

Monitor

Making the health sector
work for patients

Discussion document following Monitor's call for evidence on GP services



About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Contents

1. Introduction	1
1.1 Monitor’s call for evidence	1
1.2 Context: NHS England’s call to action	2
1.3 What we mean by GP services	3
2. What we have heard	4
2.1 Access and quality	4
2.1.1 Issues relating to access	4
2.1.2 Issues relating to quality	8
2.2 The ability of new or existing providers of GP services to develop the scope of their offer to the NHS.....	11
2.2.1 Barriers to expansion and entry.....	11
2.2.3 Workforce issues.....	16
2.2.4 Identifying and tackling poor performance	17
2.3 Providers incentivised and able to work together in ways that benefit patients	18
2.3.1 Achieving greater scale in general practice	19
2.3.2 Removing barriers to the delivery of integrated care across primary and other health care services	19
2.2.3 Information sharing	21
2.4 Conclusion.....	23
3. Summary of proposed further work	24
3.1 Further chance to comment	25

1. Introduction

General practice plays a central role in ensuring the delivery of universal, high quality care to NHS patients. For the majority of patients, general practice is their first and most regular point of contact with the NHS. As well as providing treatment and advice directly to patients, general practitioners (GPs) also act as gatekeepers to services provided by the rest of the NHS and co-ordinate those services on behalf of patients.

Like many parts of the NHS, general practice is operating under growing pressure, aiming to offer high quality out-of-hospital care to an expanding, ageing population with a growing number of multiple long-term conditions in a context of continuing financial constraints.¹

In line with Monitor's main duty as health care sector regulator – to protect and promote the interests of patients – we set out to understand how well the current arrangements for commissioning and providing general practice services are working for patients, and launched a [call for evidence](#) on 1 July 2013.²

We wanted to hear evidence from patients, commissioners, providers of general practice services and others about access to general practice and the quality of services being delivered, as well as what we might do to ensure this part of the health sector is working for patients.

This paper is not the outcome of a comprehensive review of general practice. The purpose of this document is to summarise the issues that have been raised following our call for evidence, to understand the work currently being undertaken in the sector to address those issues and, in light of this, to identify where we think work by Monitor will provide most benefit to patients.

1.1 Monitor's call for evidence

We issued our call for evidence to determine the extent to which the commissioning and provision of general practice services is operating in the best interests of patients. We invited comments on the following:

- a) patients' ability to access high quality GP services – including their ability to register at a GP surgery, to get appointments in a timely manner and to switch individual general practitioners or GP practices if they want to;

¹ These challenges have been set out in a range of recent publications, including those by the British Medical Association (2013), Royal College of General Practitioners (2012), Patients Association (2013), NHS Alliance (2012), King's Fund (2011) and Nuffield Trust (2013).

² www.monitor.gov.uk/gpservices

- b) the ability of new or existing providers of GP services to develop the scope of their offer to the NHS – including developing new services, operating in new locations, or expanding their staff or premises; and
- c) new models of primary care that local health communities are planning or considering – and the potential barriers to these being implemented.

We received 180 written responses in total from many types of respondent, including patients and their representatives, general practice service providers and other health care services, commissioners, local medical committees, provider representative bodies (including pharmacists) and others (including other regulators).³

Alongside written submissions, we reviewed relevant literature and conducted interviews and round-table discussions with patient representative groups, members of the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA), the CQC, commissioners, and other experts and commentators.

1.2 Context: NHS England's call to action

In April 2013, NHS England took over responsibility for commissioning general practice. In this role, it has been developing its approach to purchasing care on behalf of patients and published [Improving general practice – a call to action](#) in August 2013,⁴ which aimed to stimulate a national conversation about the future of general practice. The call to action, alongside NHS England's broader work on a strategic framework for the commissioning of primary care, is a focal point for shaping the development of the sector.

Referencing Monitor's call for evidence, NHS England's call to action included the following questions:

- a) how do we ensure a consistent and disciplined approach to identifying and remedying poor performance, including effective partnership with the Care Quality Commission (CQC)?
- b) how do we develop a more consistent and effective approach to market entry, eg, how far this should be targeted at areas of greater deprivation and/or lower capacity and/or limited patient choice?
- c) how might we stimulate new, innovative provider models that offer greater quality for patients?

³ Please see published written responses to the call for evidence at: www.monitor.gov.uk/gpstudy

⁴ www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/

- d) what are the potential opportunities for “primary care plus”, built on co-commissioning between NHS England, clinical commissioning groups (CCGs) and local authorities?

Many of the responses we received to our call for evidence, as well as the further work we propose conducting, relate directly to these questions.

1.3 What we mean by GP services

Since April 2013, core general practice services have been commissioned by NHS England area teams under general medical services (GMS), personal medical services (PMS) or alternative provider medical services (APMS) contracts.

