

Interim Report – January 2017

1. Background

1.1 There is broad and national acceptance that primary care is facing unprecedented pressures of a multi-faceted nature in all parts of the country. The range of these pressures is complex and the impact is not easy to describe. There is anecdotal evidence that these pressures are more severe in the inner city and consequently, Healthwatch is concerned to understand the nature and causes of these pressures.

1.2 Nottingham has a diverse and multi-cultural population with high rates of deprivation and poverty - the city is ranked the eighth most deprived district in the Indices of Multiple Deprivation¹. Inner city Nottingham in particular has higher still levels of deprivation and significantly lower life expectancy than national figures². It also experiences high levels of migration from countries across Europe and the Asian and African continents, some of whom are fleeing violence as well as other hardships, some moving for economic reasons within the EU.

1.3 Healthwatch Nottingham (HW) has been aware that pressures have been reported by some practices in Nottingham in the past 12 months and that Nottingham City Clinical Commissioning Group (CCG) has received a number of applications from GP practices to temporarily close their patient lists (to new registrations) in an attempt to manage pressures in the short-term. In addition there has been requests from practices to reduce their practice boundaries in attempt to manage their challenges. HW is also aware that the CCG has commissioned a Health Needs Assessment of the 11 practices within the Care Delivery Group (CDG) that covers some of the most deprived parts of the City - namely Arboretum, Radford, Lenton and Dunkirk - categorised as CDG4.

1.4 It is important that as a local HW we try to understand the implications for patients, where practice closures, list dispersals and temporary list closures reduce access to primary care services. Therefore, we have chosen to undertake a case study of a health centre (Mary Potter Centre) at the heart of inner city Nottingham which we hope will lead to a better understanding of the pressures on inner city primary care and will be in the best interest of patients in this area trying to access primary care. The Mary Potter Centre houses three general practices: The Fairfields Practice; The Forest Practice; and High Green Medical Practice. We acknowledge that local CCG is working with primary care providers and NHS England in order to address the matter of repeated temporary list closure and we as local HW intend to contribute to this discussion. Our aim is to ensure that patients are not negatively impacted due to lack of access to primary care, and that there is no inequality of service provision based upon where they live.

1.5 The aim of this report is to understand factors which affect primary care provision in inner-city Nottingham, using the Mary Potter Centre as a case study, and by doing so determine what factors present differing or increased pressures on inner city general practices.

¹ Nottingham Population Hub (2016).

<https://nottinghaminsight.org.uk/insight/partnerships/voluntary/population.aspx>

² Care Delivery Group 4 Health Profile (2015).

<https://nottinghaminsight.org.uk/f/139191/Library/Public-Health/Care-Delivery-Group-Health-Profiles-2015-16/>

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2. Our Approach

2.1 In order to gain a fuller appreciation of the issues impacting on GP list closures we first undertook a literature review to understand the broader pressures on General Practice in the UK. This included - but was not limited to - 'Understanding pressures in general practice'³ published in May 2016 by The King's Fund. Data was taken from the latest Care Quality Commission (CQC) reports available. Reports published by other Healthwatch - both at local and national level - around pressures on primary care provision or difficulties faced by patients in GP practices were also reviewed.

2.2 It was clear that speaking to registered patients at the three practices in the case study would not illicit insights that would uncover the issues that affect the Mary Potter Centre. Patients that are already registered with one of the three practices would be unaffected by temporary list closures. It would also be difficult to gain access to patients that are unable to register due to list closures. It was therefore decided to focus on the experiences of professionals providing primary care services within the centre and Nottingham City CCG.

2.3 HW staff and volunteers conducted semi-structured interviews with two of the three practice managers at Mary Potter Centre. Semi-structured interviews were also conducted with a GP that had formerly worked at the centre and the Assistant Director of Primary Care Development for Nottingham City CCG. Participation for interviews was on a voluntary basis and interviewees were informed that they could withdraw from the interview at any point. Before the interviews were conducted individuals were fully informed about the project and gave consent to their interview being recorded. All interview recordings were transcribed verbatim. These transcripts were coded to identify key aspects of their experiences and views related to the project objectives. An online survey was distributed amongst all GPs currently working in the centre. The results of the GP surveys are not included in this interim report as data is still being collected.

2.4 HW was also party to submissions made by all three practices within the Mary Potter centre as part of the requests to close (temporarily) patient's lists and were also sent copies of the business case made in response to the Primary Care offer from Nottingham City CCG.

3. Findings

3.1 Having undertaken the research outlined above, it became evident that four main themes underlie the increased or additional pressures on the Mary Potter practices, ones which are likely to be shared by other inner city practices in Nottingham and elsewhere in the country. These are:

- The high levels of deprivation experienced by the patients that use services at the Mary Potter Centre.
- Issues caused by the nature of the patient's demographics and in particular, the number of patients that don't have English as a first language.
- Pressures on staff members, namely recruitment and capacity.

