General practice in London
Supporting improvements in quality

Executive summary

Commissioned by NHS London
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This report outlines the challenges faced by general practice in London and the improvements needed in order to address them. The report is aimed at those who have a role in leading quality improvement in primary care, namely GPs working in London and leaders of primary care providers, clinical commissioning groups (CCGs), and the London region of the NHS Commissioning Board. Prepared by The King’s Fund and Imperial College London, it provides an independent assessment of the quality of general practice in the capital, using routinely available data sources.

We hope this report will inspire GP leaders and commissioners to think differently about the future of general practice in London, and encourage them to develop innovative, local solutions to ensure that all Londoners enjoy good health and access to high-quality care.

Introduction

Despite the demographic and socio-economic challenges facing general practice in London, it makes a hugely significant contribution to improving Londoners’ health and the health care they receive. While there are examples of excellence in general practice in London, the quality of care and health outcomes vary markedly. These variations can have many causes – some warranted, others not. Practices and clinical commissioning groups (CCGs) will need to understand the reasons for local variations in order to take appropriate action.

Demographic changes in London and the unprecedented financial pressures facing the NHS present a phenomenal challenge for general practice in London. Here we summarise the key findings of our research:

A profile of London’s population

- London’s population is very different from the rest of England. It is younger, more transient, more ethnically diverse and growing more rapidly. Income and health inequalities are greater than in the rest of England.

- Compared with national averages, London has lower smoking prevalence but higher rates of low birthweight babies, teenage pregnancy, childhood obesity, HIV, serious mental illness, and suicide.

- London has lower cancer incidence than the national average (286 and 301 per 100,000 respectively); cancer mortality is also lower (106 and 110 per 100,000 respectively) but it varies twofold across London.

- London has a low estimated prevalence of cardiovascular disease but above-average mortality from cardiovascular disease (71.5 per 100,000 compared with 67.3 in England) and there are large variations (ranging from 46 to 115) between primary care trusts (PCTs) in London.

- Overall and premature mortality are lower in London than in other parts of the country. Life expectancy for men and women in London
(2008–10) was 79 and 83.3 years respectively, compared with 78.6 and 82.6 years for England.

- All these indicators vary significantly within London and between socio-economic and ethnic groups – for example, life expectancy varies by nine years between London PCTs, and infant mortality varies threefold.
- Some of the health gaps between London and the rest of the country (as well as inequalities within London) have narrowed over the past decade.

**General practice in London**

- London has a similar number of GP full-time equivalents (FTEs) as England per 100,000 unified weighted population (61 and 59.9); however, this varies twofold between London PCTs, and the distribution of GPs remains inequitable.
- The number of practice staff per GP is lower than in other regions. Changing the skill-mix of practices and maximising their efficiency must be a priority.
- Almost 16 per cent of London GPs are over 60 years old compared with 10 per cent nationally. Staff recruitment and retention will be important.
- London practices have smaller list sizes, reflecting the high numbers of single-handed practices. Almost 20 per cent of practices are single-handed compared with 13.8 per cent nationally.
- London has one of the highest spends on primary care services in England, in part reflecting the greater reliance on GPs to deliver services.
- London practices have been early adopters of information technology (IT) but there is potential for greater use of IT to support patient care.

**Clinical quality and outcomes**

**Health promotion/ill-health prevention**

- Many London PCTs do worse than the England average on key indicators of ill-health prevention, including childhood obesity, childhood immunisation and flu vaccination, and breast and cervical screening. However, some PCTs in deprived areas have the highest immunisation rates in London.
- General practice already makes an important contribution to promoting health and reducing health inequalities, through primary and secondary prevention. General practice in London needs to work closely with health and wellbeing boards and local authorities to tackle the wider determinants of health.
Diagnosis

- There is evidence of under-diagnosis and unmet need with regard to some long-term conditions – for example, stroke and chronic obstructive pulmonary disease (COPD).

