

# Monitor

Making the health sector  
work for patients

**Responses to Monitor's  
call for evidence on  
the general practice  
services sector in  
England (GP services):  
local medical  
committees**



This document contains non-confidential local medical committees' written responses to our [call for evidence on GP services in England](#). We have published these responses with permission, in full and unedited, except for limited circumstances where text has been removed as it was identified as being confidential, or identified individual GPs or GP practices.

Alongside this document we have published responses from patients, patient representative groups, clinical commissioning groups, representative bodies, providers and other respondents [here](#).

These published submissions form part of the information considered in our [discussion document](#) following Monitor's call for evidence on GP services, which sets out what we have heard and proposed further work.

## **Local medical committees (LMCs)**

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Monitor  
Wellington House,  
133-155 Waterloo Road,  
London SE1 8UG

2<sup>nd</sup> August 2013

Dear Sir/Madam

### **Response to the Call for Evidence on General Practice**

The Beds and Herts LMC Ltd is the statutory body that represents the GPs in Bedfordshire, Luton and Hertfordshire. We are writing in response to your call for evidence on General Practice in England. We realise that the deadline has passed, but given the very short timescale for providing this important information we decided to send this to you anyway for your information.

Your call for evidence asked for submissions that showed where general practice was not working in the best interests for patients. We were concerned that this set a clear tone that you were looking for negative stories rather than starting from an objective position.

We believe that there are three specific pressures that general practice currently face which impact on services for patients: the increased workload; the increased complexity of the work; and the low morale of GPs. These three pressures must be taken into account when considering the future of general practice.

The attached document was written by one of our LMC members, a local GP of long standing, and ably illustrates these points.

We hope that you will consider this evidence as part of this consultation.

Yours sincerely

Dr Peter Graves  
Chief Executive



1. The workload is increasing.

GPs are doing far more now than when I came into General Practice 21 years ago. At that time most diabetics were under hospital care and about 2% of a Practice population were diabetic. Now the number is 5-8% and hardly any attend the hospital specialists for their routine care. 20 years ago patients routinely attended hospital to be started on ACE inhibitors – imagine if that were the case now with these drugs in routine use. Patients with Atrial Fibrillation (AF) were not treated with warfarin, now of course a Practice has large numbers of AF patients on warfarin and are encouraged to search for as yet undiagnosed AF, and most monitoring is done by the Practice. Statins are now in widespread use and they too are monitored by Practices. Hypertension is treated far more aggressively as is diabetes, hypercholesterolaemia, RA to name a few chronic conditions.

2. The complexity of the work is increasing.

The population is ageing greatly. Increased survival rates from many conditions which previously proved fatal plus the ageing population has meant that GPs workload has become much more difficult due to the increasing complexity of patients having multiple co-morbidities. There is no doubt that the role of the GP is far more complex and much difficult than 20 years ago. A further consequence of ageing is that GPs have many more patients with dementia diagnosed many of whom have complex other medical and social problems and whose carers also often have multiple medical problems as well. It is not just that much more is done in GP but it is also much more difficult as well. Alongside ageing we also have many more young patients with severe previously fatal conditions (starting with severe congenital heart disease, then cystic fibrosis and more recently severe mental and physical disability). Patients who would previously died in childhood are now commonly surviving into adulthood and those who would previously commonly died in young adulthood (eg Down's) are now routinely surviving into middle age and beyond. It is worth noting that there are not many adult physicians used to dealing with severe mental and physical disability and handicap just as previously there were no adult physicians familiar with congenital heart disease. These types of patient have also increased the complexity of the workload faced by GPs.

3. GP morale is at a very low point and seems to be worsening.

GPs are now under more strain than ever before. The increased workload, ever increasing bureaucratic demands for accountability from revalidation, CQC and commissioning requirements and falling incomes year on year (being paid less despite increased work) have led to more and more GPs becoming stressed and depressed. This is not good for patients.

**To:** Monitor - in response to the Call for Evidence on General Practice Services in England.

**From:** Derbyshire Local Medical Committee

**Date:** 18<sup>th</sup> July 2013

Derbyshire Local Medical Committee (LMC) is a statutory body, established under the NHS Acts, to represent the interests of GPs who provide primary medical services to patients in Derby and Derbyshire.

The LMC is dismayed by the short timescale afforded to this call for evidence. One month is a woefully short time in which to gather evidence about a matter as important as the model of provision of primary medical services in the NHS in England, especially at the start of the holiday season. Furthermore, the LMC is not aware that the call for evidence has been widely publicised.

Derbyshire LMC believes that there is a fundamental incompatibility between the provision of a universal, comprehensive service available to all citizens on the basis of need and a model of provision based on competition and market forces. Market theory relies on the possibility of failure of providers within the market. Even in the best regulated market there must be the possibility of failure – this may occur suddenly and unexpectedly and may be for reasons of lack of profitability, even when the standard of provision is high. The risk to patients of being left without access to primary medical care for even a short period is unacceptable. The LMC's view is that there needs to be a defined provider of last resort that is capable of providing a service at short notice, if necessary.

Medical care in the NHS is delivered on three axes – primary/secondary, community/hospital and generalist/specialist. Most people in this country think of their primary care (the care that they are able to access directly) as being provided by generalists in the community and this is the basis of list based general practice. Other models (e.g. primary specialist care in the community) are theoretically possible but their widespread introduction would fundamentally alter the nature of healthcare. The current model is, in effect, a lifetime contract between the patient and the practice ('cradle to grave care'). Patients with long term or severe medical conditions appear to value this although other members of the public with occasional, intermittent episodes of ill-health or those with undiagnosed conditions appear to place less value on it. Care given by generalists is, on the whole, more likely to be holistic than care given by specialists. Additionally, if primary care contracts are broken up to make them more open to competition, the care of patients is likely to become more fragmented, even if the different contracts are being delivered by generalist medical professionals.

