCIAL CONSTRAINTS

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

The pressure on general practice is especially concerning as expenditure on primary care has lagged behind secondary care. Since 2003-4 in England, PCT spend on general practice has increased at a slower pace than on acute hospital care (65.8% and 76.4% respectively; see Figure 4 below). The majority of the increase on primary care occurred between 2003–04 and 2005–06 (47.4%) while between 2006–07 and 2010–11 it was
10.2% and over the last two years, only 1.3%. Spending on acute services increased by 24.3% between 2003/4 and 2005/6, and by 41.9% between 2006/7 and 2010/11, with expenditure rising by 5.1% over the last two years.47

Figure 4: Primary and Secondary Healthcare Costs commissioned by PCTs, 2003–2011

General practice can reduce costs to the health service:48

- GP consultations cost less than outpatient consultations, accident and emergency and ambulance calls.
- A face-to-face consultation with a GP costs the NHS about the same as a telephone consultation with a nurse through NHS Direct.

E. THE CHALLENGES FOR GENERAL PRACTICE
The increasing complexity of healthcare and fiscal constraints are placing new demands on GPs. These demands are concentrated more in deprived communities widening the inverse health law and placing pressures on GPs’ ability to deliver health care to their increasingly complex and diverse patients. The biggest challenges facing general practice are how to meet demand for care against an overstretched workforce and how to balance access versus continuity.

<table>
<thead>
<tr>
<th>Challenges for general practice</th>
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<tr>
<td>How to continue to deliver high quality care, and accessible services</td>
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<tr>
<td>How to improve coordination, collaboration and reduce fragmentation of care</td>
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<td>How to deliver the work force to sustain primary care services, now and in the future</td>
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<td>How to address health inequalities and focus care on those who are most in need</td>
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<td>How to improve use of information and technology to improve care for patients</td>
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<td>How to address variability of care</td>
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<td>How to involve patients in decisions about their health</td>
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<td>How to lead relevant R&amp;D</td>
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Looking at the specific pressures being faced by general practice in 2012 that if not addressed will impede the ability of the profession to adapt itself to meet the challenges of 21st Century health care:
The role of the GP has changed beyond recognition over the last few decades – and is expected to encompass a wide range of clinical, academic, leadership, commissioning and managerial functions, all learnt within three years of specialist training. GPs are expected to participate in planning services for their local population and to lead service development. Not infrequently patients present with multiple problems and the GP is now having to master the management of patients on multiple medications – without the benefit of clinical guidelines that encompass multiple, rather than single diseases. Whilst home visits might have decreased, the general practice consultation rate has almost doubled in the last decade (from around three to nearly six times per year), with the elderly consulting between 12–14 times per year. Providing telephone access has added, rather than reduced the GP workload, with telephone clinics or triage clinics often reaching 30–50 contacts per surgery.

The range of activities provided in general practice has increased considerably – with GPs undertaking many activities that were hitherto the domain of the hospital specialist. Procedures previously done in secondary care, such as anticoagulation monitoring are routinely undertaken in general practice. GPs are leading the in management of patients with substance misuse and the homeless and over 85% of all care of patients with chronic mental health problems is undertaken in primary care. Over the years GPs have absorbed this work, directly in their day-to-day work, or by increasing the skill mix in their surgeries or taking on new roles such as general practitioners with a special clinical interest, rapidly adapting to changing needs and continuously expanding what would be seen as ‘normal’ general practice services. This is now unsustainable.

When asked in an RCGP snap-shot of GP opinion, the vast majority (81%) of those responding felt that the complexity of their case load had increased in recent months. This complexity was predominantly associated with complex patients with multiple conditions. For example,

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

“... each consultation seems to be 3 or 4 consultations in one with multiple presentations ‘while I’m here’ and very complex interrelated problems.”

The ageing population, increase in mental illness and demographic change in the UK was highlighted as a main contributor to complexity. By 2022 the percentage of the population who are aged over 85 is forecast to rise to
3.1% of the total UK population, more than twice the proportion of 10 years ago (1.6%). The open-ended responses highlight the elderly and mentally frail as contributing to the complexity of consultations.

