Health Committee Inquiry Submission: primary care

Key points

- The Health Select Committee's Inquiry comes at a crucial time for primary care. Primary care, encompassing general practice, dentistry, health visiting, district nursing and pharmacy services, is the foundation on which all other health services are built. It is the first port of call for prevention of ill health; it provides the vast majority of patients with their initial point of contact in the health care system; and it acts as the focus for co-ordinating care around the management of long-term conditions – something of increasing importance to the NHS.
- If we want to reduce our reliance on hospital care – an aspiration that is shared amongst policy-makers and practitioners – investing in well-functioning and sustainable primary care services is vital. Yet we are facing a workforce crisis in general practice, with record numbers of GPs retiring or leaving the profession, and training places unfilled. At the same time, spending on general practice has stagnated, and the potential offered by other professionals, such as pharmacists, to help transform care has not yet been realised.
- Measuring and understanding **quality** in primary care is complex. While data are available on quality and outcomes in general practice, there is a risk that crude data are used to measure performance without taking into account confounding factors and local circumstances. In comparison with our international neighbours, the UK performs well when it comes to primary care quality, particularly on immunisations, although concerns remain about preventable hospital admissions.
- The majority of people report a good experience when they visit their GP, but concerns are mounting about patients' **access** to their GP: patients are waiting longer for appointments and finding it harder to get in touch with their local surgery. Nevertheless, better access to GPs is not always the ultimate goal for patients – some prefer to receive continuous care from the same professional and are willing to trade off access for continuity. Evidence on the demand for seven-day GP services is patchy.

Consultation response
September 2015

- **Spending** on general practice has fallen or flat-lined for the past five years. This is in contrast to spending on hospital doctors and has coincided with growing workloads and increased expectations on GPs. The use of financial micro-incentives can result in quality improvement in specific areas of care but are unlikely to be sufficient to generate the kind of transformation that is needed across primary care.
- The future of clinical **commissioning** is uncertain. GPs are becoming more involved in the new care models proposed under the forward view, and at the same time their enthusiasm with their Clinical Commissioning Groups is starting to wane. The clinical voice in commissioning health care is vital, but it is unclear whether Clinical Commissioning Groups will withstand the changes underway within the NHS.
- Although only a small number of sites in the country are official 'vanguards' for **new models of care**, many other areas are pursuing approaches based on the same principles. Scaling-up general practice has been a trend we have observed over the last decade, yet the evidence base around the impact of such models on quality of care, patient and professional experience and service innovation is still emerging. GPs and other staff need to be given the time and space to innovate and build new relationships to make these new organisational forms work.
- There are significant challenges facing the primary care **workforce**, not least in general practice and primary care nursing, where recruitment and retention remains very difficult. But there are also real opportunities to deploy the skills and expertise of the entire primary care workforce –including pharmacists, physicians' associates, health care assistants and health coaches – more effectively to better cope with the needs of an ageing and growing population. Maximising these opportunities means breaking down barriers to accessing training, careful planning and support for change, and making adequate funding available.
- Areas outside of the remit of NHS England remain vulnerable to cuts at the autumn Spending Review. This includes the NHS training budget, currently held by Health Education England, which could contain the key to up-skilling and redeploying staff across primary care. Cutting this budget at a time of considerable need would be short-sighted and undesirable.

Overview

The Nuffield Trust is an independent health think tank with a strong track record in analysing primary care. We have undertaken research into different models of primary care both in the UK and further afield, with the aim of identifying approaches that may offer a sustainable service that meets the changing needs of the population. Our work has also included in-depth analysis of future models of care that can be delivered through pharmacy.

The Nuffield Trust recently instigated a two-year research project which seeks to understand and assess the impact of new models of primary care provision in England in terms of clinical quality, patient experience, professional experience and cost effectiveness. The research focuses on 'at scale' primary care organisations, such as GP super-partnerships, GP federations, primary care networks, and multi-practice organisations. Alongside this research, we are running a learning network involving 12 well-established 'at scale' primary care organisations.