The most common category of core provision comprises essential services to registered patients. These are defined as including, during core hours:

- management of patients who are ill or believe themselves to be ill with conditions from which recovery is generally expected;
- management of patients who are terminally ill; and
- management of chronic disease (for example diabetes).

In addition, clinical commissioning groups (CCGs), local authorities and NHS England area teams may choose to purchase additional non-core services from providers of core GP services, such as: out of hours services; cervical screening; contraceptive services; vaccinations and immunisations; maternity services; support to stop smoking; and minor surgery services.

While many of these additional services are provided directly by general practitioners, some – for example immunisation services – may be provided by nurses and other practice staff, while others may be provided by other community-based providers, such as community nurses or pharmacists.

We have adopted a broad interpretation of the term “GP services” to include both core and additional services provided by general practice.

2. What we have heard

What we heard fell broadly under three main headings:

- Access and quality;
- The ability of new or existing providers of GP services to develop the scope of their offer to the NHS; and
- Providers' ability and incentives to work together to benefit patients.

Under each heading, we have summarised the main issues raised by stakeholders and any relevant ongoing work. We have also outlined any further work for Monitor in each area.

2.1 Access and quality

NHS England's 2013 national GP patient survey,⁵ found that the proportion of patients satisfied with their experience of GP services ranged from 73% to 93% across different CCGs.⁶

The King's Fund's analysis of the British Social Attitudes survey reports that satisfaction with GP services ranged from 71% in 2001 to 80% in 2009. Satisfaction has since declined to 74% in 2012.⁷

Issues relating to both access and quality were raised in a significant number of submissions to our call for evidence from patients and patient representative groups.

We were told that different patient groups want different things from general practice. In particular, for many older patients, those with long-term conditions, disabilities or communication and language barriers, continuity of care is an important requirement. These patients prefer to develop an ongoing relationship with an individual GP who can help them to manage their treatment and co-ordinate their care.

Many time-constrained or less frequent users of general practice place a greater emphasis on swift and easy access than on continuity of care.

The information gathered through our call for evidence indicates that there are significant variations in how readily patients can access GP services and in the quality of services provided. These are discussed in turn below.

2.1.1 Issues relating to access

Many of the respondents to the call for evidence raised issues relating to registering at GP practices and obtaining appointments to see a GP. Some GPs, CCGs and

⁵ www.gp-patient.co.uk/results/latest_weighted/ccg/

⁶ www.gp-patient.co.uk/results/latest_weighted/ccg/

⁷ www.kingsfund.org.uk/projects/bsa-survey-2012/satisfaction-nhs-and-social-care-services/

local medical committees reported that in their view patient access to GP services was good, and this was reflected in patient satisfaction survey results. However, a significant number of responses mentioned difficulties in accessing GP services.⁸ Most of these responses were from individual patients and patient and consumer representative groups. These difficulties included patients' ability to register or remain registered at a practice, to obtain appointments at convenient times and locations, and to book appointments easily.

Registering at a practice

Some respondents referred to the difficulties faced by particular groups of patients when seeking to register at GP practices, for example those patients with learning and communication difficulties, refugees and asylum seekers, ex-offenders and those with no fixed address.

A number of patients commented on the inconvenience of the registration process itself and we heard that the majority of GP practices require patients to attend the practice in person in order to register, rather than allowing patients to register by telephone or online. In addition, some GP practices were reported as requiring several items of identification and/or proof of address which respondents argued may make it more difficult for patients to register.

We also received a small number of responses which suggested patients were removed from registered lists unfairly and that this particularly affected vulnerable groups of patients such as those with mental health problems and/or those who had previously complained to their GP practice. The submission from the Parliamentary and Health Service Ombudsman suggested that the unfair removal of patients from registered lists was one of the most important concerns raised by patients.

A number of respondents reported that they had been unable to register with a different GP practice when they wished to, due to restrictions on registering at a practice outside pre-determined boundaries.⁹ In some cases this meant that patients were unable to register at a practice close to where they worked, despite this being their preference. In others, it meant that patients were unable to register at a practice that was closer to their home than the one where they were currently registered.

NHS England has recently undertaken pilots exploring the potential for patients to register at GP practices other than those closest to their home address. In addition, following the latest GMS contract negotiations,¹⁰ from October 2014 GPs will be able

⁸ 52 out of 180 responses.

⁹ Practice boundaries are agreed between providers of GP services and commissioners, and determine the area within which a GP practice is required to provide home visits to its registered patients.

¹⁰ General medical services contracts are made under section 84 of the National Health Service Act 2006 in accordance with the National Health Service (General Medical Services Contracts) Regulations 2004. The BMA's General Practitioners Committee (on behalf of providers that hold

to accept patients from outside their existing practice boundaries without being required to provide home visits for those patients.

This relaxation of the restrictions on practice boundaries is likely to increase choice and improve access to GP services. NHS England will be responsible for arranging any urgent primary medical care, including home visits, for those people who have registered with an out of area practice. A number of stakeholders pointed to the importance of these arrangements working well in order to maintain access and ensure that concern over home visits does not undermine the intended objective of the new less restrictive arrangements.