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

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

That general practitioners are working harder is born out by the increased number of their consultations. Between 1995 and 2008, the number of patient consultations in England rose by 75%, from 171 million to more than 300 million. GP consultations rose by 11% and nurse consultations rose by nearly 150%. For the average patient, the number of consultations per year rose from 3.9 in 1995 to 5.5 in 2008, with the biggest increases taking place amongst the over 70s (see graph below). If the pattern of consultations remains unchanged, by 2035 there could be a total of 433 million GP consultations in England, of which 180 million would be for people aged 65 and over, nearly double the current number.47

Between 1995 & 2008 the number of patient consultations in primary care rose by 75%

Number of consultations per person per year rose from 3.9 (1995) to 5.5 (2008)

4 Calculations based on the 2010-based Subnational Population Projections, Office of National Statistics.
In their 2011 national survey of GP opinion across the UK, the BMA identified that of those respondents who had been working in general practice for the last five years, the vast majority (88.1%; 16,163 of 18,348) reported that the intensity of their in-hours workload had increased in the last five years. Just 9.6% of respondents (1,753 of 18,348) reported that the intensity of their in-hours workload had stayed the same and 2.4% of respondents (432 of 18,348) said that that their in-hours workload had decreased.

**Question:** In the last five years has the intensity of your in-hours workload decreased, increased or stayed the same? (by main current status) (%)

<table>
<thead>
<tr>
<th></th>
<th>Decreased (n)</th>
<th>Stayed the same (n)</th>
<th>Increased (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP contractor/principal</td>
<td>1.0 (144)</td>
<td>6.8 (975)</td>
<td>92.2 (13,312)</td>
</tr>
<tr>
<td>Practice-employed salaried GP</td>
<td>4.3 (92)</td>
<td>16.4 (352)</td>
<td>79.3 (1,702)</td>
</tr>
<tr>
<td>NHS trust-employed salaried GP</td>
<td>5.6 (15)</td>
<td>21.9 (59)</td>
<td>72.6 (196)</td>
</tr>
<tr>
<td>Private sector-employed salaried GP</td>
<td>10.5 (8)</td>
<td>21.1 (16)</td>
<td>68.4 (52)</td>
</tr>
<tr>
<td>Freelance GP (locum)</td>
<td>12.6 (118)</td>
<td>24.2 (226)</td>
<td>63.1 (589)</td>
</tr>
<tr>
<td>GP trainee</td>
<td>6.3 (6)</td>
<td>31.6 (30)</td>
<td>62.1 (59)</td>
</tr>
<tr>
<td>Other GPs</td>
<td>12.3 (49)</td>
<td>23.9 (95)</td>
<td>63.7 (253)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.4 (432)</strong></td>
<td><strong>9.6 (1,753)</strong></td>
<td><strong>88.1 (16,163)</strong></td>
</tr>
</tbody>
</table>

Note: Caution, base size of private sector-employed salaried GPs and GP trainees is less than 100.
Hospital admissions (planned and unplanned) are a useful proxy of GP workload – the lower the admission rate the more work is carried out in the community (including but not exclusively general practice). Activity data collected by the Department of Health (England)\(^5\) shows that whilst hospital and emergency admissions and outpatient attendances have increased year-on-year their rate of increase is declining.

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

**WORKFORCE PRESSURES**

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

The Centre for Workforce Intelligence report on the ‘Shape of the Medical Workforce’ in England has said, [if]

“the current growth in general practice is not strong enough to meet the predicted need”.\(^{49}\) It anticipates that if current workforce trajectories persist there will be an over-supply of fully trained hospital doctors and by 2020

\(^{49}\) Personal Communication, DH official.
consultants’ salaries (if all eligible doctors become consultants) will increase by over 50% from £3.8 billion to £6 billion. Conversely, if as they recommend, there is a redistribution of hospital training posts to general practice to achieve a 50:50 balance in workforce numbers then this increase in GP numbers will go some way towards addressing the needs of our changing population. In the past decade the full-time equivalent GP workforce in England has grown 18% from its 2000 baseline. In comparison the number of hospital consultants grew 61% (ostensibly to provide consultant led care – but in reality to facilitate more and more sub-specialisation), over the same period.

The shortage of general practitioners is not evenly distributed across the country, with shortages more apparent in areas of highly deprived communities (where consultation rates and complexity are higher). Despite the objectives of NHS plan in 200050 and subsequent initiatives to increase the number of GPs in deprived areas, by 2008, 65% of primary care trusts in spearhead areas still had lower levels of GP coverage than the recommended number of 60 GPs per 100,000 population when weighted for age and need.51 Primary Care Trusts with the highest GP provision have almost twice the number of GPs per 100,000 patients compared with areas with the fewest doctors per capita, such that the impact of any workforce shortages will be felt most in isolated or deprived communities.52