- London has a slightly higher than expected rate of emergency admissions for a first diagnosis of cancer than the England average ratio of observed to expected at 1.04 in London (national average as 1), and this ratio ranges from 0.88 to 1.22 between London PCTs. Many factors can contribute to emergency presentation, and the reasons should be investigated locally.

- There have been improvements in London in the identification and recording of risk factors, such as for heart disease.

- A more proactive approach is needed to target high-risk groups to improve uptake of preventive services and to encourage them to present early.

Referrals

- Variation in referral rates is to be expected, and it is difficult to establish referral thresholds objectively. However, there is a threefold variation across London practices in outpatient attendances, which merits further investigation to avoid the risks of both under- and over-use of specialist and secondary care.

- Urgent referral rates for cancer in London PCTs were mostly below the national average, and showed a more than twofold variation.

- London compares well with the national average in terms of meeting required waiting times for urgent referrals for cancer.

- London has a lower percentage of urgent referrals that result in a diagnosis of cancer (7.6 per cent compared with 9.8 per cent nationally), with London PCTs having some of the lowest rates, and a somewhat higher proportion of newly diagnosed cancers that do not arise through the two-week referral route.

- There is a need for GPs, together with colleagues in secondary and tertiary care, to understand and address the reasons for variations in referral rates.

Prescribing

- Several London PCTs are in the highest quintile for prescribing of anti-diabetic items; nationally, there is no correlation between PCT spending on insulin and non-insulin anti-diabetic drugs and the percentage of people with diabetes with controlled blood sugar.

- London spends less overall on prescribing and pharmaceuticals in primary care than other regions of England. This could be related to higher levels of undiagnosed disease, reflecting the population challenges faced by London practices.
Studies show there are inequalities in prescribing by age, sex and ethnicity in London.

There have been improvements in safe and appropriate prescribing of non-steroidal anti-inflammatory drugs in London.

Further investigation of differences in prescribing rates and expenditure is needed and effective support to ensure that prescribing is in line with best practice. GPs must also seek to provide better support for appropriate medicines management, particularly for older patients who are taking several prescription medications.

Acute, emergency and urgent care

London has the highest A&E attendance rates nationally (340 per 1,000 population compared with 290 nationally) and intra-London variations are large (from 251 to 432 between PCTs).

London’s 28-day hospital emergency readmission rate is similar to the national average (11.9 per cent compared with 11.6 per cent) but there is significant intra-London variation between PCTs (from 9.3 per cent to 13.8 per cent).

London PCTs have higher rates of bed days for people over 65, with 7 of the 31 London PCTs being among the 10 PCTs with the highest rates nationally.

Less than 10 per cent of patients nationally are satisfied overall with out-of-hours GP services. In London, as few as 7 per cent of people are satisfied.

GPs need to work with others and through their clinical commissioning groups to ensure that patients’ acute and urgent care needs are met, both during surgery opening hours and out of hours.

Closer co-ordination of care with other services could reduce the need for emergency readmission and length of hospital stays among older people.

Managing long-term conditions

London has a lower rate of emergency admissions for ambulatory care sensitive conditions (ACSCs) than the national average (428 and 436 per 100,000 respectively); however, there is fourfold variation between London PCTs (from 223 to 857).

Although London’s performance on some clinical quality indicators (eg, cholesterol control among patients with coronary heart disease, or blood pressure control among stroke patients) is similar to the national average, there are large variations within London, with some PCTs covering relatively deprived populations outperforming PCTs in more affluent areas. There is also evidence of inequalities based on ethnic groups.

The National Diabetes Audit found that only 54 per cent of people with diabetes in England received all nine care processes. Among PCTs in London, the range was from 31 per cent to 63 per cent; again, some
deprived areas in east London had the highest rates of people with diabetes receiving all nine care processes.