The history of competitive tendering for primary care contracts in Derbyshire has been chequered. Since 2004 six contracts have been tendered. Four were won by external providers with no track record of provision in Derbyshire, ranging from a large multi-national corporation to GP led organisations based in other parts of the country. Of these, two have resulted in non-renewal of contracts with subsequent list dispersal (causing major inconvenience to patients), one has changed ownership four times with changes in staff,

management style and the way services are offered to patients and only one remains stable. Two contracts were won by existing local practices (one with no competition) and these have remained stable, providing high quality care.

The use of the market to promote competition tends to lead to larger organisations dominating provision within that market (and hence the need for regulation to prevent anti-competitive behaviour as the number of players diminishes). Primary generalist health care in this country is largely provided by small organisations which have no desire to grow significantly. The basic service provided is the one to one consultation between a patient and a health care professional. In the current model of relatively small partnerships the controlling minds of the organisation (the partners) are generally providing the fundamental service themselves and are in regular contact with the patients (customers) at the operational level. This should lead to organisational problems being detected early and corrected in a timely manner. The Francis Report has shown how detachment of the controlling minds from the basic business of providing care led to poor quality of care, demoralisation of the workforce and pursuit of objectives that did not chime with patients' wants and needs. Derbyshire LMC believes that the sustained high level of trust in GPs demonstrated in survey after survey can be largely attributed to the model of provision by small stable organisations.

As noted above, there is a significant risk that the introduction of competition into the primary care sector will lead to disaggregation of elements of patient care (e.g. diabetes care, psychological care) with the separate elements of care being delivered by ever larger and more remote organisations. It is difficult to reconcile this with the Secretary of State's recent suggestions that every patient should have a named clinician responsible for his/her care at all times and that every patient should be able to contact his/her practice at all times.

It must be apparent from the above that Derbyshire LMC is opposed to marketisation of primary health care. Nevertheless, the LMC recognises that there is a political will for this to be explored (notwithstanding the Secretary of State's aspirations, above) and that Monitor is charged with undertaking that exploration.

If marketisation is to occur there will have to be some very fundamental changes to the contracts under which primary care is delivered. The first and most important of these is the removal of the ban on the sale of goodwill relating to the ownership of a contract to provide primary care. The second is the removal of the ban on primary care contract holders to provide on a private basis to patients in respect of whom they hold contracts any services that are not commissioned under the contract. The third is the complex nature by which primary care premises are financed – the divorce of this income stream from the rest of the contract gives current providers a degree of stability (the importance of which, for patients, is emphasised above) but clearly creates a non-level playing field for new entrants to the market on different types of contracts; conversely, the strict rules regarding the use of rent-reimbursed premises for purposes outside the contract makes it difficult for current contract holders to experiment with other models of provision.

Dr J S Grenville, Secretary Derbyshire LMC

18<sup>th</sup> July 2013

## **Lancashire & Cumbria Consortium of LMCs**

Monitor's call for evidence on the commissioning and provision of general practice services has not been well publicised and many GPs and LMCs were not aware of the exercise.

However at this late stage I would like to offer the following comments on behalf of the four Local Medical Committees in Lancashire and Cumbria. We cover a population of 2m people served by 340 general practices.

**Commissioning** – General practice has never been “commissioned” – at least in the last 10 years or so. The GMS or PMS contract is administered – nothing more. There has been no Health Needs Analysis or resulting plans as to the level of resource and infrastructure needed in primary care to address the issues highlighted in your “Call for Evidence” – the increasing elderly population, the increased role in managing long term conditions, transfers from secondary to primary care, care closer to home and greater access.

Although PCTs were charged with developing primary care there is little evidence that any of them developed a Primary Care Strategy to inform investment in new and expanded services. There has been no local manpower planning or review of the primary care estate to establish whether it is fit for the purpose of delivering more care in a primary care setting. Indeed the opposite has been happening with systematic reductions in the amount of money available to primary and community care as money is diverted to prop up cash strapped hospitals. Local health economies have not been strong enough to stand up to such pressures or have enough vision to realise that the answer to pressures in hospitals may better be relieved by investing in primary care.

There have been clumsy attempts in the past to introduce competition into primary care through the Darzi walk in Centres. Very few of these have been proved to work and most have folded. The impact has been to raise costs for the local health community based on a fee for every patient that walks through the door. It is plainly unfair to pay a provider £50 for a single (probably low level) consultation, yet pay not much more in the core contract to a GP for a whole year's care for a patient. Where these Walk in Centres have been introduced, largely in deprived or under-doctored areas, they have left surrounding practices with no resources to improve their services.

We are worried that the fragmentation of the health service under this recent reorganisation may make it more difficult to transfer resources between secondary and primary care – with CCGs responsible for secondary care budgets and NHS England responsible for primary care resources. There is also confusion over who will hold resources for premises improvement and development between NHS England and NHS Property Services.



**Provision of Services** – This is essentially the flip side of the argument on commissioning. Practices are now under increasing pressure to deliver a more complex range of services to their patients, demand and expectations have risen and there is an inexorable tide of shifts from secondary care that well-meaning GPs, in the interests of their patients, find hard to refuse. GPs are getting tired and demoralised. The older wants are bringing forward their retirements and the younger ones looking enviously at Australia and Canada. This could have a catastrophic effect on the ability of the NHS to continue providing viable primary care services.