There is a similar need to address the changing profile of general practice with increasing numbers of female doctors and the associated rise in less than full-time working. This changing workforce will require greater numbers simply to maintain historic levels of provision let alone meet the increasingly complex needs of patients and of the service. In 2010 56% of medical students and 62% of Foundation doctors were female and numbers of female GPs have grown by 6% from 2001 to 2010. The Royal College of Physicians predicts that there will be more female doctors than males on the GMC register by 2017.53 Compounding the lack of general practitioners is the predicted GP retirement bulge (often threatened in the past), which now finally appears to be taking place, with 13% of GPs expecting to retire in the next 2 years. The Centre for Workforce Intelligence (CfWI) recommends a 17% increase in recruitment into GP specialty training to be phased over the next 4 years, which will necessitate a reduction in recruitment into training in the hospital specialties. This will require significant work to encourage young graduates to enter the specialty of general practice, since at present only 20% of recent graduates indicated this as their first choice.49

The numbers of other primary care staff are also falling. Between 2010 and 2011, the total number of qualified nurses, midwives and health visitors working in community services (including community psychiatry and community learning disabilities services) in England decreased by 1995 FTE. Over the same period, the number of district nurses in England declined by 10%, bringing the total lost between 2001 and 2011 to 3590, a reduction of 34%. The number of FTE practice nurses increased by an annual average of 3.1% between 2001 and 2011, but has declined from its peak in 2006, down from 14,616 to 13,573. Figure 3 shows the proportion of practice nurses to the total number of qualified nurses.
A diminishing primary care workforce is not unique to the UK. American primary care generalism has seen a steep decline over the last few decades with this being responsible for a reduction in the number of GPs. By 1942 only half of US doctors were general practitioners and by 1989 the proportion of primary care doctors (now comprising a mix of family physicians, general adult internists and paediatricians) had fallen to one in eight with the drop most marked in rural areas.54

TIME FOR CARING

This paper has already made reference to the ageing UK population and the rise in incidence of chronic disease. Primary care has been demonstrated as being one of the most effective ways of delivering health care services and an effective way of delivering care to patients with complex comorbidities. The key deficit, however, in maximising the effectiveness of general practice is time, especially so for patients with multi-morbidity. Time with the patient is what shapes the relationship between the patient and their GP. Without time, the GP is unable to deliver health promotion and prevention: unable to undertake opportunistic screening: assess need, diagnose, assess the requirement for specialist care and so forth. The length of GP clinical encounters is shorter in the UK than in many other developed countries. Although numerous studies have shown an association between consultation length and markers of consultation quality, such as patient enablement, a Cochrane review some years ago concluded that there was insufficient evidence from controlled trials to conclude that longer
consultations improve outcomes or patient satisfaction. However a subsequent systematic review did indicate a likely benefit of longer consultations to patients with psychological problems.

Figure 6 details the average length of patient consultation in the UK in 2006/7, according to location and staff type. It shows that the average length of time for a surgery consultation by a GP partner was 11.7 minutes, compared to 15.5 minutes for practice nurses and nurse practitioners.

Figure 7: Average Consultation length for GPs and other health professionals in 2006/7

General practitioners are offering longer time in the consultation – but with increasing consultation rates and complexity this can only be achieved by reducing access or increasing work. The average length of surgery consultations with GP partners (as opposed to all GPs) increased from 8.4 minutes in 1992/3 to 11.7 minutes in 2006/7 with salaried GPs requiring an average of 12.1 minutes in 2006/7.

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

The NHS Plan 2005 emphasised that the development of primary care services was key to the modernisation of the NHS. The plan set out its ambition to make primary care more accessible, offer patients more choice and move more services from secondary to primary provision as well as create new roles for GPs as general practitioners with special clinical interests.

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

High workload and job stress is associated with lower practice performance and providing more time in the practice, more time per patient and experiencing less job stress are all associated with perceptions by patients of better care and better practice performance.

F. MEETING DEMAND AND COMPLEXITY WITHIN CURRENT CAPACITY

Attempts to manage demand against capacity have been tried over the years, for example:
IMPROVING SKILL MIX IN THE PRACTICE

General practitioners work in teams with skill mix within the primary care team reflecting the needs of the local practice population.

Skill mix is a term without a precise definition and has repeatedly been suggested as the solution to increasing demand against diminishing capacity.

The term is variously used to refer to the:

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

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

For example:

Delegation/Substitution

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

Diversification

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

Many of these nurses have undertaken specialist training and offer a wider range of services than was previously available.

The move towards increased skill mix in primary care is fuelled by:

- Rising demand and cost of care, which has increased interest in the possible economies to be made by shifting care from expensive to cheaper health professionals
• NHS policy changes which encourage a shift from hospital based to community based care, thereby increasing the volume and range of services demanded of primary health care professionals

• Anticipated changes in the general practitioner workforce, consequent on a recent decline in recruitment to the speciality and a shift towards part-time working related to the increasing proportion of female doctors.