Patient Deprivation

³ The King's Fund (2016). <https://www.kingsfund.org.uk/publications/pressures-in-general-practice>

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3.2 Nottingham City Council's Health Profile shows that CDG4 - the CDG that the Mary Potter Centre falls within - is relatively deprived, with over half of the area's population relating to the poorest 20% nationally⁴. It is a reasonable assumption that this level of deprivation is consistent within the patient lists at the Mary Potter practices. The CQC's latest report (December 2016) for High Green Medical Practice states that *"the income deprivation affecting children of 33% is higher than the national average of 20%. The level of income deprivation affecting older people of 43% is higher than the national average of 16%."*⁵ The King's Fund has found that *"not only are people living in areas of worst deprivation more likely to access services, they are also using them more frequently."*⁶

3.3 It is likely that these deprivation figures would be higher but are masked by a high student population though in the area. 50% of all residents in Arboretum Ward, where Mary Potter Centre is based, are aged between 15 and 24. This is over twice as high as the percentage overall in the City of Nottingham (23%), and four times higher than the national average (13%)⁷. This would indicate that the levels of deprivation experienced by older residents that were not students would be higher than the CDG4 figures suggest.

3.4 A 2014 study in The British Medical Journal, quoted by the King's Fund states that *"someone aged 50 in the most deprived quintile consults their GP at the same rate as someone aged 70 in the least deprived quintile."*⁸ This is supported by the practice manager HW spoke to, who told us that:

"When you have deprivation... our 40-60 year olds need as much care as a 70 year old."

The additional pressure put on practices such as those Mary Potter Centre that experience a high level of patient deprivation is further underlined by the King's Fund report: *"As the level of deprivation increases, so does the number of chronic conditions."*⁹ In addition to this, the report states that the largest proportional increases in patients having more than one serious health issue is found with the 40% of people nationally that are most deprived.

Changing Patient Demographics

3.5 The member of staff interviewed from Nottingham City CCG told us that:

"I think that sometimes it is particularly harder for the inner city practices and I think part of that is because of the demographics."

Looking at each practice individually shows that High Green and Forest have comparable demographics in their patient lists. In their latest report for each respective provider, the CQC states that the Forest Practice *"provides general practice services to 5479 patients."*

⁴ Care Deliver Group Health Profiles (2015-16)

<https://nottinghaminsight.org.uk/f/139191/Library/Public-Health/Care-Delivery-Group-Health-Profiles-2015-16/>

⁵ CQC - High Green Medical Practice - Dr Z Khan <http://www.cqc.org.uk/location/1-510032732/reports>

⁶ The King's Fund (2016). <https://www.kingsfund.org.uk/publications/pressures-in-general-practice>

⁷ Ward Profile – Arboretum

https://nottinghaminsight.org.uk/insight/static_content/Arboretum.pdf

^{8,9} The King's Fund (2016). <https://www.kingsfund.org.uk/publications/pressures-in-general-practice>

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About 65% of the practice population are white British and 35% are from black and minority ethnic (BME) groups¹⁰.

3.6 In comparison, High Green provides care to a significantly larger list size, 9805 patients as of April 2016, although the demographics are similar. CQC notes that *“the practice has a high proportion of patients from ethnic minorities, 24.9%, compared to the England average of 17.1%. The largest ethnic minorities are South Asian (47.6% of the practice population) and Eastern European (15% of the practice population).¹¹”*

3.7 Fairfields Practice has a far higher proportion of BME patients that make up their list of 7529 people. CQC notes that; *“31.4% of the population is British/Mixed British, 17.4% is Pakistani, 5.3% is Caribbean, 4.7% is Indian/British Indian, 4.6% is Polish and the remaining 36.6% of the practice is made up of 47 separate ethnic groups.¹²”*

3.8 HW found that having a diverse population is not *in itself* the issue that has most impact on these three practices, as the practice manager we spoke to reflected:

“When the centre was opened eight and a half years ago, it was made for the local demographic and the local population.”

The issue that puts additional pressure on the three practices is that during recent years these demographics have changed. Most importantly, the area supported by the Mary Potter Centre - even discounting the student population - has a high transitory population.

3.9 Before the patient list was closed Fairfields Practice *“experienced a high turnover of patients, registering on average of 70 new patients a month, many of the new patients are new to the area.¹³”* CQC also notes that at High Green *“the patient group is transient and this migration of people has seen the number of patients join and those that have left in a 12 month period give a turnover that has ranged between 12% and 22% in recent years¹³.”* This high turnover presents a burden on administration, due to the extra time it takes administrators to register new patients time will also be spent when patients leave - summarising notes and sending to their new practice. As the practice manager pointed out:

“You’ve always got a third of your list being rotated round... so our list looks stable but what it’s not showing and what you wouldn’t see by looking at data is actually the amount of change.”

3.10 Another direct consequence of the changing demographics within the three practices is the impact of patients that do not have English as a first language. The practice manager calls the area supported by the Mary Potter centre:

“An area with a huge concentration of multi-language citizens.”