This submission follows the terms of reference outlined by the committee, drawing on our existing analysis and perspectives to offer insights in each of the six areas within the scope of the inquiry: **quality**; demand and **access**; **funding**; **commissioning**; **future models of care**; and **workforce**.

1. Quality

1.1. Using quality and outcomes data

There is an established body of evidence already available on primary care quality through the Quality and Outcomes Framework (QOF). Other national indicators, such as data on preventable hospital admissions and emergency admissions can also give an indication of the effectiveness of the primary care system.

Using such data to monitor and understand variation in outcomes is vital. However, the use of crude data can be problematic if it is used as a performance measure without adjusting for known confounders. For example, attendance at an A&E department is known to be higher among people living nearer to the service than those living at a distance. Simply comparing raw data may imply a GP surgery close to the A&E department is performing badly in the number of patients attending as emergencies, and this might be taken as a sign that it is providing poor access to services. However, adjusting for distance from A&E may mean that the surgery moves from being an apparent statistical outlier in attendance towards average performance.

Furthermore, the level of deprivation in an area may also lead to confounding factors on many measures of clinical outcomes and primary care use, also requiring adjustment.

The committee will be aware that Health Foundation is working on behalf of the Department for Health to select a cluster of outcome measures for general practice. Better use of data can be a valuable way to understand quality in primary care and boost accountability. However, given the issues with raw data mentioned above, we would urge caution about how such metrics are used and interpreted, and would be concerned if this became a crude benchmarking or scorecard exercise.

1.2. How primary care quality compares internationally

In addition to examining care quality over time, interpreting health care performance in international context can provide another lens through which to understand quality. Our recent publication *Focus on: International comparisons of health care quality* compared quality of care in the UK health system with that of 14 similar countries over time through a comprehensive analysis of 27 care quality indicators collected by the OECD (Kossarova and others, 2015).

We examined nine indicators on the quality of primary care, including immunisation rates, avoidable hospital admissions, and antibiotic prescribing. We found that the UK performs better than most of the comparator countries on five out of nine indicators, including high immunisation rates and lower antibiotic prescribing rates (although antibiotic prescribing is on the rise).

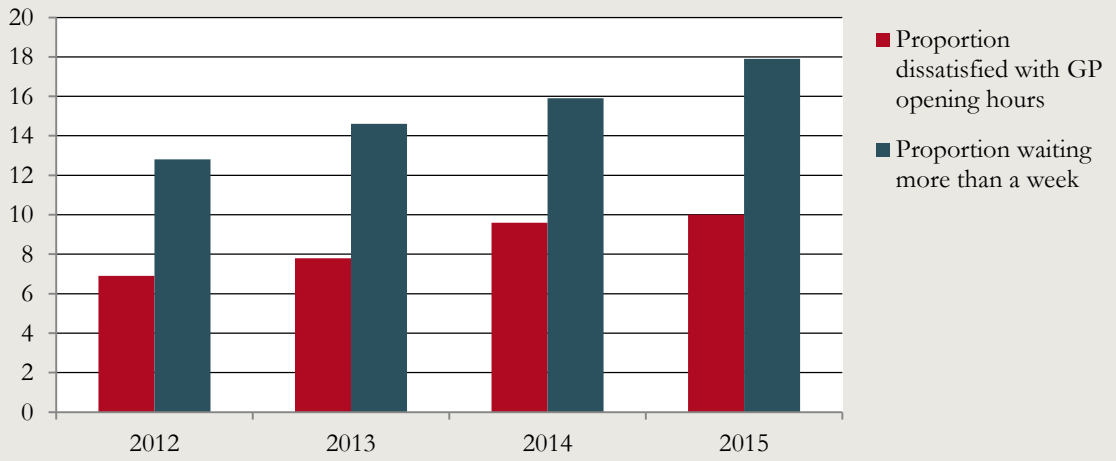
However, rates of potentially preventable hospital admissions for chronic respiratory conditions, including asthma and lung diseases, remain relatively high in the UK. For example, by 2011 there were 61 UK admissions for asthma per 100,000 population, compared to 13.6 in Canada and 11.4 in Italy. We concluded that the UK can and should do more in reducing potentially preventable hospital admissions.