Making appointments

The results of the NHS England's 2013 national GP patient survey¹¹ showed that across different CCGs the percentage of people that were:

- able to get an appointment when they wanted ranged from 71% to 92%;
- able to easily contact their GP surgery by telephone varied from 49% to 89%; and
- satisfied with the opening hours of their GP ranged from 71% to 85%.

In its submission to our call for evidence, the Patients Association cited its own 2013 patient survey in which 61% of those surveyed reported having to wait longer than 48 hours to book an appointment with their GP and 57% said the process was either "very difficult" or "could have been easier".¹² The Patients Association also found that 22% of working age patients surveyed had taken a day off from work to visit their GP.

A recent survey by Monitor of patients using walk-in centres¹³ who were registered with GPs elsewhere found that 22% had tried to contact their GP but found no appointment available. Another 24% said they did not try to contact their GP because they assumed they would not get a convenient appointment.

These reported difficulties in accessing GP services may reflect the number and distribution of GPs in England. A range of respondents told us that in their view there are not enough GPs to meet increased levels of patient demand for services.

general medical services contracts) has negotiated with NHS Employers (on behalf of NHS England) amendments to the general medical services contractual arrangements in England from April 2014.

¹¹ www.gp-patient.co.uk/results/latest_weighted/ccg/

¹² Patients Association (2013), *Primary Care: Access Denied*. Available at: [www.patients-association.com/Portals/0/PCR_Vol-II%20\(Access%20Denied\)_Final.pdf](http://www.patients-association.com/Portals/0/PCR_Vol-II%20(Access%20Denied)_Final.pdf)

¹³ Monitor (2013), *Patients' Use of Walk-In Centres*. Available at: www.monitor.gov.uk/sites/default/files/publications/Patient%20survey_final%20report.pdf

The needs of patients vary significantly and are likely to be affected by geography, age and social deprivation. Therefore, the demands on individual GP practices will vary according to geographic location and patient population.

In addition, the distribution of GPs varies significantly across the country. Socially deprived areas of England tend to have fewer GPs per head of population.¹⁴ This is despite patients in these areas often having higher levels of need, more complex long-term conditions, and greater problems with self care.

In areas with ageing populations GP practices may face increased demand for home visits as well as an increased need to co-ordinate primary care with community and secondary care services.

However, as outlined below, difficulties in accessing services may also reflect that services could be provided more efficiently in some places, for example through appointment booking processes, online access to services and better use of practice nurses and other allied healthcare professionals.

Appointment booking processes and online appointments

Discussions with patient representative groups illustrated that the process for making an appointment with a GP varies significantly between practices. We were told that many patients are required to telephone or arrive at a GP practice at a specific time to obtain an appointment from a limited number released on that day, resulting in difficulties accessing services for many patients.

The use of technology is likely to deliver higher quality and better access to GP services. However, the King's Fund, the RCGP and the Patients Association all argued that there is significant scope for the increased adoption of technology across general practice. For example, in its response to our call for evidence, consumer association Which? cited its own survey results from 2012 which found that just 34% of GP practices offered an online booking system.¹⁵

The view that the increased use of technology across general practice would be beneficial was also expressed during discussions with patient participation groups. We heard about GP practices that provide online services, GP or nurse practitioner appointments at evenings and weekends, and/or telephone triage systems to manage demand for appointments and text message services, all of which were reported as being popular with patients.

One group of practices in London reported a significant reduction in face-to-face GP appointments following their implementation of an online consultations system, with

¹⁴ Centre for workforce Intelligence (2013), *GP in-depth review: Preliminary findings*. Available at: www.cfw.org.uk/publications/gp-in-depth-review-preliminary-findings

¹⁵ Please see the Which? response to our call for evidence in the "[Other submissions](#)" document.

a number of patients suggesting that online consultations made it easier to raise embarrassing issues.

From April 2014, changes introduced by the recent GMS contract negotiations¹⁶ require GPs to promote and offer all patients the opportunity to do the following online: book appointments; order repeat prescriptions; and access to their medical records.

2.1.2 Issues relating to quality

We heard from patients who said they were happy with the quality of the service they receive from general practice. However, some respondents raised concerns about the quality of services received by patients from their local GP service and about how responsive GPs are to patients' needs and views.

Variability in quality

Some responses from patient representative organisations said that certain patient groups were more likely to experience a poor quality service, for example deaf patients, patients who have difficulties with English, and care home residents.

One commonly used indicator for assessing quality in general practice is the hospital admission rates for Ambulatory Care Sensitive (ACS) conditions.¹⁷ Research by the Nuffield Trust using Health and Social Care Information Centre statistics identified that the ACS admission rates for patients from different GP providers ranged from 2 patients per 1,000 to 67 patients per 1,000,¹⁸ suggesting variation in the clinical quality of general practice services.