Any development in GP premises has tended to be via LIFT schemes whereby GPs are encouraged to group together into large primary care resource centres alongside other community services. Whilst there are arguably advantages to such a model, particularly in densely populated urban areas the model is not right in suburban and rural areas. Patients have to travel too far. The effect of this has been that any money that has been available to invest in the primary care estate has been concentrated into these large centres and there has been no money available for the average community based practices. Those that have been willing and able to go into the large centres find themselves having to pay significantly higher service charges and consequently have less resources to invest in direct patient care.

Over the years practices have just been expected to soak it all up. Whilst in the early days there might have been some scope for that this point has well been passed. Whilst there is opportunity, through the service level agreements available to practices from their CCGs to attract some more resources to fund work previously done in secondary care, this does not address the core funding required for the core provision of primary care services.

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24 July 2013

GP Services Call for Evidence  
Monitor  
133-155 Waterloo Road  
LONDON  
SE1 8UG

Dear Sir/Madam

**Re: Leeds LMC's response to Monitor's call for evidence on general practice services sector in England**

Leeds Local Medical Committee (Leeds LMC) is the professional body which represents and supports all GPs in the area. Monitor's call for evidence was discussed at the July meeting of our committee and members asked that the following points be noted by way of response:

**1. Timetable**

Leeds LMC is concerned at the timetable set out for the review. The consultation period of just one month, which also coincides with the main holiday period in England, is felt to be totally inadequate and unrealistic. Evidence takes time to assemble. Prior to receiving their committee papers from the LMC, not one of our GP members was even aware that this review was taking place. This is most concerning.

**2. Background**

We note Monitor's comments that GP services are an important part of primary care and that general practices are paid over £7 billion each year. Whilst this is a significant amount of public money, it only a very small fraction of over £110 billion spent on the NHS as a whole. The fact that practices provide 300 million consultations to patients each year suggests that general practice represents excellent value for money. The consultation should start from this point, rather than suggesting that there is a major problem and indeed the consultation should question why general practice is so under-funded and whether this is related to competing pressures elsewhere within healthcare arrangements that have not been addressed.

**3. Patient access to GP services and choice of GP practice**

In Leeds there is good patient access to GP services, as is borne out by the latest patient survey results. Leeds practices offer a combination of same day, open access and pre-bookable appointments, together with telephone consultations where appropriate. Many practices across Leeds offer extended hours, eg early morning, evening and Saturday morning surgeries but this is balanced by the need to prioritise services between core contracted hours. The risk of spreading existing services more thinly over a wider range of hours is that it would lead to a reduction in the overall quality of care and limit choice by reducing the availability of GPs that patients want to see during core hours.

Patient choice of GP practice is important and in Leeds we are not aware of any problems in this regard. Patients can change practice if they wish and Leeds LMC is not aware of any practices in the city which have closed their lists. The reality appears to be that very few patients want to change their practice and indeed they value the continuity of care which is such a feature of the current general practice model.

Continuity of care and a strong relationship between GP and patient is particularly important for elderly patients and those with long-term conditions. The 2010 King's Fund research paper 'Continuity of care and the patient experience' noted that "the balance of evidence is that relationship continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes".

#### **4. Investment in general practice**

Leeds LMC is aware of many local practices which would like to develop and expand the scope of NHS services which they offer to their patients. There are several constraints to this and the main barrier is lack of resource and investment.

As you will be aware, compared to the £110 billion spent on the NHS overall, the proportion of funding to general practice has been falling year on year since 2006. Changes to the GP contract for 2013/14 will reduce practice funding further and the uncertainty caused by yearly GP contract changes is a disincentive for practices to plan and invest in the future.

With regard to GP premises developments, locally we have been very disappointed that several projects have stalled as a direct result of the April 2013 NHS reorganisation. These include cases where the proposed practice developments have been supported by local patient groups, the CCGs and local Councillors. The GPs concerned have been involved in many months of planning, meetings and associated costs in order to get the projects underway. We are told by the West Yorkshire Area Team that these 'legacy issues' are being picked up but they have capacity issues and to date these much-needed new facilities have still not been given the final go-ahead.

General practice is seeing a constant shift of work from secondary care to the community but the funding to support the delivery of this work does not shift with it. This therefore puts increased pressure on practices and makes it harder to deliver the level of quality of care GPs would want to achieve. Many practices would like to provide more extended services for their patients and, where appropriate, take over some work currently carried out by the acute trusts. However, as well as improvements and expansion of premises together with recurrent funding to support the service delivery, there needs to be investment in primary care staff education and training to ensure that the workforce is fit for purpose now and in the future. Health Education Yorkshire and Humber has deemed primary care development to be their top priority for the year 2013/14. It is interesting to note, however, that this priority is only allocated less than 10% of the HEYH budget for the same year.

Although there are opportunities to move services from secondary care, there is a lack of flexibility required to resource this shift of workload. For example, in Leeds we have been involved in protracted discussions with the local CCGs, Area Team and local mental health trust, Leeds and York Partnership Foundation Trust, trying to agree a protocol and funding to enable patients to transfer to primary care to receive their anti-psychotic depot injections but to date it has proved impossible to unpick the

contract to allow the money to follow the patient. Many local practices would be willing to provide this service but they need adequate and reliable long term resources to invest in the necessary staff and training to enable the safe transfer of the patients involved. This is only one small area of work but it demonstrates how difficult it is to move resource from secondary care to primary care.

#### 5. **Competition and commissioning new services**

The commissioning of time-limited APMS contracts can have a negative impact on patient care and continuity of service. Their time-limited nature does not encourage long term investment in practices or the long term commitment of doctors to them.

There is often not a level playing field in bids for APMS contracts. Large providers have the capacity to put in cheaper bids than smaller, often GP-led competitors, meaning that the awarding of these contracts can be based on size of provider rather than their ability to deliver high quality patient care. There is also a risk of such bids being loss leading, which could be anti-competitive in the long term. Complex documentation and procurement processes are common and are likely to be a challenge for practices which do not have the necessary staffing and expertise to deal with these time-consuming exercises.