2. Demand and access

2.1. Data on demand and pressure

The so-called 'crisis' in general practice does not seem to be reflected in general patient satisfaction data which suggests that the majority of people report a good experience when they visit their GP. However, a closer look at the latest survey data suggests some indicators moving in the wrong direction. Since, 2011/12, the national GP Patient Survey indicates a year-on-year increase in patients reporting difficulty getting through to their practice on the phone, longer waits for appointments and dissatisfaction with opening hours.

Figure 1: Trends in GP access, 2012–15



Source: GP patient survey, Ipsos MORI

2.2. Continuity of care and access – a trade-off?

The political and media focus in general practice tends to be overwhelmingly on how quickly and conveniently patients can access care. But evidence suggests patients have a broader agenda. A 2007 study found that patients were happy to wait longer to see a GP who was well informed about their case when they had a problem causing uncertainty or needed a routine check-up, suggesting that many patients will trade off speed of access for continuity of care (Turner and others, 2007).

There are scenarios in which timely or convenient access and continuity of care could be in tension, as when initiatives to extend opening hours rely on using a wider pool of clinicians interchangeably. But faster access and continuity of care do not always exist in complete tension - trade-offs made by patients can vary with the type of clinical problem they are experiencing, with people more likely to seek continuity for ongoing or complex problems.

Alongside continuity, other characteristics of good care for people with complex ongoing problems may also come into tension with ease of access. Good multi-disciplinary team working – where GPs work in partnership with staff from other organisations, like social workers, community matrons and mental health nurses – is also important for this group. But this may be harder to achieve if clinicians are spread more thinly across extended hours of practice and therefore less available to meet other staff.

2.3. Additional commitments

In a bid to respond to a perceived desire from patients for better access to GP services, the government announced in June 2015 that GPs will be required to provide seven-day services (Department for Health, 2015). In return, they will benefit from a boost to numbers in the general practice workforce and greater investment in new services and surgeries. How these newly recruited staff are trained, deployed and developed will be critical, especially at a time when general practice is already facing workforce shortages and funding for the NHS is tightly constrained (see point 6.2 below).

Furthermore, the evidence on demand for seven-day services is patchy. A recent pilot project in North Yorkshire was suspended following limited demand from patients for GP opening at weekends (Lind, 2015) and a recent evaluation of weekend GP services in Manchester suggested demand was weaker than during the week (NIHR CLAHRC, 2015). Redesigning general practice is likely to be about much more than just changing opening hours.

3. Funding and finance

3.1. Overall funding for general practice

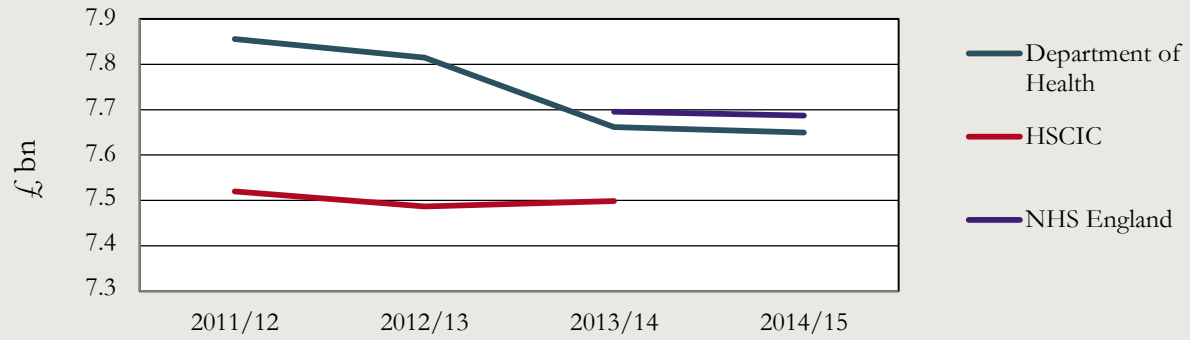
Despite rhetorical emphasis, spending on general practice has fallen or flat-lined for the past five years.