There is, however, a dearth of research in this area and many changes in skill mix within primary care have yet to be adequately researched, in particular how effective skill mix is in reducing costs or freeing up GP time.\textsuperscript{63,64}

What can be said, is that skill mix is important but is not the panacea to the challenges facing British general practice and the health service.

**USE OF GENERAL PRACTITIONERS WITH SPECIAL CLINICAL INTEREST**

The 2000 NHS plan signalled the creation of general practitioners with special clinical interest (GPwSI),\textsuperscript{65} with the expectation of creating GPs, who with additional skills, knowledge and training could undertake extended roles without and outside the surgery. The expectation was that these individuals would improve access for patients to specialist care, reduce secondary care costs and cut waiting times. Special interest is a vague term and can refer to a GP anywhere along the spectrum from finding a particular area of practice interesting (maybe the practice lead) through to having a postgraduate qualification and expertise in a defined area of practice or disease. Many GPwSI positions to date have largely been based on the traditional specialty-based area, for example, dermatology, minor surgery, headache, ENT, epilepsy, all of which have hospital based equivalents and where the GP essentially behaves as a sub consultant, managing part rather than the whole of the patient. The expectation for the introduction of GPwSI was to reduce costs and reduce fragmentation and improve quality of care. There is no evidence that GPwSI in specialty-based areas have reduced hospital admissions, reduced costs or indeed improved the skills of general practitioners.\textsuperscript{66} However, like most people GPs seek variation in their work and career and undertaking additional training in a specific area can re-energise the GP and help with retention of the workforce and reduce burnout.

Irrespective of workload/workforce issues, the use of the GPwSI needs to be reconsidered and rather than create another cadre of ‘expert-GPs’ working in disease specific areas, the future GPwSI would be best placed supporting the care of patients who currently fall between gaps within the health and social care system (for example the homeless, frail elderly, patients with dementia) or in sites where the expertise of a generalist, combined with additional knowledge, skills and expertise would ensure better and safer care for the patients within that site - for example, general practitioners working in nursing homes, urgent care centres or custodial settings. If used correctly the GPwSI has the potential for ‘specialist’ GPs to bring their unique in-depth
knowledge of primary care to the respective clinical area and to work across the physical, social and psychological paradigms, and the potential to add value, rather than replace specialist services.\textsuperscript{67}

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

\textbf{JOINT WORKING WITH PHARMACISTS\textsuperscript{68}}

\textit{“There remains a significant unexploited potential for pharmaceutical care provided in community settings to alleviate GP workloads and improve health outcomes and service user satisfaction.”}

Joint working between community pharmacists and general practitioners makes sense in both improving the care for patients as well as removing work from the GP that more sensibly sits with pharmacists, such as medical reviews and the management of self-limiting illness.\textsuperscript{69} The community pharmacist is a trusted and respected professional and provides significant first contact care for patients and the public. This means the community pharmacist is well placed to be the first port of call for minor ailments and can be a useful partner in the management of long-term conditions and help patients adhere to prescribed medicines as well as taking on new extended roles, such as caring for patients with substance misuse and providing smoking cessation services.

The new opportunities for joint working/joint patient management arising from the pharmacist’s prescribing role have been taken up in some areas but greater use of these new skills could bring more benefit to patients. Prescribing from a community pharmacy location is less common currently except where arrangements have been made to link to practice clinical systems. Currently most of the pharmacist prescribers in primary care provide their services from general practice, working closely with GPs and practice nurses. Once referred to the pharmacist led clinic by GPs and practice nurses, patients benefit from regular consultations that include medication review and monitoring, prescribing and adjustment of appropriate medication in line with latest evidence and national guidelines.\textsuperscript{69} In NHS Grampian for example, partnership working between prescribing community pharmacists and their local general practices now involves 13 community pharmacists (around 15\% of the total).\textsuperscript{70}
Despite the obvious advantages of joint working across the two professional groups, in reality contractual and communication barriers mean that this potential is not realized. In addition, the evidence for substitution to pharmacists for routine medical reviews in older people being cost effective is mixed; such that clinical medication reviews in collaboration with GPs can have a positive effect and the community pharmacy may not be the appropriate environment.

WORKING DIFFERENTLY

Advanced Access

Advanced Access, developed in the US\textsuperscript{71} was introduced into general practice in the early 2000s\textsuperscript{72} and reflected insights from queuing theory about the cause of delays in systems. It aimed to improve access to primary care and improve continuity without a corresponding need to increase workforce\textsuperscript{73} or workload\textsuperscript{74}, doing so by ensuring that practices provided sufficient capacity to meet demand for same day appointments as well as booking ahead.