There are also significant variations in the proportion of patients that have been diagnosed with cancer after presenting at A&E departments, where the condition has not been previously diagnosed by their GP.¹⁹ The National Institute for Health and Care Excellence (NICE) recognises such events as indicators of the quality of the patient's primary care service.²⁰

The CQC has responsibility for monitoring, inspecting and regulating primary care services and has recently published the results of inspections of GP practices

¹⁶ The contract negotiations between the BMA's General Practitioners Committee and NHS Employers (on behalf of NHS England) on amendments to the general medical services contractual arrangements in England from April 2014.

¹⁷ These are conditions that lead to admission to hospital where hospitalisation could have been avoided by interventions in preventive and primary care. These include chronic, acute and preventable conditions such as diabetes, pneumonia and diseases that can be prevented by immunisation.

¹⁸ <https://indicators.ic.nhs.uk/webview/>. Nuffield Trust on ACS conditions: www.nuffieldtrust.org.uk/projects/index.aspx?id=918.

¹⁹ National Cancer Intelligence Network data showed that the rate of cancer diagnoses made in accident and emergency departments varied between 7% and 60% depending on the GP service provided to the patient. See: www.ncin.org.uk/cancer_information_tools/profiles/gp_profiles

²⁰ http://www.nice.org.uk/media/074/24/1.9Cancersdiagnosedbyemergencyroutetesting_report.pdf

undertaken in 2013. These indicated that a significant proportion of those inspected were not meeting all the CQC's essential standards for health care providers.²¹

Responsiveness to patients

In discussions with patient participation groups it was clear that the extent to which different GP practices engage with their patients to understand and respond to their views about what works well and what works less well within their practice varies significantly. Some GP practices were reported as welcoming and encouraging patient participation, while others were described as being less inclined to engage with patient representatives or listen to and act on feedback.

Recent changes to the GMS contract include promoting greater innovation in how practices seek and act on patient insight and feedback, and to include the views of patients with mental health needs. In addition, from December 2014, the friends and family test, which asks patients whether they would recommend services to their friends and family, will be extended to cover GP practices and community and mental health services.

In our discussions with a local patient group, one participant suggested that there may be a role for local Healthwatch organisations to highlight those practices that do not currently have a mechanism for engaging patients and to actively promote the benefits of introducing one.

Switching rates

Despite the variations in access and quality and decreasing patient survey satisfaction rates, it appears that patient switching rates from one GP practice to another are low. In its submission to the call for evidence Which? cited research it had undertaken which found that while 79% of people surveyed said they would switch GP practice if they were unhappy with the service; just 3% of people actually switched GP for that reason.²²

While in some cases this may reflect high satisfaction levels, in others it may indicate:

- a lack of information about patients' right to choose their GP;
- a lack of accessible information about the availability or quality of different providers of GP services;
- the inconvenience of switching, such as onerous registration processes; or
- a lack of alternative provision in a convenient location.

²¹ [www.cqc.org.uk/search/doctors-gps?f\[0\]=im_taxonomy_vid_36%3A9494&f\[1\]=im_taxonomy_vid_46%3A9537](http://www.cqc.org.uk/search/doctors-gps?f[0]=im_taxonomy_vid_36%3A9494&f[1]=im_taxonomy_vid_46%3A9537)

²² Please see the Which? response to our call for evidence in the "[Other submissions](#)" document.

Patients have been entitled to choose their GP since the creation of the NHS in 1948. The *NHS Constitution*²³ sets out health care service users' right to choose their GP practice and to be registered by that practice unless there are reasonable grounds for refusal.²⁴ The constitution also gives patients the right to express a preference for seeing a particular doctor within their GP practice and requires the practice to try to comply with that preference. However, it is not clear that these rights are widely known.

Patients can compare information about GP practices on the [NHS Choices website](#), can check the results of the national GP patient survey,²⁵ and can read reviews on websites such as www.iwantgreatcare.org and www.patientopinion.org.uk. These and other sources provide a range of information on some service quality indicators relating to access as well as patient satisfaction survey results. However, we found that these sites offer little information on the clinical quality of general practice services.

In its submission Which? cited its own research, which found that patients rely heavily on subjective and informal sources of information when choosing a GP practice, such as reputation and personal recommendations. This suggests that some patients may not be aware of differences in the service or clinical quality of local GP practices.

The CQC recently appointed a Chief Inspector for General Practice. In a 2013 publication, it set out how the new Chief Inspector would be working to improve the information on practice quality available to patients, including measures relating to access, outcomes, patient experience and integration.²⁶

²³ Department of Health (2013), *The NHS Constitution: The NHS belongs to us all*. Available at: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

²⁴ Although this has previously been limited by practice boundaries

²⁵ www.gp-patient.co.uk/results/latest_weighted/ccg/

²⁶ CQC (2013), *A fresh start for the regulation and inspection of GP practices and GP out-of-hours services*. Available at: www.cqc.org.uk/sites/default/files/media/documents/20131211_-_gp_signposting_statement_-_final.pdf

Access and quality: proposed further work by Monitor

1. Understanding variations in access and quality in general practice: In order for commissioners and policy makers to successfully address national variations in access and quality, it is necessary that they understand the extent, causes and distribution of these variations.