For such a crucial component of the NHS budget, there is no single sum figure for this area of spending, an issue that the Nuffield Trust has explored at the committee's request during the last parliament (Nuffield Trust, 2014). Our opinion is that the most reliable figures are likely to be those produced by the Health and Social Care Information Centre.

But these do not currently extend to the last financial year, whereas two other official figures from the Department of Health and NHS England do.

In the long term, HSCIC's recording of payments to general practice - the first report of which is published this year - may provide a definitive figure. As the graph below shows, however, all these data sources are in broad agreement about a flat or declining budget in recent years.

Figure 2: Measures of general practice spending since 2011/12 in real terms



Sources: HSCIC (2014); Department for Health accounts 2011/12 to 2014/15, latest available here; NHS England accounts

Over this time the workload of general practice has increased (see point 6.3 below). In the acute sector, which has had considerable additional funding over the same period, the financial strain has now been visible for several years. Given these facts, these recent trends should be understood as a very challenging settlement.

3.3. Resources needed to meeting rising expectations

At the same time as a tight financial settlement, there are growing expectations of the roles that GPs should fulfil. *Transforming Primary Care in London: A strategic commissioning framework* (NHS England, London Regional Team, 2014) estimated that investment of between 2 per cent and 5.6 per cent of the current budget is needed to deliver a vision for accessible, proactive and coordinated primary care.

Selected high performing primary care organisations in the United States, such as ChenMed and Iora Health, aim to deliver coordinated, high quality care with a strong emphasis on prevention for patients with complex needs. These organisations spend approximately twice as much on primary care as standard health systems (in the region of 12 per cent of the capitated budget which in the case of Iora Health equates to $50-60 per month compared to $25-30 in other systems) (Luo, 2013).

However, these innovative service providers provide services in new ways, making use of skill mix incorporating remote monitoring and other medical technologies; and delivering care using efficient, standardised systems and processes. Policymakers should consider the benefits of such approaches in the English primary care system.

3.3. Financial micro-incentives

The use of financial incentives to encourage the achievement of targets or to change behaviour is widespread in general practice. The most obvious example is the Quality

Outcomes Framework, which gives out awards based on achievement across 121 indicators.

However, while they can stimulate change in specific areas of care, evidence suggests that incentives such as these are less effective for encouraging complex tasks such a co-ordinating care for patients with multiple needs (Gillam and Steel, 2013). Moreover, they are not effective at stimulating deeper service transformation and are blunt instruments, which can distort priorities and detract from patient care.

Our recent review of the levers for change in general practice suggested that a different balance is needed between creating financial incentives for change and investing in other forms of developmental support to practices. Such support should address skills deficits, strengthen inter-professional working relationships, build leadership capability and develop new organisational systems and processes. (Rosen, 2015)

4. Commissioning

4.1. The future of Clinical Commissioning Groups

Despite being less than three years old, Clinical Commissioning Groups face an uncertain future. NHS England's Five Year Forward View called for a shift from traditional NHS structures to provider models, which would unite hospital care, community care and general practice (NHS England, 2014). These new arrangements have considerable implications for the way that local services are budgeted, as well as the role of Clinical Commissioning Groups, which could wither away as new structures based on scaled up general practice or hospital-led commissioning move in.

Furthermore, the move towards local devolution and the pooling of health and social care budgets, as proposed in Manchester, could see CCGs' roles diminished.