- Compared with the England average (29 per cent), London had a higher percentage (35 per cent) of households receiving intensive home care, although there is wide intra-London variation (from 25 per cent to 48 per cent).
- There is potential for exchange and learning across the capital’s practices about how to transform services and deliver high-quality care, given the unique challenges London faces.
- The rising number of people over 85 requires general practice to be integrated with community services and social care to prevent unnecessary and costly hospitalisations or admissions to care homes for frail older people.

**Mental health and dementia**

- Prevalence of mental health problems varies twofold between the most and least deprived parts of the capital; use of secondary care community mental health services varies fourfold and admission rates for psychotic disorders vary eightfold.
- The admission rate for mental health problems among London’s black population is 2.6 times higher than the national average.
- A third of GPs in London did not feel they had sufficient training to diagnose and manage dementia. There is a 10 per cent variation between London PCTs in the proportion of patients with dementia whose care has been reviewed in the previous 15 months.
- General practice in London is not doing as well as it could in promoting the physical health of people with severe mental health problems.
- Care of people with mental health problems could be improved by closer integration of mental health support with primary care and chronic disease management. Educational support for GPs is needed to ensure that they are equipped to diagnose and effectively manage people with dementia and support their families and carers.

**End-of-life care**

- London PCTs have relatively low rates for the proportion of all deaths that occur in the usual place of residence, and among the highest rates of deaths that occur in hospital among children aged 0–17 years with life-limiting conditions.
- There is a need for stronger community support services for palliative care in London and more information for GPs about services that are available locally.

**Inequalities in health care**

- There have been improvements in equity among London PCTs for some indicators.
However, health inequalities by age, ethnicity and socio-economic status persist and need to be monitored through regular equity audits.

**Patient experience**

- Patients in London report a less positive experience of using GP services than the national average across all domains of patient experience, although overall satisfaction levels remain high (80 per cent).

- The large variations in patient experience between London practices suggest that practices have much to learn from each other.

**Access**

- Londoners report being less satisfied than people in the rest of England on most dimensions of access to care, including the ability to book appointments, the ability to see a GP of their choice, and access to out-of-hours care.

- 78 per cent of Londoners said they were satisfied with their practice opening hours compared with 81 per cent in England overall.

**Continuity of care**

- In London, 56 per cent of patients report being able to see their preferred GP always or most of the time compared with 63 per cent nationally.

**Patient engagement and involvement**

- Although satisfaction levels remain high across most London practices, there are large variations within London. Londoners are somewhat less satisfied with the quality of consultations with their GP compared with the national average (84 per cent and 88 per cent respectively).

- Similar patterns are apparent for consultations with practice nurses.

- London has lower proportions of patients reporting that they have an agreed care plan to manage their condition than elsewhere in the country.

- All London PCTs (54 per cent on average) were below the national average (64 per cent) on the proportion of patients with a long-term health condition who felt supported by local services to manage their condition.

- However, there was relatively little difference between London and the England average in the proportion of people with long-term conditions who felt confident about managing their own health (91 per cent and 93 per cent respectively).
The future of general practice in London

Changing the skill-mix

- GPs need to be supported by a wider range of health (and social) care professionals.
- General practice needs to access specialist advice, either from GP colleagues with specialist interests or directly from consultants.

Shared care

- General practice has a pivotal role to play in co-ordinating care across care providers and settings, and helping patients, users and their carers to navigate the health and social care system.
- General practices, as active members of clinical commissioning groups, can influence the quality of care and treatment of their patients regardless of where in the system those patients are receiving care and treatment.

Partnership with patients

- Patients should be actively engaged in decisions about their care and treatment, and supported to self-care and self-manage as part of patient-centred care planning.
- Primary care should be the gateway to education and support for patients and carers.
- Patients with urgent care needs should feel confident that they will be responded to promptly during surgery opening hours and out of hours.

Meeting the health needs of the wider population

- Any expansion in facilities and staff needs to be matched to local needs and areas of undersupply.
- General practice needs to engage proactively with local authorities to seek new and innovative ways to prevent ill-health and tackle long-term and persistent inequalities.