Building on existing data from NHS England we intend to develop a detailed picture of the nature and extent of supply and demand for GP services across England.

2. Factors which prevent patients making choices about their care: We will conduct research into the factors that prevent patients from identifying and choosing the GP or GP practice that best meets their needs.

2.2 The ability of new or existing providers of GP services to develop the scope of their offer to the NHS

In those areas where current provision is failing to adequately meet patient needs (including areas where there is an insufficient number of GPs), enabling high quality providers to expand or high quality potential providers to begin offering their services are two ways of addressing unmet demand and stimulating more innovative practices.

We were told of a number of obstacles experienced by high quality providers of GP services keen to expand or invest in their services and which hinder high quality new providers from beginning to offer their services. We describe these obstacles in more detail below. The size and distribution of the GP workforce and wider general practice team also affects the potential development of services, as do current arrangements for identifying and tackling inadequate provision of GP services.

In addition, particularly in those areas where patients are unable or unwilling to exercise choice, it is important that struggling providers are offered help to improve or to cease offering their services.

2.2.1 Barriers to expansion and entry

GPs told us that the main barriers to high quality existing providers of GP services expanding and to potential providers setting up new practices arise from misaligned incentives and problems getting the necessary permissions from commissioners.

The responses we received about these barriers suggested that they arise from:

- concerns that new entrants may select patients who are relatively easy to treat (or who are less frequent users of general practice services);
- the costs associated with funding investment in premises;

- the impact of perceived or actual conflicts of interest when CCGs commission services from general practice; and
- burdensome procurement processes making it difficult for smaller practices to bid to provide services.

Currently permission to set up a GP practice and offer GP services to patients is granted by commissioners. Feedback to our call for evidence from general practice providers suggested that there is significant scope for commissioners to facilitate expansion by existing providers or the establishment of new practices. Some respondents suggested that any provider registered with the CQC should be able to offer their services to patients.

However, we understand that commissioners are sometimes reluctant to create these opportunities out of concern that doing so could be expensive and potentially threaten the sustainability of existing providers. In addition, there may be concern that any new provision needs to be targeted in those areas that currently have too few doctors or have lower quality or greater demand for services. Any measures to help commissioners support the expansion of general practice need to address these concerns.

Incentives to invest in premises

Where GPs own their premises they may make capital gains on the value of their property when they sell their premises. It was suggested to us that this creates an incentive to maximise the value of the property at the point of sale, rather than to invest in a way that increases its value to patients.

A small number of providers argued that this is reinforced by restrictions on the sale of goodwill²⁷ which also reduce the incentives to develop the premises as a health care asset.

Other comments we heard on this issue from GPs and commissioners suggested that the restrictions on the sale of goodwill are important for maintaining long-term stability and ensuring continuity of provision. Concerns were also expressed that lifting the restriction could make it prohibitively expensive for GPs to buy into partnerships at a time when there are already concerns about whether there are sufficient GPs to meet projected levels of demand.²⁸

²⁷ See section 259 of the National Health Service Act 2006 for restrictions on the sale of goodwill.

²⁸ See Section 2.2.3 below, on Workforce Issues.

We heard that APMS contracts²⁹ of short duration make it more difficult to develop sound business cases for investment in premises, raising the costs associated with new entry for both prospective providers and commissioners.

Funding investment in premises

Providers of GP services told us that where they do wish to invest in or expand their premises, they found it difficult to secure commitments from commissioners that they would cover the funding of that investment, either in the form of grants or increases to their subsequent income. It was suggested that this has been a particular issue during the transition to new commissioning arrangements. We have heard of delays in the processing of business cases, and commissioners perceived as being unable or unwilling to meet the additional financial burden of funding investment.

The minimum practice income guarantee³⁰

We heard arguments from potential providers of GP services that use of the minimum practice income guarantee (MPIG) has the potential to reduce the incentive for providers to improve the quality of their services by weakening the link between the practice income and the extent to which it is successfully attracting and retaining patients.

It was also argued that the MPIG makes it more expensive for commissioners to allow prospective providers to establish new practices. This is because commissioners risk having to maintain the income of existing providers at the minimum guaranteed level even if patients have chosen to register elsewhere.

However, some GPs argued that the MPIG plays an important role in ensuring that providers operating in rural areas with small populations are able to generate sufficient income to provide a high quality service.