The impact of advanced access in the NHS shows limited impact. For example, a controlled, before and after study comparing advanced access with control practices showed that those using advanced access provided slightly shorter waiting times for an appointment with any doctor, but both types of practices had longer waiting times than NHS access targets and there was no in practice workload or continuity of care.\textsuperscript{75}

Commentators have pointed out that advanced access, with its focus on prioritizing same day appointments, has led to a decrease in self-care and increase in workload (even if undertaken by others within the primary care team) as patients present very early in the course of what would amount to a minor-self limiting illness or present too early in the natural history of a disease to be able to exclude a more serious illness, and need to be seen again. Other aspects of advanced access have also raised concern, including claims that the emphasis on rapid access would disadvantage people such as the elderly and those with chronic illnesses for whom seeing a particular health professional may be a higher priority.\textsuperscript{76}

It is important to note, as is frequently the case amongst policy makers, that translating what works in the US health system to the UK system is often inappropriate due to the fundamental differences in health systems. For example, the improvements in access following the introduction of advanced access techniques in the US were conducted in the context of health care centres that were seeking to reduce delays to obtain an appointment which had been between 18 and 55 days\textsuperscript{77,78} far longer than that experienced in any general practice in the NHS.

NHS-Direct

One of the aims in the development of telephone consultation is to reduce the burden on general practitioners and accident and emergency departments. One of the largest telephone consultation systems in operation is NHS Direct in the UK. This is a 24-hour nurse-led telephone advice system, based in England, which aims to
help callers self-manage problems and reduce unnecessary demands on other NHS services. A Cochrane review examined the evidence to determine whether telephone consultation was safe and effective. The results showed that in general, at least half of the calls were handled by telephone only (without the need for face-to-face visits). The systematic review found that telephone consultation and triage reduce immediate GP, or home, visits and that, in general, at least 50% of calls can be handled by telephone advice alone (ranging from 25.5% to 72.2%).

Telephone Triage

The evidence for telephone triage reducing the demand for face-to-face appointments with a GP is mixed. A study examining the effects of demand for same day appointments before and after the introduction of GP-run telephone triage was reduced by 39%, with most calls taking less than 5 minutes and good patient satisfaction. However another study where patients asking for same day appointments were randomized to telephone triage or face-to-face appointments (patients specifically asking to speak to the doctor by telephone for advice, those deemed very urgent cases and those with no contact telephone number were to be excluded). Use of telephone consultations for same-day appointments was associated with time saving (shorter consultations), but this short term saving was offset by higher return-consultation rates. Similar findings have been found in other studies.

Integrated Care and Care planning

The section earlier points out the benefits of joint working – across different professionals, to improve the coordination and continuity of care for patients. GPs are best placed to lead this joint working as they have the overview of end-to-end care for their patients. The evidence for the benefits of integrated care in improving health outcomes and reducing costs is largely lacking. A recent Department of Health evaluation of integrated care pilots in England found that although integration did lead to better processes, such as an increased use of care plans and improved organisation of care following hospital discharge, the patients themselves did not generally feel that this had translated into an overall improvement in their experience of care. Moreover, on some measures, such as continuity of care, patient experiences had actually declined. In addition, although there were significant reductions in elective admissions and outpatient attendances, these were balanced by increases in the costs of emergency admissions.

For patients with complex multi-morbidity and long-term conditions, a care planning approach through which patients, health professionals and carers work collaboratively and review outcomes on a regular basis has been shown to be effective in improving patient outcomes. Care planning is an essential component of coordinated care. Care planning however takes time to undertake the needs assessment and to engage in collaborative working. Mathers and Thomas concluded in their editorial on Integration of care, that “without the right investment and infrastructure, general practice will not be able to be an effective provider and facilitator of such models of integrated care”. This means investment in GP capacity, competence and infrastructure such as IT to facilitate joint records and sharing of information.
PROMOTION OF SELF CARE/NHS CHOICES

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

Evaluation of NHS Choices found that a significantly large proportion of the population of internet users have been influenced by medical websites to change their health-services-seeking behavior and the use of NHS Choices did modify demand for health services: frequent users of the site consulted their GP more often and there are indications that NHS Choices may have encouraged hard to reach groups to appropriately consult their GP. Both these findings, whilst appropriate led to an increased, rather than decreased GP workload, increasing demand rather than preventing it from occurring in the first place. 37% of NHS Choices users who use the service for the GP consultation (70% of all users) reported that it decreased their use of GP services (and does so appropriately).