The Nuffield Trust supports the direction of travel outlined in the Forward View and has welcomed a shift towards provider-led reforms. However, we would urge policymakers to ensure that, whatever structures local areas pursue in organising and paying for health care, the clinical voice in commissioning remains strong.

4.2 GP leadership in Clinical Commissioning Groups

The Nuffield Trust and the King's Fund are carrying out a joint project to track six case study CCGs over the years, examining their development, how they engage clinicians, and whether they are coping with pressure and new demands (Holder and others, 2015; Naylor and others, 2013). We found that among CCG leaders, the enthusiasm seen in the first year after the establishment of the new bodies had started to wane. Less than half reported that they had the support, time and resources to undertake their role effectively.

There were concerns about how long leaders would remain in post given these factors and given the emergence of dynamic roles in new scaled up GP provider networks. There were concerns around succession planning for leaders beyond the "usual suspects" who had initially become involved.

With progress towards CCGs playing a role in commissioning of GP services ("co-commissioning"), our research suggests a growing confidence in the legitimacy of a role developing primary care. However, there will be several obstacles:

- CCG members typically do not feel that performance management of GPs is an appropriate role for the body to carry out.
- There are strong concerns from leaders about having the time and support to carry out a wider role.
- The potential for conflicts of interest is likely to increase, and will need to be carefully dealt with.

5. Future models of care

5.1. The rationale for change

The need for transformational change in general practice is well established: a healthy person needs a different kind of appointment from an older person with several long-term conditions. For the former, rapid access through telephone and e-mail consultations is already available in some areas for common ailments. This needs to become the norm, while longer appointments offering continuity with a GP must also be available for patients with complex problems like diabetes, dementia or lung disease.

5.2 Scaling up general practice: the evidence

Our work in primary care has identified a trend towards the 'scaling up' of general practice with individual practices joining together under different arrangements. These larger units of delivery enable providers to extend the range of services offered and may also enhance the sustainability of practices. These different organisational forms have been taking shape since the NHS (Primary Care) Act in 1997 but have accelerated in recent years. Indeed, the Five Year Forward View set out a vision of future primary care centred around large, integrated delivery units. We have also observed similar developments in other countries such as New Zealand, the US, Canada and the Netherlands.

Although the national Vanguard programme has acted as a catalyst for the development of new models, other non-Vanguard areas are pursuing approaches based on similar approaches. Some of these examples have been developing over the previous decade. These established organisations are the subject of a research programme being undertaken by the Nuffield Trust.

A key observation from our work is that, whilst scale offers some benefits, there is no one organisational model of primary care that should be advocated across the board. Rather, the local context and needs of the local population should determine the form. A second emerging finding is the need for different management skills from those found in general practice and for close collaboration between clinical and managerial leaders in these emerging organisations. Finally, whilst there appear to be benefits to scaling up in terms of sustainability, the evidence base around the impact of such models on the quality of care or the patient and professional experience is still emerging.

5.3. Freeing up time and supporting initiatives to transform services

Adapting to new models of care is not a straightforward process: time is needed to build shared goals and values about new ways of working; to develop innovative processes of care and to build effective inter-professional working relationships. These development challenges need time out of the day job and expert facilitation to build trust between different professional groups and teams. One of the greatest challenges facing the primary care workforce will be to deliver routine services to required standards whilst also making time for transformational change (Rosen, 2015).

6. Workforce

6.1 Staffing

There are real pressures affecting the primary care workforce - most notably in general practice, which has not seen the same growth in staff numbers as hospital doctors (a rise of 4.8 per cent in the numbers of full-time equivalent GPs in England between 2010 and 2014, compared to a 7 per cent rise in hospital doctors according to the HSCIC). This is despite considerable growth in activity (although data on activity levels is patchy – see point 6.3 below).