These issues are in the process of being addressed by the Department of Health's decision to phase out MPIG payments over a seven-year period. From April 2014, MPIG payments will be reduced by one-seventh every year for the next seven years, with funding recycled into global sum payments. NHS England has also said that it is committed to ensuring that the small number of "outlier" practices where MPIG payments make up a significant proportion of their income can continue to provide appropriate services for their local populations.³¹

²⁹ Alternative provider medical services contracts are arrangements for primary medical services made under section 83(2) of the National Health Service Act 2006 in accordance with the Alternative Provider Medical Services Directions 2013.

³⁰ The minimum practice income guarantee (MPIG) was introduced in 2004 to support some practices in moving to the new General Medical Services (GMS) contract and guaranteed the level of payment that a provider would receive would not be less than under previous contractual arrangements.

³¹ www.england.nhs.uk/wp-content/uploads/2013/11/gms-contr-let-at113.pdf

Where a provider faces unavoidably higher costs due, for example, to operating in a rural area where populations are smaller, it may be possible to address this by introducing local pricing adjustments, an approach already in place for some other health care services.

Concerns about selecting easier and cheaper to treat patients

Allowing new providers to offer alternative options for patients can help to drive up access and quality of GP services. However, it was argued by some GPs that new providers may seek to attract those patients who are less frequent users of general practice, leaving existing providers with a disproportionate number of patients who require more of their time and are therefore more expensive to treat. This may in turn result in a reduction in quality and access for those patients who have the highest levels of need.

To some degree, controls already exist to reduce the extent to which this is possible. Where a practice has an open list it may accept new patients regardless of whether they live within the practice boundary. If practices wish to close their list to new patients they must seek the approval of the commissioner.³² However, GPs told us that there are nevertheless ways of making a practice implicitly more or less attractive to different groups of patients, such as targeted marketing and opening hours. Furthermore, geographic disparities may mean that some GPs, for example those in socially deprived areas or areas with an older population, may naturally find themselves with patients who require more of their time than those served by GPs in other areas.

As when the issue of selecting certain types of patients arises in secondary care settings, this may best be addressed in the pricing system. In the acute sector some providers may treat more patients with complex needs than others and given the different levels of specialisation across the sector, this is very often the most clinically appropriate set of arrangements. Likewise, in future, providers of general practice may choose to tailor their services to meet the needs of particular groups of patients, such as children or those with long term conditions. What is important in these cases is that the case mix of the patients treated by each provider is reflected in the payment that those providers receive for their services, and that commissioners have the necessary discretion to ensure this happens.

NHS England is currently working to refine the Carr-Hill formula, used to determine the funding that a GP provider receives for delivering core primary care services to its registered patients.³³ Monitor may be able to offer useful and relevant insights

³² Where a list is closed the provider may still accept new patients in limited circumstances.

³³ The Carr-Hill formula is based on adjustment for the age and sex, nursing and residential homes index, adjustment for the additional needs of the population, relating to morbidity and mortality, adjustment for list turnover and adjustment for the unavoidable costs, including market forces factor and rurality index.

from our ongoing work to develop more cost reflective prices in secondary and community care.³⁴

Conflicts of interest

Some respondents raised concerns about actual or perceived conflicts of interest faced by CCG members when commissioning services from general practice that go beyond the scope of the core GP contract.

It was argued that in some cases this may result in CCGs awarding contracts to a GP with significant influence at the relevant CCG even when this GP may not be the best-placed provider. In other cases it may result in overcautious CCGs failing to award a contract to a GP due to concerns over the perception of a conflict of interest.

Guidance on managing conflicts of interests has been published by NHS England.³⁵ Our substantive guidance on the Procurement, Patient Choice and Competition Regulations³⁶ also includes guidance on this issue.³⁷ Feedback we received suggests that it would be useful for NHS England and Monitor to continue promoting awareness of this guidance during their engagement with the sector on the Procurement, Patient Choice and Competition Regulations.

Commenting on this issue, the BMA has also recommended the development of scrutiny committees for CCGs to provide assurance and confidence in their procurement processes.³⁸ This may be something which NHS England wishes to consider in due course.

Burdensome procurement processes

A number of GPs argued that unnecessarily complex or burdensome procurement processes are making it difficult for smaller providers to bid for contracts, including for those opened up under the “Any Qualified Provider” framework. We also heard that some practices are finding it difficult to bid for contracts due to those contracts being let over large areas.

Monitor’s substantive guidance on the Procurement, Patient Choice, and Competition Regulations highlights the importance of commissioners using sensible and proportionate processes in order to identify the providers which are best placed

³⁴ Monitor (2012), *Evaluation of the reimbursement system for NHS-funded care*. Available at: www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-15

³⁵ www.england.nhs.uk/wp-content/uploads/2013/03/manage-con-int.pdf

³⁶ The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.

³⁷ Monitor (2013), *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*. Available at: www.monitor.gov.uk/s75

³⁸ <http://bma.org.uk/practical-support-at-work/commissioning/commissioning-lmcs-primary-care-commissioning>

to deliver high quality and efficient services. We will continue to emphasise this as we engage with the sector on the regulations and supporting guidance.