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

USE OF E-HEALTH

A recent evaluation of a randomized control trial of the effects of remote care for patients with long-term conditions showed that the treatment group (that is the group provided with equipment to monitor blood pressure, diabetic control and so forth) had 20% fewer admissions than the control group, this corresponding to a difference of 0.14 admissions per person over a 12 month period. However as the Nuffield Trust evaluation showed, although the intervention of e-health experienced a 20% reduction in emergency admissions compared to the control group, these reductions were from a low base, and further more the control group appeared to experience more emergency hospital admissions shortly after being recruited into the trial, compared to before the trial. The reasons for this are unclear but it is possible that the trial recruitment process affected admissions – meaning that tele-health may have a different impact (maybe less impact) in routine practice compared to practice found in a clinical trial.

The use of remote or e-services to deliver care to patients has been commonplace in primary care for decades. GPs offer telephone appointments, telephone triage and increasingly, email consultations. GPs use text

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6 E-health is used as an umbrella term to encompass all remote, electronically mediated health care.
messaging to notify patients of appointments. The Department of Health has highlighted a number of other areas where e-health can add value to the care of patients and at the same time reduce the workload of general practitioners and other health professionals and as well as the level of complexity to implement.88

There is little evaluation of the use of e-health in primary care but the expected benefits are:

- Reduction in the number of unnecessary visits to the GP and practice nurse
- Reduction in travel requirements for patients
- Fewer face-to-face appointments leading to a reduction in cost
- Reduction in the carbon footprint
- Patients seen quicker, with more availability of face-to-face appointments for serious complaints.

http://www.rightcare.nhs.uk/index.php/shared-decision-making/

G. THE VALUE OF GENERAL PRACTICE TO PATIENTS AND TO THE NHS

Primary care and the value of general practitioners has been described extensively and is seen as an evidenced based priority for all health services across the world.

The following is adapted from WHO89
Primary care provides a place to which people can bring a range of problems
It is the hub from which patients are guided through the disease system
It facilitates on-going relationships between patients and clinicians, within which patients can participate in decisions about their health and health care
It builds bridges between personal health care and patient’s families and communities
It provides opportunities for disease prevention and health promotion as well as early detection, where necessary, of disease.
International surveys have found lower rates of patient-reported errors in health care systems with a strong orientation towards primary care.\textsuperscript{90}

**MEDICAL GENERALISM AND THE HEALTH OF INDIVIDUAL PATIENTS**

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

The value of generalism has been recognised for decades, for example, the 1963 Gillie Report\textsuperscript{91} states:

“He [the general practitioner] acts as an essential intermediary in the transmission of specialized skills to the individual. Without this function of the personal doctor the hospital services can be used wastefully, even damagingly to the patient.”

From the 1970s a major review of the health service was undertaken\textsuperscript{92} which identified that a health service based upon the general practitioner is likely to be less costly than a hospital-based service and the aim should be to provide the maximum amount of care in the community.

An Independent Commission on Generalism (2012) concluded that is essential that the essence of generalism (based in holistic and patient-centred care) is valued and preserved.\textsuperscript{93}

Starfield has shown that whilst “supply-driven care” in secondary care has been shown to lead to increased costs and reduced effectiveness, increasing numbers in primary care does not have the same effect. She has proposed six mechanisms to account for the beneficial impact of primary care on population health.\textsuperscript{94}

These are:

- Better access for relatively deprived population groups
- Better quality of care delivered by generalists
- Impact of primary care on prevention
- Better early management of health problems in primary care
• The contribution of primary care characteristics to more appropriate care
• The role of primary care in reducing unnecessary and inappropriate specialist care.

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

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

Iona Heath, President of the RCGP (2011)

The intellectual and contextual framework within which expert generalists operate is as demanding as that of expert specialists; however, it is different in several key parameters:

<table>
<thead>
<tr>
<th>A generalist must develop the skills to:</th>
<th>A specialist must develop the skills to:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tolerate uncertainty</strong> – generalists must manage a large proportion of patients with undifferentiated symptoms; including those who present early in the course of illness, those with evolving conditions, or those whose symptoms do not form a characteristic pattern of disease.</td>
<td><strong>Reduce uncertainty</strong> – specialists are expected to discover a diagnosis and to investigate until this is achieved. If they are unable to identify a diagnosis within their own specialty, they are usually expected to discharge the patient or suggest referral on to another specialist, rather than manage the diagnostic uncertainty.</td>
</tr>
<tr>
<td><strong>Explore probability</strong> – generalists see patients from an unscreened population with a relatively low incidence of serious disease. They require highly developed consultation and generalist diagnostic skills, including recognition of common conditions and awareness of the limits of their knowledge. Their clinical decisions are based on the epidemiology of the local community and the consequent probability that any given symptom is medically significant.</td>
<td><strong>Explore possibility</strong> – specialists see a pre-selected population of patients with a relatively high incidence of serious disease. They require expert knowledge of the rare and esoteric conditions that are relatively more likely to be the cause of the problem in this population.</td>
</tr>
</tbody>
</table>
Marginalise danger – a key skill of a general practitioner is to recognise and act on potential danger to patients even when there is diagnostic uncertainty; this often requires referring the patient or initiating treatment before a diagnosis has been established (e.g. in a case of suspected meningitis or cancer).