Moreover, the numbers of GPs saying they intend to quit the profession has risen: almost 1 in 10 GPs under the age of 50 say they intend to 'quit direct patient care' in the next five years, a rise of over a third between 2010 and 2012. (Hann and others, 2013). Last month a sixth of GP training posts in practices were unfilled after two rounds of recruitment (Rimmer, 2015).

6.2. Boosting the primary care workforce

The Government has pledged to increase the GP workforce by 5000 by 2020. With GP staffing numbers a concern, investing in more staff is the right aspiration. However, we would urge the committee to question the impact of applying fixed targets for staff numbers in this way, and have previously warned that pledges to recruit a specific number of doctors or nurses may do more harm than good (Nuffield Trust, 2015). Targets may leave significant workforce gaps and miss opportunities for workforce innovation.

Furthermore, setting fixed numbers for extra GPs will not solve wider problems of recruitment and retention. General practice is often seen as an unattractive career option for trainee doctors; and future shortfalls will emerge as GPs retire. The recent report by the independent Primary Care Workforce Commission – of which our Director of Healthcare Systems and Workforce, Candace Imison, was a member – outlined a number of proposals for improving the recruitment and retention of GPs (Primary Care Workforce Commission, 2015). The commission endorsed the 'Ten Point Plan' for building the general practice workforce recently published by RCGP, BMA, NHS England and HEE.

This included proposals such as promoting general practice in medical schools, enhancing recruitment to specialist training schemes for general practice, and investing in schemes to retain doctors in the workforce. The Commission also recommended that efforts should be made to retain experienced doctors who are nearing retirement by allowing them to adopt a 'portfolio' approach and diversify into other areas. We urge the committee to support these proposals.

Finally, the committee should be mindful that the shortages of GPs are matched by equally serious but less well publicised shortages in primary care nursing. Like general practice, primary care nursing also struggles to attract trainees and faces the impact of large numbers of retiring nurses over the next decade. For this reason, the Primary Care Workforce Commission has rightly highlighted the need for measures equivalent to the Ten Point Plan agreed for GPs to improve recruitment and retention in primary care nursing.

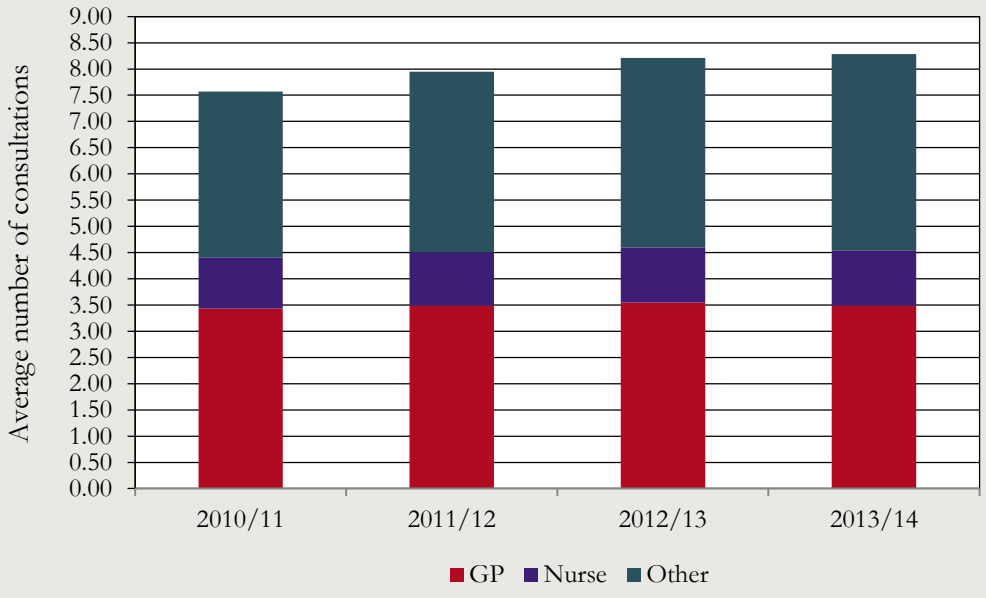
6.3. GP workload and regulation

There is no national data set on GP workloads, and no national database of how many consultations are carried out, where, or by which staff group. The last nationally representative study was carried out at the University of Nottingham, which examined trends in the year 2008-9 (Hippisley-Cox and Vinogradova, 2009). Extrapolations from this work, now seven years old, are the basis for claims usually made about GP workloads rising since 2010.