2.2.3 Workforce issues

Respondents raised both the size and distribution of the GP workforce as issues affecting the expansion or entry of high quality providers of GP services.

Total numbers of GPs

A number of respondents suggested that the demographics of the GP workforce are changing, for example more GPs are choosing to work part-time and a high proportion of GPs are approaching retirement age. Research by the Centre for Workforce Intelligence indicates that the GP workforce is not growing as quickly as that in other areas of the health service and that this could result in an overall shortfall in the number of GPs during a period when demand for their services is expected to continue rising.³⁹

Health Education England's mandate requires it to make significant progress towards 50% of postgraduate doctor training being in general practice and it has recently announced a plan to increase the number of GPs being trained each year by 2.7% to counter the issues described above.⁴⁰

Other respondents argued that there is sufficient potential to respond to these workforce issues through the increased efficiencies to be gained from providers achieving greater scale, better use of technology, and greater use of nurses, pharmacy and other allied health professionals. Each of these factors may affect the number of GPs required in future years.

Areas with insufficient numbers of GPs

The RCGP and other respondents pointed to evidence of significant variations in the numbers of doctors per head of population in different parts of the country.⁴¹ We have been told that it is difficult to recruit staff to socially deprived areas of England, which often have a particularly high demand for GP services. Respondents offered a number of suggestions for addressing this problem.

First, some argued that commissioners should remove restrictions on new providers being able to set up practices. However, others argued that if permission to set up new practices is not granted in a targeted manner, it could exacerbate the problem by attracting doctors away from deprived areas instead of to them.

³⁹ The Centre for Workforce Intelligence (CfWI) is currently undertaking a review of current and future workforce trends in general practice. In their preliminary findings they state that a boost in GP training numbers of 3,250 by 2015 is required to meet expected future patient demand by 2030.

⁴⁰ See <https://hee.nhs.uk/2013/05/28/new-education-and-training-measures-to-improve-patient-care/>

⁴¹ CfWI (2013), *GP in-depth review: Preliminary findings*, p.16. Available at: www.cfwi.org.uk/publications/gp-in-depth-review-preliminary-findings

Second, both existing and prospective providers reiterated the importance of ensuring that the funding formula for GP services accurately reflects the mix of patients served by GPs. If that were the case, the relative revenues of providers in socially deprived areas would be likely to rise. Where this is not the case, GPs told us that it can result in additional pressure on their workloads, low morale, and difficulties meeting the needs of patients in those areas.

Third, other GPs pointed out that there are broader factors that are likely to affect where GPs choose to locate. There may therefore be value in NHS England and Health Education England carrying out further research into the factors that make it difficult to attract GPs into remote or socially deprived parts of the country and how this has been addressed in other professions.

2.2.4 Identifying and tackling poor performance

Most GMS and PMS⁴² arrangements to provide GP services are long term or, in the case of GMS contracts, are not time bound. This means commissioners cannot rely on the contract renewal process to provide a regular opportunity to assess the quality of the services a GP provides and address any issues that arise. In addition, as outlined above,⁴³ patients receiving a poor quality service may face difficulties in changing their GP service. These two factors make it particularly important for commissioners and regulators to have effective means of identifying poor performance in general practice and taking action when patients are not receiving high quality services.

While we heard some examples of commissioners that had been very effective at identifying and addressing instances of poor performance, most stakeholders who commented on this issue suggested that in general this has not been the case. A number of respondents suggested that there was very little contract management taking place during the transition to new commissioning arrangements, with a perception among CCGs that NHS England area teams⁴⁴ are too remote and/or insufficiently resourced to perform this role.

A number of CCGs told us that they were unclear about their responsibilities in relation to general practice. While they were clear that the commissioning and contract management responsibilities lay with their local NHS England area team,

⁴² Personal medical services agreements are made under section 92 of the National Health Service Act 2006 in accordance with the National Health Service (Personal Medical Services Agreements) Regulations 2004.

⁴³ See the discussion about switching rates, in Section 2.1.2, above.

⁴⁴ NHS England has 27 area teams but acts as one single organisation operating to a common model with one board.

they said that they were less sure about their role in identifying poor performance and in helping develop and support struggling providers.⁴⁵

In a recent publication,⁴⁶ the Chief Inspector for General Practice set out how CQC intends to identify and address instances of poor quality provision in general practice.

What we have been told suggests that clarifying and explaining the division of responsibilities between the CQC, NHS England area teams and CCGs for identifying and tackling poor performance in general practice should be a priority.

The ability of new or existing providers of GP services to develop the scope of their offer to the NHS: proposed further work by Monitor

3. Investment in premises: Monitor will work with NHS England to consider how the capital funding and reimbursement regime for general practice could be improved to better support investment in premises and the delivery of high quality out-of-hospital care.