Marginalise error – a specialist must ensure that they reach an accurate diagnosis and treatment for the patient, in order to enable a successful outcome.

Each health care system is different and the use of generalists varies between different countries but across the world, countries with strong primary care delivered by doctors with generalist training produce better health outcomes, at lower cost and the numbers of primary care physicians and the consequent availability and effectiveness of primary care relates closely to improved health outcomes and lower costs. Studies comparing generalist and specialist care report that the quality of clinical care, when planned and executed by generalists, was either the same or that for primary care it was better.\textsuperscript{96,97,98} In the UK more GPs per head of population is associated with lower all-cause mortality (especially cancer and heart disease) and the supply of GPs appears to have more influence on lower standardized hospital mortality than the ratio of specialists in a hospital.\textsuperscript{99}

In the NHS in England, over 300 million consultations take place in general practice per year, which represents 90\% of all NHS contacts.\textsuperscript{100} The majority of these are undertaken by general practitioners.

The traditional gate-keeper and coordinator roles of the GP and the skill of the GP in managing uncertainty, ensures that health service costs, whilst increasing, represent value for money. Although the average patient has 5.3 consultations with their GP every year, only one out of every 20 consultations (5\%) results in secondary care referral. Everything else is dealt with in primary care.\textsuperscript{101} A whole year’s care in general practice costs about one tenth of a day in hospital, the former receiving around £80 per patient per year (UK) for unlimited numbers of consultations.

In England, an increase in just one general practitioner per 10,000 population is associated with a 6\% decrease in mortality.\textsuperscript{102}

A year of care by a GP costs the same as a 1/10 th of a day’s stay in hospital

An increase of just one GP per 10,000 population is associated with a 6\% decrease in mortality
American policy-makers and researchers are now recognizing the clinical effectiveness of the family physician in both providing continuity of care and in the utilization of the concept of ‘medical home’, especially for helping patients with co-morbidity. This comes after years of focus on single-condition case management – and an emphasis on technological intervention within strictly controlled care pathways, rather than a generalist, integrated or holistic approach.

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

- Improve the quality of patient care in comorbid conditions\(^{103}\)
- reduce costs to the health service\(^1\) (through reduced referrals, reduction in prescribing errors, reduction in hospital admissions)
- improve the care of long-term diseases\(^{104}\)
- facilitate more effective shared decision making
- help to reduce health inequalities\(^{105,106,32,107}\)
- provide better preventative care\(^{108}\)
- improve patient self-care

**General Practice and Population Health**

Primary care works by delivering person centred, comprehensive, integrated and continuous care to patients and their families. At present, continuity of care in UK general practice is preserved by the registration system at the level of the practice and the primary care team, who are able to provide continuous long-term care through regular discussions and information sharing about patients, shared electronic records, and other communication routes. This allows the GP to be responsible for a defined population and to build up continuous relationships with community and social care providers and other sectors and to coordinate the care of hospitals, specialists and community organisations.
The need for the whole population to have access to quality general practice has been highlighted by a large USA-based review of all studies published between 1985 and 2005, which quantified the health benefits of GPs in reducing health inequalities and improving morbidity. The findings suggested that an increase of one GP per 10,000 population was associated with an average mortality reduction of 5.3%, equivalent to 49 fewer deaths per 100,000 population per year.

A series of comparative studies published by the Commonwealth Fund on the performance of 12 international health systems has ranked the United Kingdom consistently high overall, in comparison to others. The United Kingdom’s comparative performance shows that it has performed strongly in terms of access to care, equity, effectiveness and patient safety.

The features that were consistently associated with good or excellent primary care included the comprehensiveness and family orientation of generalist-led primary care practices, within a wider system in which governments regulated the distribution of health care resources through taxation or national insurance. England and Wales rated top both in practice and system characteristics.