To try and address the lack of reliable evidence on GP workloads, the Nuffield Trust last year acquired data held on a private basis by the Clinical Practice Research Datalink, which recorded consultation trends across a sample of 337 practices (Curry, 2015). This did not include the information we would need to make the sample nationally representative, and there is the possibility that coding error also swayed the results.

Nonetheless, we were able to see clear trends. From 2010/11 to 2013/14, consultations in total rose around 11 per cent. The number of consultations per person per year registered on a practice list also rose – from 7.6 to 8.3. However, it is noteworthy that consultations with GPs themselves only rose by around 2 per cent (from 3.43 consultations per person in 2010/11 to 3.49 consultations per person in 2013/14), in the context of a workforce which also grew by around 2 per cent in the same period. We speculate that if pressure on GPs has sharply increased, it might be more related to an increase in other tasks. Anecdotally, GPs may be spending more time than they used to co-ordinating care the care their patients receive with hospitals and local authorities.

Figure 3: Crude consultation rates per person–year by clinician type (England)



When considering workload pressures on general practice, policymakers should therefore also take into account the extra tasks performed by GPs – from liaising with other care providers, participating in multi-disciplinary meetings, following up tasks transferred from hospital doctors and responding to requests for information from schools and employers.

In addition, some GPs are devoting time to clinical commissioning and emerging GP provider networks. Organisations such as the NHS Alliance and NAPC have highlighted the negative consequences of over-regulation and red tape in general practice, and our own analysis of the GP role in Clinical Commissioning suggests the volume of administration involved in commissioning is onerous (Holder and others, 2014). The Government's 'new deal' for general practice is right to highlight the need to examine this, but balancing the need for accountability without resulting in over-regulation is a perennial problem facing the organisation of health services.

6.4. Training and upskilling the workforce

There is wide variation across the country in how much access and time NHS staff have for training. Access is a particular problem for non-medical staff across the primary care workforce, whilst training can be particularly difficult to arrange in small GP practices, which may lack opportunities and the resources for adequate cross cover. To tackle this, we would urge policymakers to support initiatives that give staff groups protected time for training and development.

In recent years, Health Education England has promoted the establishment of local Community Education Provider networks to promote learning across health care professions in a way that is tailored to the needs of the local population. These networks provide opportunities to help address the problems described above regarding lack of consistent access to training. But, while they are up and running in some areas of the country, coverage appears to be patchy. We would therefore urge the committee to follow up on the progress and support for Community Education Provider Networks.

The ultimate success of these networks depends on how appropriately they are financed – and with the training budget for the NHS potentially under threat at the autumn Spending Review (see section 7 below), we would urge the committee to seek assurances that funding for training in primary care will not be undermined.

The desire to shift care out of hospital and into the community will also have implications for the training of GPs and other primary care practitioners. We know that there is currently wide variation of skills and capacity of current GPs, so hospital specialists will need to redirect some of their time to the education of GPs. There is also scope for primary care nurses and other professionals, such as pharmacists to take on a much greater proportion of the primary care workload – but they will require training to do so.

6.5. Improving skill mix and developing new roles

There are considerable opportunities to enrich and broaden the skill mix of staff in primary care – extending the roles of nurses and pharmacists; using physicians' associates; obtaining greater input from staff with specialist skills (including hospital specialists, allied health professionals, mental health and child health professionals); and using support staff to reduce the administrative burden on GPs. Some of highest performing primary care systems are already transforming their workforce in this way in order to rebalance the services they offer from the treatment of illness to focus more on prevention and wellbeing.