In Leeds a walk-in-centre was imposed on the city but whilst popular with the patients that used it, it duplicated existing services and was not good value for money. It largely encouraged patients to present earlier in an episode of what was often a self-limiting illness. It has therefore been closed with no discernible deterioration in the health of the local population. It could be argued that such services, and the simplistic focus on easy access to services, actually disempower patients and reduces confidence to self-care. They also contribute to the current and unsustainable supplier-induced demand that is so evident in many areas of the NHS today.

Leeds LMC members are concerned that there is an underlying perception that competition will necessarily produce better services. In fact an increase in the number of providers could lead to an increasingly fragmented service and inherent risks to patient safety. The health service would become more difficult to navigate for patients, particularly older and vulnerable patients who are often the very people most in need of better care. Leeds LMC believes that greater emphasis needs to be placed on providing high quality, integrated services which will best serve the interests of all our patients.

We trust that you will find our comments helpful. Please do not hesitate to contact us if you require further information. Please acknowledge safe receipt of this submission.

Yours faithfully



**RAJ MENON**  
Chair

# Monitor's call for evidence on general practice services sector in England

July 2013

## Londonwide LMCs' response

Londonwide LMCs represents 27 borough LMCs. The borough LMCs are statutory bodies established to represent the interests of NHS GPs, and their practices, providing primary medical services. The GPs the LLMCs represent are caring for the vast majority of patients in London.

In spite of Monitor's avowed aim to "engage widely and openly with the sector throughout the call for evidence" the very short timescale for the consultation process makes this aim for engagement impossible.

The time constraints for our response as Londonwide LMCs mean that we are forced to respond in short bullet points to the aspects of the provision and commissioning of general practice services listed under the seven headings offered by Monitor in the consultation document.

### **1. The ability of patients to access GP services, including their ability to switch practices.**

The ability of practices to offer the access to their patients they would like is affected by:-

- Chronic underinvestment in general practice. The Nuffield Trust's report "The anatomy of health spending 2011/12" says that PCT spending on GP services has been static since 2005 and has fallen by 0.2% per year since 2007/8. In contrast the report says spending on secondary care has increased by 40% between 2003 and 2011.
- The increase in patient demand. Data quoted by the DH suggests that GP consultation growth averaged 3.9% per year from 2000 to 2008, while GP lists grew on average by only 0.6% per year. The DH attributed this to an ageing population.
- Premises that are not fit for purpose as a result of under investment. Many GPs would like to expand the services they offer to patients but cannot do so because of the limitations they face for premises development. It is widely recognised that many general practice premises in London are inadequate. In 1992, the Tomlinson report highlighted the poor standard of general practice premises in London. At the time, 46% of premises in four inner boroughs were below minimum standards, compared with 7% nationally. In 2010, a Freedom of Information request by Pulse to PCTs

suggested that 59% of GP surgeries in London fell below the minimum standard set by buildings inspectors; many were unfit for disabled people or were too cramped to provide proper treatment, while others needed washing and heating facilities upgraded. A third of practices in London were 'dangerously below standard'. All 27 surgeries in Hammersmith and Fulham were below statutory requirements and eight were 'dangerously below standard'. In Barnet, 49% of surgeries were below standard, and in Camden, 62%. (Ref: The King's Fund report "General Practice in London. Supporting improvements in quality". 2012).

- An increase in workload in general practice because of the demands of QOF, GPs' commissioning responsibilities, the increasing complexities of the health needs of patients, patient turnover and the increasing demands on the health service that result from economic pressures coming from wider social policies affecting benefits, unemployment and lack of suitable housing.
- An increase in the burden of work that is not patient facing and includes the administrative burden of QOF and enhanced services and complex case management. The DH recognises that here is a 35% administrative "tail" for every consultation i.e. the administrative workload which is additional to the consultation.
- A national policy, reinforced by the Health and Social Care Act 2012, to move more and more of secondary care work into primary care which means, amongst other things, sicker patients being cared for in the primary care setting.
- Workforce shortages in general practice with a surge in early retirement of GPs expected.

The demoralisation of the profession is a not insignificant contributing factor to this problem. There is an extraordinarily large number of GPs who currently wish to retire in the next two years (A 2011 BMA GP opinion survey recorded that 13% of respondents reported an intention to retire in the next two years). Almost 16 per cent of London GPs are over 60 years old (one in four in north east London, where there are already shortages in supply) compared with 10% nationally. (Ref Kings Fund Report *ibid*). Recruitment of practice staff is difficult in London with higher rates of pay needed compared to the rest of the country. General practice is also adversely affected by a recruitment crisis for District Nurses and Health Visitors where grade inflation in some areas has made for chronic shortages. In the absence of community health professionals, general practice has had to take on their work. Areas of high deprivation suffer the most from shortages of GPs and other health care professionals. (Source: "GP in-depth review. Preliminary findings". Centre for Workforce Intelligence. March 2013).

- An increase in the volume and complexity of health and social care needs, as more people live for longer with long term and often multiple conditions. Patients with long term care needs require longer consultations and subsequently require an increased level of case management.