The foundations of future general practice

Building effective networks of practices

- Effective networks of practices can enable practices to retain their identity and knowledge of the population they serve, while also enabling the provision of services they would find difficult to provide on their own.

Remodelling the primary care estate

- Strategic and innovative approaches are needed to maximise use of the buildings and land owned by the NHS, the wider public sector, and
other community-based organisations, as well as looking at alternative locations for general practices while ensuring that they remain embedded within local communities.

**Better and smarter use of information**

- Data and information tools must be used by clinical commissioning groups (CCGs) and providers to identify and prioritise areas for quality improvement; general practice must own this information-driven, quality improvement agenda.

- Practices and CCGs will need to understand the underlying reasons for local variations in performance in order to take appropriate action.

- Ethnicity coding in general practice must improve to support monitoring of this important dimension of inequality.

- Primary care and CCGs must develop an open culture in which comparative and timely performance data are shared transparently (with professional peers, patients and the public), and the ability to challenge is balanced with the need for support.

- Exploiting the potential of IT to support patient care – for example, through record-sharing, linkage of patient records, and giving patients access to their records – should be a priority.

**Developing the primary care workforce**

- Investment in training and development needs to benefit new staff and existing staff, to ensure that GPs, nurses and other community-based staff gain the experience and confidence necessary to deal with the growing complexity of health care needs and to work together effectively in teams.

- The skill-mix in general practice must change further, with a greater role for nurse practitioners and a much wider range of professionals working alongside GPs in the community.

- Strong clinical leadership should be fostered in order to develop the clear vision and shared values through which effective collaboration and teamwork can flourish.

**A commitment to change**

- There is currently a strong focus on the reconfiguration of acute services; however, the transformation of care will not be realised without a similar focus on general practice and other community-based services.

- The health and social care system needs to keep pace with the needs and expectations of local people; incremental changes are unlikely to be enough and a bolder approach is needed.

- These are not easy transitions to make, and practices, networks and CCGs will need to exercise strong leadership to challenge the status quo and deliver a new vision for the future of general practice.
A summary of the key areas for improvement

- General practice needs to do more to promote health, prevent ill-health, and reduce inequalities, working closely with local authorities to tackle the wider determinants of ill-health as well as delivering primary and secondary preventive services for those at highest risk.

- General practice must adopt a more systematic approach to the early diagnosis of all chronic conditions and a more proactive approach to encourage high-risk groups to present earlier.

- There is a need for GPs, together with colleagues in secondary and tertiary care, to understand and address the reasons for variations in referral rates.

- Further investigation of differences in prescribing rates and expenditure is needed to ensure that prescribing is in line with best practice. GPs must also provide better support for appropriate medicines management, particularly for older patients who are taking several prescription medications.

- GPs need to work with others and through their CCGs to ensure that patients’ acute and urgent care needs are met, both during surgery opening hours and out of hours.

- Although the rate of unplanned admissions for patients with long-term conditions is lower in London than elsewhere, general practice must ensure that it delivers care to patients with chronic conditions in line with best practice.

- The rising number of older people forecast for London requires general practice to coordinate care with community services and social care to reduce unnecessary and costly hospitalisations and admissions to care homes for frail older people.

- Care of people with mental health problems could be improved by integrating mental health support with primary care and chronic disease management. GPs need educational support to ensure that they are equipped to diagnose and effectively manage people with dementia, and support their families and carers.

- There is a need for stronger community support services for palliative care in London, and more information for GPs about end-of-life care services available locally.

- Although overall patient satisfaction levels in London remain high, London practices perform poorly on patient experience compared with practices elsewhere, and need to improve the experience of their patients and reduce variations. It is important that practices enable patients to have timely and convenient access and offer a degree of personal continuity.

- Health inequalities in London by age, ethnicity and socio-economic status persist, and need to be monitored through regular equity audits.

- While inequalities, population mobility and diversity present significant challenges, some areas in London are demonstrating that it is possible to improve the quality of care through a more systematic and co-ordinated approach.