Figure 8: UK ranking in international comparison of health systems by dimension of quality

<table>
<thead>
<tr>
<th>Overall ranking (2010)</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality care</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Effective care</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Safe care</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Co-ordinated care</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Patient-centered care</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Access</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>Cost-related problem</td>
<td>6</td>
<td>3.5</td>
<td>3.5</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Timeliness of care</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Efficiency</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Equity</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Long, healthy, productive lives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Health expenditures/capita, 2007</td>
<td>$3,357</td>
<td>$3,985</td>
<td>$3,509</td>
<td>$3,837*</td>
<td>$2,454</td>
<td>$2,992</td>
<td>$7,290</td>
</tr>
</tbody>
</table>

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organisation for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009); Davis et al (2010).
In England, in its White Paper *Equity and Excellence*, the coalition government has set out its proposals for further reform of the NHS. The intention to increase patient choice and competition is likely to result in a greater diversity of primary care providers. The White Paper also puts a strong emphasis on involving patients in decisions about their treatment and care – under the slogan ‘no decision about me without me’. This will require GPs to engage patients more actively in decision-making about their treatment and care.

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

The Scottish Government’s plan *Better Health, Better Care: Action Plan*, supports the role of general practice as being well placed to support high quality patient care. RCGP Scotland’s, *The Future of General Practice in Scotland, a 5 – 10 Year Vision* aspires to a health service where care is safe, clinically effective and person-centred, and involves:

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

In Northern Ireland the Government recently launched a major review of the Health and Social Care system, *Transforming Your Care*, which positions the role of general practice at the heart of providing high quality co-ordinated patient care. Many of the aspects of the implementation of this review are recognised in, *The Future of General Practice in Northern Ireland – a 10 Year Strategy*, an action plan for delivering on the key challenges for the profession identified by RCGPNI/GPCNI in 2010 which includes:

a. Developing a framework for effective management of general practice in the future
b. Improving leadership and management effectiveness within general practice
c. Improving organisation within the infrastructure of general practice
d. Improving service and accessibility
e. Working with Trusts and Commissioners
f. Resourcing general practice
g. Addressing the educational and training needs of general practice.
In Wales, the main features of the policy environment within which general practice operates are contained in the following documents:

- Setting the Direction: Primary and Community Services Strategic Delivery Programme (Feb 2010)
- Together for Health: Five year vision for the NHS (2011)
- Programme for Welsh Government: Section on 21st Century health care

Key themes emphasised in the above are:

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

I. CONCLUSION

The issues facing GPs throughout the UK are consistent even if the structure of healthcare services differs. The pressures on primary care and on the general practitioner to deliver effective care are mounting as is the ability to deliver continuity of care and accessible services. The crises of demand vs capacity has not arisen over night and neither can it be solved quickly. However solutions must be found to increase workforce and enable GPs to spend longer with their patients and communities and have training that is relevant to their new roles and responsibilities. He/she however, must continue to provide first contact care, to patients with undifferentiated illnesses and must continue in the role of gatekeepers and increasingly, navigators of care. They will continue to provide holistic care to registered patients, in the context of their families and communities, across the physical,
social and psychological domains, from cradle to grave, using the tools of the consultation and continuity of care to deliver this.

**The RCGP believes that:**

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For GPs to play their rightful role in caring for patients in the NHS, it is important that there are enough GPs to deliver care, that these doctors have sufficient time both in and outside the consultation to provide the interventions needed and that the doctors have sufficient training to develop the competencies required to undertake the roles expected from them.

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

It is difficult to predict the future – but based on the current direction of travel, the future patient is likely to access a nurse or GP remotely, attend virtual ‘outpatient’ clinics and communicate with their GP via text message or Facebook. The patient in the future will be able move from registration to treatment remotely, and be able to interact with their GP with full access to and control of their medical records. The gatekeeper role of the GP is likely to diminish with patients more than likely to be able to self refer for physiotherapy, talking therapies and others. The role of the GP will be as community generalist, leader of MDTs and integrated teams, working closely with nurses, health practitioners and community based specialists. Like physicians, the future GP is likely to be primarily an expert in the application of a biopsychosocial approach to the diagnosis and management of disease, able to manage patients with long-term multiple chronic diseases. The future GP must have time and opportunities to interact more closely with their specialist colleagues – who themselves will need to leave the traditional hospital setting and provide their expertise in a more flexible manner than the traditional ‘out-patient’ model.
These challenges can be overcome and improvements made. General practitioners have always adapted to change and have been at the forefront of innovation and embracing new systems and ideas. However, given the demands on general practice as a profession and general practice as a system of care that it currently faces, without significant new investment it will be difficult to realise its potential.

Longer and more flexible consultations will be required in the future to deal effectively with patients with complex care needs. There are many ways that practices can help achieve this – including use of remote care (tele-health), better use of skill mix and working with patients to promote better self care.112

The challenges for general practice are how to realise its potential and evolve to deliver 21st century health care.
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