- A more mobile, ethnically diverse population. The transient nature of the patient population is a particular issue in London where a list turnover of 30% is not uncommon. This increases the workload of practices as they have to get to know and deal with the needs of the one in three patients in their practice that are new to them and this demands a lot of consultation time. It is recognised that consultation rates are 40% higher than the average rate in the first few weeks of joining a practice. Patients whose first language is not English require extra time in consultations (mostly consultation times are doubled) and although the ethnic mix in London varies vastly across the city, the Office for National Statistics (ONS) 2009 population estimates that non-white groups comprise 30 per cent of the population in London, compared with 13% in England overall.
- We are not aware of patients having difficulty switching practices: However the therapeutic, professional, relationship between GPs and their patients is more complex than a simple consumer relationship. It is often built over time and can sometimes involve GPs having to give difficult messages to patients. This doctor/patient relationship is undermined by patients having the freedom to shop around in response to the legitimate challenges to their behaviour they sometimes receive from their doctor. This and other aspects of the quality of the GP/patient relationship are lost if this relationship is simply viewed as a consumer relationship.

## **2. The impact of rules for setting up and/or expanding a general practice.**

Our experience of the impact of the “marketisation” of these rules and the effects of competitive tendering where price rules the day is that these have led to a bidding process which frequently rewards the lowest bid. This can be destructive to high quality, consistent practice because it rewards organisations that can afford to submit “loss lead” bids, and such organisations frequently have the wherewithal to throw expensive resources at the bidding process. This militates against the likelihood of success for local GPs with a proven record who can offer local commitment, local knowledge, loyalty, and expertise but who cannot compete on equal terms in the bidding process. Furthermore it leads to an increasingly fragmented service if bids are won by a variety of commercial organisations with no necessary commitment to working together for the benefit of the local health economy and with no loyalty to the community of GPs in the area. We are aware of many examples of contracts that have been won on the cheapest bid quickly becoming financially unsustainable and failing. This has undermined continuity of care for patients and patients have suffered.

We have plenty of examples of local GPs who wish to expand their practices being stopped from doing so by the lack of funds for premises development and suffering from a long winded and remote bureaucratic decision making process for premises investment from NHS E which has stymied development opportunities.

## **3. The impact of the different contractual terms under which practices operate.**

General practice operates under three contractual terms. These are the GMS, the PMS and the APMS contracts. The national GMS contract remains and until April 2013, the alternative

contracts of PMS and APMS were locally negotiated with Primary Care Organisations. Since the Health and Social Care Act 2012, and the abolition of PCOs, all three are held by NHS E with no locally negotiate contracts for general practice.

PMS contracts in particular afforded local flexibility to cope with particular circumstances ( i.e. under doctored areas or areas with special health needs). However since April 2013, all three contracts have been managed centrally and so the ability to respond flexibly with contracts for GP services that can meet the particular health needs of a local community has been lost. In addition, the extra funding for some PMS practices that was given to enable them to tackle particular local health needs is being withdrawn so these communities will lose the funds they need. This will be to the detriment of some areas as their health needs will no longer be recognised and provided for.

#### **4. The ability for new or existing providers to expand the scope of the NHS services they offer, particularly the factors that may influence CCGs or local authorities in deciding whether to commission services from general practice.**

CCGs are unwilling to commission services from general practice because of the fear of conflicts of interest. In our experience this has tied CCGs in knots and many have been unable to sensibly commission from general practice as a result. But even if the inherent contradictions in their role were sorted and clear, CCGs have a fraction of the money available to PCTs - less than half of the funds generally.

Local authorities have difficulties in commissioning from general practice because of their lack of awareness of the complexity and breadth of their role and their limited understanding of the “business” of general practice. There is, in addition, the practical problem of a contractual relationship with a multitude of individual practices. Furthermore Local Authorities (LAs) are strapped for cash and they have to respond to the political demands of their councillors which are by and large short term and are not necessarily driven by widely accepted, evidence based health interventions. Thus, for example, sexual health interventions to reduce teenage pregnancies may not be regarded as important if the LA’s political ambitions do not recognise this as a politically advantageous strategy with their electorate. Some Local Authorities are dependent on the political power of some religious groups who disagree with the prioritisation of health strategies that within the health community are regarded as uncontroversial e.g. freely available contraception and advice for teenage patients or support for patients with substance misuse problems.

The arguments that Londonwide LMCs has made to Local Authorities for commissioning services from general practice are listed below. General practice should be the preferred option for services that:

- Require holding a registered patient list.
- Offer opportunistic care in the patients’ usual setting.
- Involves screening/case-finding.
- Includes education of the GP community in order to raise standards/outcomes in Primary Care.



- Improves quality and safety by co-locating prescribing and monitoring and record keeping.
- Involves provision of primary medical care to a particularly challenging complex needs registered population.
- Drives improvement of service quality over and above core contract levels of service delivery.
- Enhances the gate keeper role by monitoring the appropriateness of onward referrals.
- Supports capacity alignment with pathway or service development, so that patient care can be delivered in the right place, first time.
- Facilitates change in working culture, promoting a more integrated collaborative interface with other providers, including other practices, to the benefit of the patient or is in line with the ambition to integrate care around the patient at their usual point of care.
- Provides a cost effective, high quality (high value) alternative with robust governance measures and is either not tenderable elsewhere or as an alternative option for patients.
- Improves patient experience by delivering care closer to home.
- Reflects patient choice of where delivery should occur and by whom.
- Promotes equity of access.
- Benefits holistic approach to managing co-morbidity.
- Improved health outcomes are delivered by patients receiving care from the doctor they choose.

Lack of funding for general practice, inadequate premises and the overwhelming workload general practitioners currently face have prevented some from expanding their services to include extra “enhanced” services and this has led to an inequity of provision in some areas of these enhanced services for patients. This has been an obstacle for commissioners who understandably wish all patients to benefit from their commissioned services. This is frustrating for GPs who on the whole are keen to expand their services- as history has proven.