The CCG representative noted that new patients to the practices:

“Tend to have to have longer appointment times, because they need translation services.” Acknowledging that these longer appointment times *“has an impact on the access that they [the practices] can provide to the whole population.”*

¹⁰ CQC - Forest Practice <http://www.cqc.org.uk/provider/1-199711407/services>

¹¹ CQC - High Green Medical Practice - Dr Z Khan <http://www.cqc.org.uk/location/1-510032732/reports>

^{12,13} CQC - Fairfields Practice <http://www.cqc.org.uk/location/1-550105271/reports>

¹³ Care Quality Commission

http://www.cqc.org.uk/sites/default/files/new_reports/AAAG0016.pdf

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The GP formerly employed by a Mary Potter Centre practice described that it is not possible to conduct an appointment with a patient that does not have English as a first language in under 10 minutes, and that 20 minutes could feel rushed:

“I found it a challenge... you may be able to just cover one thing... but there may be things that I felt were important as well or the patient did and then we’d struggle to cover that.”

3.11 Nottingham City CCG has commissioned a service for asylum seekers, providing enhanced health checks:

“Recognising that they need a longer appointment.”

Although the CCG provided an interpretation service - praised as “exceptionally good” by the practice manager - comes at no financial cost to practices, a patient using the translation service will require a ‘double appointment’. As the practice manager explains;

“If you’ve got twenty appointments in a morning but half of them have to be double appointments, you’re actually reducing your access and that actually disadvantages our patients compared to a practice down the road.”

The GP now employed elsewhere echoes this view, believing that having a higher proportion of double appointments hinders the practices financially:

“The NHS needs to recognise that non-English speakers take double the time of English speakers and so the cost of a non-English speaking patient is significantly higher than the cost of an English speaking patient to manage.”

They also outlined the added complexity of using the service, noting that:

“We had locums on occasion really quite daunted about the thought of having to have an interpreter.”

Practice Capacity

3.12 The complexity of needs associated with high deprivation levels and changing population demographics amongst the Mary Potter Centre practices’ patients has two significant consequences.

- As previously mentioned, the requirement for many ‘double appointments’ that reduce the number of patients a practice can see each session.
- The increasing number of patients wanting to access the practices. Both significantly affect the three practice’s capacity.

3.13 We know that the demand for GP services has increased everywhere. The King’s Fund notes that “activity in general practice has increased significantly over the past five years¹⁴.” The practice manager told us that all three practices have:

“Grown our list sizes considerably compared to eight years ago, they have more than doubled in that time.”

This presents two problems that were both acknowledged by the practice manager and the CCG representative: the practice’s physically have no room to treat more patients; and are unable to recruit GPs to meet demand.

¹⁴ The King’s Fund (2016). <https://www.kingsfund.org.uk/publications/pressures-in-general-practice>

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3.14 It is evident that were it possible, some of the practices within the Mary Potter Centre would be willing to expand. The CCG employee notes:

“There are practices there that would be happy to grow but their premises, they’re not able due to the space that they’ve got.”

This is echoed by the practice manager, who states:

“Within the building and within the structure there has been no capacity to grow.”

All three practices are located next to one another, with general practice being one of many primary care services offered at Mary Potter.

“As the building’s evolved... simple things like putting in the library, which is a great facility and what it does is bring more people into the centre but actually what it doesn’t do is it doesn’t give us the capacity to be able to serve new people.”

3.15 Nationally there is an issue with the number of GPs. The King’s Fund states *“there is a shortage of GPs, which is predicted to worsen.”*¹⁵ Their study found that only *“31% intended to do full-time clinical work one year after qualification.”*¹⁶ This national trend appears to be more severe for the Mary Potter practices. The practice manager remarked;

“Four years ago when we put an advert for a new partner or a GP we got sixty applications. We have been advertising for a GP for a year and got zero.”

The CCG acknowledges that:

“Workforce is a big one [issue], so certainly recruiting and retaining GPs and I think that that sometimes is particularly harder for the inner city practices.”

The GP interviewed agrees with this sentiment:

“I think it’s always been a less attractive practice to work in because of the deprivation. People are aware that that in general carries a higher workload than a more suburban practice... you have to have a genuine interest in wanting to work there because it is definitely, definitely way harder than working here in this [their current] practice.”

4. Conclusions

4.1 This is an interim report, written in order to ensure that some of our initial findings could be considered as part of the Health Scrutiny Committee discussion. Consequently, it would be unwise to draw firm conclusions with not all data collected. It is nevertheless apparent that the combination of deprivation and changing demographics which we have highlighted in this case study has created pressures which are unique to the inner city. When combined as they are at Mary Potter with a lack of physical capacity then this has a direct impact on access to services and creates a significant challenge to those tasked with ensuring that every citizen has equal access to primary health care.

¹⁵ The King’s Fund (2016). <https://www.kingsfund.org.uk/publications/pressures-in-general-practice>

¹⁶ The King’s Fund (2016). <https://www.kingsfund.org.uk/publications/pressures-in-general-practice>