Developing this broader skill mix provides opportunities to address current workload issues and improve the quality of care, particularly for those with long term conditions. They could also help save money, although we would caution against the assumption that

broadening skill mix automatically results in significant financial benefits. What is clear is that the introduction of new roles requires careful planning and support and close attention to quality assurance and mentoring for staff undertaking new work. Practices should first analyse their clinical caseload in order to decide on the skills that will meet the needs of their practice population.

New roles such as physicians' associates are hampered by their inability to prescribe medicines. They need to be formally regulated in order to enable this and we would urge the committee to support this change.

7. Primary care and the 2015 Spending Review

Despite the Government's welcome pledge to increase the NHS budget by £8 billion by 2020, the November Spending Review could have worrying implications for primary care. This is because of the vulnerability of spending lines affecting primary care that sit outside of the NHS England budget.

The most obvious of these is the budget for Health Education England, which sits within the Department of Health but would not necessarily be covered by the protection offered to the NHS. Some 67 per cent of HEE's budget is spent elsewhere in the NHS, funding the work-based training of post-graduate medical and non-medical staff. Cuts would mean a large proportion of this cost falling back on NHS commissioners or providers, with the end result of the NHS not being able to train the staff it needs to transform care for the future.

A further area of vulnerability affecting primary care is public health, which straddles Department of Health and local authority budgets. Reduced capacity in public health is likely to have a knock on impact on the quality of primary care: if funding is cut to preventative services like sexual health, immunisation and health visiting, the consequences will be felt most acutely in GP surgeries and other primary care settings. Similarly, further cuts to social care will also have a knock on effect on primary care.

References

Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester (2015) NHS Greater Manchester Primary Care Demonstrator Evaluation. National Institute for Health Research

Curry N (2015) Fact or fiction? Demand for GP appointments is driving the 'crisis' in general practice. Nuffield Trust.

Department of Health (2015) Jeremy Hunt sets out the first steps in a new deal for GPs.

Gilliam S and Steel N (2013) The Quality and Outcomes Framework—where next? BMJ 2013;346:f659.

Hann M, McDonald J, Checkland K, Coleman A, Gravelle H, Sibbald B and Sutton M (2013) Seventh National GP Worklife Survey. University of Manchester.

Hippisley-Cox J and Vinogradova Y (2009) Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch database. HSCIC.

Holder H, Robertson R, Ross S, Bennett L, Gosling J and Curry N (2015) Risk or reward? The changing role of CCGs in general practice. Nuffield Trust and the King's Fund.

Kossarova L, Blunt I and Bardsley M (2015). International comparisons of healthcare quality The Nuffield Trust and The Health Foundation.

Lind S (2015) 'PM's seven-day GP access pilot scrapped after proving 'unpopular with patients'', Pulse, 11 June 2015.

Luo E (2013) SOAP Notes on the Business of Health Care: Iora Health. Institute for Health Improvement Open Blog

Naylor C, Curry N, Holder H, Ross S, Marshall L and Tait E (2013) Clinical Commissioning Groups: Supporting improvements in general practice? The King's Fund.

NHS England (2014) The Five Year Forward View. NHS England.

NHS England, London Regional Team (2014) Transforming Primary Care in London: A strategic commissioning framework

Nuffield Trust (2014) Clarification: spending on general practice

Nuffield Trust (2015) Health and social care priorities for the Government: 2015–2020

Primary Care Workforce Commission (2015) The future of primary care Creating teams for tomorrow

Rimmer A (2014) A sixth of GP training places are unfilled after two recruitment rounds. BMJ Careers, 13 Aug 2015.

Rosen R (2015) Transforming general practice: what are the levers for change? Nuffield Trust.

Turner D, Tarrant C, Windridge K and others (2007) Do patients value continuity of care in general practice? An investigation using stated preference discrete choice experiments. *Journal of Health Services Research & Policy* 12, 132-137.

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