##### **5. The process for commissioning new services from general practices, the factors that influence these commissioning decisions and any challenges commissioners face.**

The main issues here have been covered above but to these problems we would add the effects of the complications associated with the fragmentation of responsibilities for commissioning and hence in effect “managing” general practice between NHS E, LAs and the CCG. The actions of each of these three organisations impact on each other and indeed

on general practice and so this leaves general practice vulnerable to the consequences of commissioning decisions from a variety of sources. None of the organisations commissioning general practice work have the overall responsibility for ensuring the sustainability and continued survival of general practitioners.

## **6. Factors that affect potential provider's willingness or interest in providing new services.**

To repeat what has already been said in answer to other questions, general practitioners - who are generally keen to take on new challenges as has been demonstrated time and time again over the years - are prevented from doing so because of inadequate premises, or overwhelming workload, or recruitment constraints. GPs are also reluctant for good reason to take on short term (most commonly one year only) commissions for services that require additional resources like staff because of the practicalities of doing so with no guarantee of a future for those services. Small practices in particular have little flexibility to increase their capacity for additional services that may only last for a short time.

## **7. Any new forms of primary care or integrated care that local health communities are planning or considering and any potential enablers or barriers that need to be considered.**

We know that many GPs are working on providing integrated care and the main enabler for these initiatives is the enthusiasm and commitment and hard work GPs are prepared to offer to improve care for their patients. The main barrier is that GPs are coming up with these new models of integrated care and are working together in their own time and with no funding. GPs need funding to employ the expertise and the extra resources to make integrated care happen.

The models we have seen in London where integrated care has been a top down arrangement with general practice contracts being held by secondary care have run into significant difficulties with serious recruitment and retention problems of salaried GPs and a lack of continuity of care for patients.

## **Conclusion:**

The solution to much of the challenge to the NHS in supporting general practice in London clearly lies in redirecting investment both towards practices' workforce, infrastructure and technology needs, and towards stronger extended primary health and social care teams centred around the practices that serve their communities. CCGs need to feel empowered to commission on this basis. It is ludicrous that A&E attendances for non-emergency related issues are resourced when the means to direct them away from hospitals is not addressed. CCGs need to work out what LESs are needed to support these two needs including decent community, social and mental health services, and shift resources and incentives away from hospitals towards better primary care. This would be greatly aided by the ability and willingness of NHSEL to support tariff disaggregation and a coding inspection regime to prevent trusts from gaming and distorting the funding system.

## **Manchester LMC response to Monitor 'Call for evidence on general practices services sector in England'**

It remains unclear why (apart from political expediency) Monitor has been asked to examine competition and provision of general practice services: NHS general practice is a universally provided cradle to grave service to patients, in the same way as fire, police and ambulance services are universally available, and we are not aware of any evidence nationally or internationally to support the view that commercial competition is beneficial to the recipients of such services; in contrast, there does appear to be considerable evidence that integration and co-operation between services works to the benefit of patients.

The current model of NHS general practice is recognised internationally as the leading model of primary care, with best patient outcomes for lowest cost, and many countries including the USA are attempting to move away from alternative competition based models towards the UK model – see documents embedded below Appendix 1&2 from the Commonwealth Fund.

Both government sponsored and practice patient surveys confirm on a recurrent basis a high level of satisfaction with GP care and access, and continuity of care is consistently identified as being highly valued by patients.

Locally in Manchester there is not any evidence that commercial/APMS providers are actually providing either a better service or better outcomes for patients, in fact in some areas the opposite is the case, with patients raising issues about lack of access to medical staff due to understaffing. Some of the APMS contracts are now coming up for renewal, and patient care is being disrupted by the fact that the commercial providers are not renewing the contracts due to perceived lack of profitability, resulting in dispersal of patient lists at short notice – this despite the fact that the payment per patient for these contracts is well in excess of that to GMS or PMS practices locally.

With regard to the considerations of the Fair Playing Field Review, we would consider that there is certainly not a fair playing field status pertaining to general practice commissioning at present, as the funding for APMS practices is as far as we are aware considerably in excess of grossly inequitable compared to that provided to GMS or PMS providers: exact figures are impossible to ascertain, because whereas the funding per patient is openly available for GMS and PMS practices on request, that for APMS contracts is withheld on grounds of 'commercial sensitivity'. We consider that full transparency of funding for all types of provider is necessary to allow for a level playing field approach to commissioning and best provision of general practice services.

We consider there are several aspects of the current commissioning and provision of general practice services which are acting against patients interests.

1. Requests for significant amounts of documentary evidence of address and domiciliary status prior to registration of patient on practice list: this is not actually a regulatory requirement, but is driven by demand from patient registration offices, NHS CounterFraud and UKBA, despite the fact that fraudulent registrations are locally less than 0.1% of total : this discriminates unfairly against patients with learning difficulties, housing problems, migrants and those for whom English is not a first language.
2. Uncertainty and excessive caution in the interpretation of EU contract tendering legislation and it's applicability by both CCGs and NHS England – it is increasingly difficult for existing providers to tender to provide new services to benefit patients as this requires a substantial back-office functionality to prepare and submit the vast tender documents, with often an unrealistically brief timescale for submission.
3. Premises – the lack of premises development and funding over the past decade (apart from specific PFI type projects) and the lack of information and obscurity around current funding processes means that many surgery premises are barely fit for purpose and unable to expand to provide new or additional services for patients. GPs and general practice have always been the most flexible and innovative part of the NHS, and in the past premises funding arrangements were designed to facilitate this. The current progressive year on year fall in real GP income and the lack of confidence in achieving either a return or cost neutrality on premises development and investment is stifling innovation and the provision of new services.
4. The fragmentation of primary care teams due to current and recent NHS reorganisations, with both organisational changes (e.g. Health Visitors and District Nurses no longer based around practices but instead linked to Local Authority footprints) and managerial changes (e.g. District Nurses now employed and under control of Acute Trust rather than primary care) has significantly adversely impacted on continuity and integration of patient care, and has in the view of the majority of GPs worsened the risks of safeguarding incidents due to a reduction in day to day communication between relevant professionals, as they no longer encounter each other on a daily basis.
5. The continuing increase in patient demand, with significant increases in both the number of consultations per patient per annum and the complexity of these consultations has rapidly outstripped capacity, both in terms of numbers of WTE general practitioners and resourcing for other clinical staff; adding to this the ongoing leftward shift of workload transferred from secondary care to primary care without accompanying resources and the political imposition into the contract of largely unevidenced screening work against the advice of both GP and NHSE advisors has resulted in a situation where general practice (as confirmed by a CfWI report in March of this year) does not have capacity to

meet current demand, much less predicted future demand without significant workforce and resource expansion.

