

“USING ROUTINELY COLLECTED DATA TO FIGURE OUT WHERE THE NHS IS GOING WRONG.”

This [Powerpoint presentation](#), shared with Deep End GPs at their annual conference on 24/11/15, is based on analyses carried out by Dr H Irvine, CPHM and Mr J Gomez, Senior Information Analyst at NHS GG&C. These analyses investigated the Board's persistent financial over-parity, trends in hospital activity, and poor and declining compliance with the 4 hour A&E HEAT target. The results showed:

- NHS GG&C financial overparity (i.e. spending above target share of the national territorial budget) (slide 12) is explained not by under-funding of the needs of patients in socio-economically deprived areas but by increasing hospital activity involving patients from more affluent areas (slides 5,6,10,11).
- Relative to the rest of Scotland, over-subscription of hospital activity applied to all SIMD quintiles in GG&C but was greatest and rising most rapidly in the most privileged quintile, and was particularly marked in elective care (slides 5-9).
- Poor compliance with the 4 hour A&E target over a recent four year study period in both GG&C and the Rest of Scotland correlated with clusters of very old patients, the rate of ageing of A&E attendees increasing two to three times faster than the ageing of the resident population, suggesting a failure of services supporting patients living at home and other community settings (GG&C data are shown in slides 13-17, RoS data available on request).
- Analysis of manpower and funding trends suggests that disinvestment in general practice in GG&C since 2006 (slides 19, 20, 25), combined with a reduction in the number of fully qualified district nurses since 2007 (slide 31) and reduced funding for social care of the elderly since 2009 (slides 33 and 34) are likely major determinants of increased unscheduled hospital use as the last line of care.
- The above findings are part of a national picture of relative disinvestment in general practice, with resultant weakening of the gatekeeper function, in association with a shift in resources to community health services budgets under the control of CH(C)Ps (now, HSCPs) (slides 19 and 32).
- In October 2015, the Auditor General reported financial and performance failures in NHS Scotland (slides 36, 38 and 40) which we believe are attributable to the above strategic trends, implicating central government health service planning and decision-making. See:http://www.audit-scotland.gov.uk/uploads/docs/report/2015/nr_151022_nhs_overview.pdf

Balancing needs and demands, quality and equity

- Current financial and performance difficulties in NHS Scotland (slide 36) are largely the result of rising demand for hospital services, which is outstripping supply, despite increasing investment in hospital services, rising throughput and rising numbers of hospital medical staff (slide 21).
- Productivity and efficiency on the hospital side of the service in Scotland is not rising fast enough (slides 29,30) to enable it to deliver the quality of service required, in terms of meeting targets, despite the increasing resources currently allocated.
- Short of substantially increasing investment in the NHS to European levels, the Scottish Government needs to examine whether it has the right balance of financial and manpower trends to deliver a high quality service whilst ensuring equity, the latter achieved by maximising the match between the levels of need and service at a geographic level.
- These difficulties in the acute sector, especially within A&E departments, have distracted attention and diverted resources (slide 18) from upstream factors which play a major role, namely the reduced ability of general practice to act as gatekeeper to the entire service, moderating the demands by the “worried well” for specialist investigation and treatment and preventing or delaying the need for, and use of, emergency services by patients in deprived areas.

Underfunding of care in the community

- Although these problems are multi-factorial in origin, many stem from the historical underfunding of general practice (slide 19), which has been singled out in recent years for real-terms reductions (slide 20).
- Although this is a national, indeed UK-wide problem, it is felt most acutely in deprived and rural/remote areas where unmet need accrues and GPs struggle to provide a service.
- The effects of the underfunding of social care (SC) of the elderly resulting from the council tax freeze (slides 33 and 34) and the reduction in numbers of fully qualified district nurses (DN) (slide 31) have been exacerbated by the maturation of the 1920 baby boom cohort (slide 35).
- This underfunded triad (GP, DN, SC) is important in the aetiology of the steep rise in emergency admission after 2006 in GG&C (slide 13) and the 4 hour A&E compliance failure after 2010 in GG&C (slide 15) and elsewhere in Scotland.
- The weakening of general practice as a gatekeeper to unnecessary investigation and treatment must be considered a factor in the steep rise in demand for elective health care in GG&C since 2000 (slides 7-9).