6. The current models of financing for expanded or additional services are unfit for purpose, as they generally involve either a one year contract without guarantee of renewal or one-off pots of non-recurrent funding with no clarity as to process when this runs out. A minimum of a 5 year contract is necessary to allow for staff employment, training, premises development and to allow for adequate auditing of outcomes- patient health, particularly in long term conditions, will not show measurable outcome changes over short timescales.

In summary, we remain unclear how increased competition, the promotion of which is required within the remit of Monitor, is in any way likely to improve any of the pressures and difficulties identified above, and consider that rather than adversely affect current services by the introduction of commercial competitors with short-term profit motives, the way forward is to adequately resource general practice to provide the services required, if necessary by reducing the proportion of total NHS budget to secondary care and shifting this instead into primary care, which has actually had a reducing share of the total budget over recent years.

[Files supplied with this submission:

[\*The Commonwealth Fund 2011 International Health Policy Survey of Sicker Adults in Eleven Countries\*](#)

[\*Multinational Comparisons of Health Systems Data, 2011\*](#)]

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## **Newcastle and N Tyneside Local Medical Committee**

GPs have served the NHS extremely well since its inception and deals with about 90% of all health care but only costing less than 10% of the budget. It is the envy of the world and the patient satisfaction is very high and there are very few problems with patients wishing to change their GP.

General practice needs significant investment to promote a true integrated service and any further competition would just fragment patient care and push up costs.

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## **Sefton Local Medical Committee**

The Sefton LMC is the representative body of General Practitioners in Sefton District of the Merseyside Health Economy. The LMC has been established under the NHS Acts to represent the interest and views of General Practitioners providing Primary Medical Services to patients in the above district.

In respect of "Call for Evidence" regarding patient services, and the satisfaction of patients with General Practitioner Services, I should direct the attention of Monitor to the results of the last completed GP Patient Survey January - September 2012 in which it was found that 89% of patients surveyed in the Sefton area felt the overall experience of their General Practitioner's surgery was good and 81% would recommend their GP to someone who had just moved into their neighbourhood. This level of consumer satisfaction would, in any commercial enterprise, be regarded as exceptional and cause for commendation.

The national findings of the GP Patient Survey showed that 88% of respondents felt their overall experience of their GP surgery to be good and 81% would recommend their GP to a new arrival in their neighbourhood.

Added to this local evidence one could cite the King's Fund Survey 2013 which has found that 61% of their representative sample were very or quite satisfied with the services provided by the NHS.

Further one could cite the Commonwealth Fund Survey of Health Services in Europe, USA, Canada, Australia, etc. which found the UK NHS Health Services to be superior across a range of measures to all but the Health Services in Switzerland.

A recent survey of the Commonwealth Fund found that 84 million US citizens of working age could not afford adequate Health Care Insurance in the US Healthcare Market.

In light of the above, which are readily available to your researchers, we find the call for anecdotal evidence within an extremely limited timeframe to be puzzling, if indeed, the call for evidence is a genuine quest for reliable information/data.

Recent literature on the NHS Reforms has suggested that the objective of the Reforms is the introduction of a Health Care Marketplace based on Health Care Insurance and provided by private corporate interests. The "Call for Evidence" by Monitor given the tight timescales noted above, regrettably suggests the pursuit of such an agenda.

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## Sheffield Local Medical Committee

With reference to Monitor's *Call for evidence on general practice services sector in England*, I am very interested that Monitor should be taking an interest in these issues. I have had the opportunity to reflect upon Derbyshire LMC's response to this consultation process and would endorse the points they have made but, due to the short timescale afforded to this consultation, it is not possible to consult our committee members and offer a full and detailed response. Therefore, what follows is initial feedback from Sheffield LMC Executive.

In general terms, there is a lot of evidence available about the way health services are organised, especially in different countries. Monitor could usefully review the report by The Commonwealth Fund that compares different healthcare systems around the world. The review is done on a regular basis, is of high quality and looks at many factors, including patient satisfaction and cost effectiveness.

The most recent survey findings were presented in London earlier this year at a conference hosted by Lord Darzi and attended by David Nicholson and many other NHS leaders. General Practice, as it is delivered in the UK, performed the best, or nearly the best, on virtually every measure when compared with other models. Models relying on a great deal of competition between providers seemed to produce relatively poor results at great cost and relatively poor patient satisfaction. This is only one of many authoritative studies and, therefore, the evidence base is fairly strong on these findings.

That is not to say that general practice is perfect in this country. Even if it was, it is facing some very significant challenges. Some reasonably significant changes are likely to be needed and there is currently much debate about what these should be. We should be aware of the current high standards, but also the longevity of the existing model that delivers such good results. In our reforming zeal we risk doing a great deal of damage to a very valued healthcare system.

The consultation asks some specific questions in Paragraph 12. Taking these in turn:-

1. As the paper says, patients already access GP services in enormous numbers. About 8% of the population sees a GP every week. It is not clear what level of access is the right level, but this is clearly an astonishing footfall. Patients have always been able to switch practices if they wish, but this requires that other practices are available in the area. This may well be true in urban conditions, but not necessarily in rural settings.
2. The rules around setting up of practices are probably helpful in controlling cost to the NHS. In recent years many health economies set up a variety of additional primary care resources, known colloquially as Darzi Centres, but also including Walk-in Centres and Minor Injury Units. Some health



economies subsequently closed down these units. They did not seem to make any significant impact on demand in routine practice, or on demand in other settings such as Accident and Emergency (A&E) departments. Nevertheless, they cost a lot to put in place and, therefore, seem to have not made much difference from the point of view of patients, but do seem to have implied an increased cost in local economies.

3. There are numerous contractual terms within GP contracts and between the three main different types. The open ended General Medical Services (GMS) core contract is the part that has stood the test of time and is probably the part that is valued the most by patients. Through this mechanism they can approach the practice for a consultation whenever they feel that it is necessary. Patients initiate this contact, and usually value it highly. Other contractual terms such as Quality and Outcomes Framework (QOF) and Enhanced Services are usually practice driven. It has been difficult to show significant benefit from these investments, although one would expect that good management of long term conditions would produce demonstrable benefit. Similarly, it is not clear that the extra services invested in Personal Medical Services (PMS) practices or Alternative Provider Medical Services (APMS) practices produced tangible benefit in many cases.

There are some specialised general practice services which may cater for specialised populations in a way that the GMS contract cannot, such as those dealing with asylum seekers and other vulnerable populations, but these are the exception rather than the rule.

4. It has always been difficult to expand the scope of services in general practice because Primary Care Trusts (PCTs) and other commissioners have not been convinced of the value of doing this. Whereas services in hospitals are not subject to review through submission of business cases and so on, any proposal around expansion of services in general practice is usually submitted to extreme evaluation, with the bar generally so high that investment does not follow. Therefore, many health economies continue to rely on hospital services which may or may not be efficient, rather than making the move to community service provision. In my view this attitude has not been helpful to patient care. Patients often have to travel to hospitals for routine investigations and treatments, which could be delivered more conveniently in their own communities.

The new commissioners in the form of Clinical Commissioning Groups (CCGs) have an additional problem in evaluating service transformation, which is that they will be accused of having a conflict of interest. In my view, this is unlikely to be material, and in any case should be overridden by the patients' best interests considerations.

5. The processes for commissioning new services are very similar to those in previous regimes, apart from the new additional difficulty of consideration of conflicts of interest.
6. The main problem with provision of new services through general practice is the significantly increased workload in recent years. Most of this has been absorbed with not only no increased investment, but actually a decrease in investment in general practice. A change in provision will require significant investment of time and effort by existing providers. This time and effort is currently being consumed by rising demand. The capacity for change is therefore significantly impacted. The alternative is to bring other providers in to the community. This, of course, produces fragmentation of care which itself is time consuming.
7. Primary care could adopt some new models building on existing strengths. This would include the model of federation proposed by the Royal College of General Practitioners (RCGP), but might include other models. There are advocates for vertical integration with secondary care as well. I believe that there is limited evidence to show that any of these models are effective, cost effective or produce increased patient satisfaction. Some of these models have been explored through the paper described at the beginning of this reply as well as others, but I do not think the evidence base is sufficient to embrace one model over another, even at a local level, never mind at a one size fits all national level.

*Conclusion* - There is no doubt that primary care is facing severe challenges at the present time. There are many rules describing how primary care operates in this country, and most of these have been helpful to date although there are exceptions. It is reasonable to be looking at what the regulatory framework enables and inhibits as we consider the future of primary care. It remains unclear to me that regulation can of itself produce any of this improvement. In my view, improvement is more likely to come from education and training, along with wise commissioning decisions.

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## Wakefield Local Medical Committee

The main barrier currently that impacts on patient care and the responsiveness of General Practice to patient need is the division created under the Health and Social care act of CCGs and NHS England's area teams. Commissioning of general practice services that was previously done by PCTs is now the remit of NHS England. The CCGs are responsive to local needs and priorities but the area teams want to standardize things across areas. This means that it is very difficult and bureaucratic to set up any new services or improve old ones, particularly across the primary care , secondary care interface. Examples of this in my area have been the attempts by the CCG to continue investment in a scheme in primary care aimed at avoiding A+E attendances and increasing practice capacity that NHS England recurrently impeded and delayed.

The removal of Local Enhanced Services and the fact that many services may have to go out to tender also makes simple changes that could improve patient care very difficult. Examples of this are hospitals trying to devolve what was previously secondary care work to general practice. To do this well GPs require funding to employ necessary staff. Previously this would have been by a LES. Now everything stalls because no one can approve a funding stream. For the patient this means the work dribbles in an unplanned way into primary care and they and their results and care get lost in the middle.

General practice needs more GPs if it is to deliver efficient and responsive care to GPs. The factors that impact on this are the financial uncertainty facing GPs ( due to loss of income under the imposed contract, threatened PMS reviews and the tendering process for various LESs)and lack of GPs overall in some areas. Expanding the salaried GP workforce can create GPs who have no ownership of patients or problems as can creating a myriad of access alternatives such as walk in centres etc. This leads to patients not being followed up appropriately and no continuity of care. This does not matter for simple problems but for the elderly and those with complex health needs it is essential to avoid A+E attendances and unnecessary admissions.

PMS in our area was used to create a contract that was felt to improve the care locally and extra resources were used to make certain things part of core general practice. These improvements in care have not been seen in GMS practices as mechanisms for funding them to provide extra services are difficult. All PMS practices had access requirements that were greater than those of GMS and it was felt locally to be an efficient and fair method of achieving this.

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Making the health sector  
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