Imbalance in medical manpower

- The ratio of the hospital consultants to GPs has climbed steadily in both England (slide 23) and Scotland from 0.75 to 1.25 (slides 21,22), and has been very similar in the two countries for a decade (slides 23,24).
- Many of Scotland's policies, directives, targets, funding and manpower trends, and resultant problems appear to be the same as those observed in England (slide 37), raising doubts about the Scottish Government's willingness to exploit devolution of health policy, achieved in 1999, to Scotland's advantage (slide 39).
- GG&C has a particularly high consultant:GP ratio, even when adjusted for incoming cross boundary flow (slide 23).
- The combination in GG&C of relatively high bed provision, high consultant provision, super-specialisation, multiple hospital sites, and relative underprovision of the GP/DN/SC triad favours relative overuse of secondary care overall, but particularly of elective care in the affluent, and emergency care in the socially deprived.
- The 'mismatch' of service provision and need, is the most likely explanation for the falling morbidity and life circumstances index (MLC) (slides 10 and 11) and rising financial over-parity in GG&C (slide 12) in relation to the National Resource Allocation Formula, particularly in recent years.

Integration is unlikely to solve the problems

- Against the national backdrop of a top heavy NHS that preferentially funds secondary care (59% of NHS funding) over general practice (7.6%), the funding of the community health (CH) service budget increased by more than 35% after 2006 to achieve in excess of 17% (slide 19). The remaining 16% of NHS funding went to the other primary care services (dental, ophthalmic, pharmaceutical) that have given up a small amount to fund the rise in CH services.
- We believe that shifting resources from general practice to the community health services (slide 19), and allowing the disengagement by HSCP management of HVs, DNs and other CH professionals from previous close working relationships with general practice, has been a serious strategic error, failing to control or moderate the excessive use of emergency secondary care which rose over the same time period (slide 13), and therefore a significant factor in the cause of the failing performance of the NHS as a whole (slides 36, 40, 42 and 43).
- Despite being mandated by legislation, and underpinned by an unprecedented £8b budget, integration has yet to show signs of viability and cost effectiveness (slides 36, 37, 38). Scotland is currently embarking on an even more ambitious integration programme.
- Social care budgets require adequate funding in their own right. When underfunded social care services are integrated with top heavy health care services, health care managers will be unwilling to relinquish their commitment to current treatment standards (and funding), to fill the hole in their partner's budgets.

The need for transparency

- The lack of openness surrounding the review of how resources are allocated between general practices by the Scottish Allocation Formula reinforces the sense that the distribution of this funding is beyond open scrutiny and debate, even amongst the GPs themselves, because of the unique degree of secrecy afforded to deliberations, on the grounds of commercial sensitivity (slide 41).
- The use by senior politicians of GP manpower data based on a headcount rather than WTEs, and a headcount that includes trainees, allows perpetuation of the myth that 'Scotland has never had so many GPs' (slide 28).

The future

- A range of recommendations is made that emphasises the need to reverse most of the strategic funding changes that occurred between 2004 and 2007 (slides 13, 44-46).
- A key recommendation is to increase the percentage spent on general practice, because of its crucial role, to 12% of NHS funding with a view to expanding the WTE number of principal and salaried GPs by halting premature retirement, retrieving recent retirees and attracting junior doctors to take up unfilled training posts (slide 44).
- Reducing expenditure on hospital services from 59% to 57%, and on community health services expenditure from 17% to 15%, of the national territorial budget, would free up the funding required for general practice.
- The proponents of integration may 'talk up' general practice, but have yet to address or begin to reverse the negative consequences of ten years of relative under-funding of general practice. Scarce resources should not be wasted on trying to enhance the image of general practice while denying the resources it needs.
- It is uncertain whether and to what extent GPs can be substituted in sufficient numbers by nurses, AHPs and pharmacists in the delivery of the high level functions required of GPs (managing risk, uncertainty and complexity), as argued by the BMA, to reduce unnecessary admissions.
- The way to attract doctors to enter and stay in general practice is to invest in the speciality and give the clear message that the main gatekeeper to the NHS is respected, here to stay, and needed more than ever.