4. Conflicts of interest: NHS England and Monitor will continue to promote awareness and understanding of their guidance on conflicts of interest through their ongoing engagement with the sector about the Procurement, Patient Choice and Competition Regulations.

2.3 Providers incentivised and able to work together in ways that benefit patients

A theme that emerged in many of the written submissions we received and during stakeholder events is the scope for delivering greater benefits to patients by providing out-of-hospital care in a more integrated way, involving primary, community, secondary and social care settings.

It was argued that this could help deliver better preventative care and self care for patients with long-term conditions, reduced hospital admissions and quicker discharge back into the community for patients receiving care in an acute setting.

Stakeholders highlighted a number of ways in which they believe this could be achieved, including: increasing the scale at which providers of general practice services operate; removing perceived or actual barriers in the contractual and

⁴⁵ Some CCGs told us that they would like to take on responsibility for commissioning general practice, while others argued that this would raise too many difficulties concerning conflicts of interest.

⁴⁶ CQC (2013), *A fresh start for the regulation and inspection of GP practices and GP out-of-hours services*. Available at: www.cqc.org.uk/sites/default/files/media/documents/20131211_-_gp_signposting_statement_-_final.pdf

reimbursement system; and by better information sharing between providers within and across different care settings.

2.3.1 Achieving greater scale in general practice

We heard about different ways of achieving greater scale being explored by GPs, including mergers, networks and federations. It was argued that these arrangements have the potential to bring about two types of benefit.

First, we heard that different providers coming together to achieve greater scale (either through co-operation or consolidation) may allow them to reduce their unit costs, for example by sharing back office functions.

Second, it was argued that serving a larger population may allow providers to develop business cases to hire specialist medical and nursing staff and begin offering services that would traditionally be provided in an acute hospital setting.

A number of stakeholders were concerned that some attempts to increase the scale at which providers operate may give rise to competition concerns, and asked for clarification about whether this would be the case. This suggests to us that it would be useful for Monitor to help the sector understand the right way to consider the potential costs and benefits associated with operating at greater scale.

In their joint publication *Securing the future of general practice*,⁴⁷ the Nuffield Trust and King's Fund recommended that Monitor examine "the experience...of super partnerships, networks, multi-practice organisations and community health organisations, in order that the benefits of 'at scale' primary care are not compromised by concern about (actual or perceived) limits to choice and competition of practices working in more collaborative ways."

2.3.2 Removing barriers to the delivery of integrated care across primary and other health care services

A number of commissioners and providers are starting to explore innovative contractual and organisational models across primary, community and secondary care in order to enable and encourage providers to co-operate in ways that they believe are good for patients.

These include a range of different models, including the commissioning of patient pathways, the introduction of arrangements that hold groups of providers collectively to account for outcomes across a population, and the development of fully integrated primary and secondary care organisations.⁴⁸

⁴⁷ King's Fund/Nuffield Trust (2013). Available at: www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice-full_report_0.pdf

⁴⁸ Similar to Accountable Care Organisations (ACO) that exist in the United States.

Many respondents told us that they view these arrangements as key to delivering more co-ordinated and better managed care, particularly to the frail elderly and those with chronic conditions, preventing unnecessary hospital admissions and/or reducing patients' lengths of stay in a hospital setting.

A number of actual or potential barriers to this being achieved were described by respondents, as set out below.

Inflexible contracts

Commissioners and providers highlighted the difficulties created by general practice and community and secondary care services being commissioned through different contractual routes, with some arguing that it would be easier to commission services from a range of providers if it were possible to commission all services under the NHS Standard Contract.⁴⁹

However, other respondents were keen to emphasise the flexibilities that already exist for commissioners to use PMS agreements or APMS contracts to introduce new ways of working across a defined area, but argued that commissioners do not make sufficient use of these.

In addition, a number of GPs argued that a significant number of the outcomes specified in the Quality Outcomes Framework (QOF)⁵⁰ do not fully reflect local priorities. Some added that it would be desirable to link payments for GP services more closely to quality outcomes than to patient numbers. However, others were keen to emphasise that here too flexibility does exist for commissioners and providers to negotiate local quality targets. Furthermore, following recent negotiations, the 2014 GMS contract will include a sharply reduced number of QOF targets.

Potential competition concerns

Questions were raised by commissioners about the regulatory implications of some attempts to integrate services and whether these would raise concerns relating to procurement rules. This suggests that Monitor should continue to provide more guidance to the sector about the application of the Procurement, Patient Choice, and Competition Regulations.

Payment systems

A number of commissioners and providers told us that there may be scope for the payment system to develop currencies that support the delivery of more integrated care. They argued that the current system incentivises secondary care providers to

⁴⁹ www.england.nhs.uk/nhs-standard-contract/

⁵⁰ Under which GPs' reimbursement is partially linked to achieving a nationally specified set of outcomes.

maintain high levels of activity in acute settings when patients might more appropriately be treated outside hospital. Participants in our round-table discussions raised the question of how these currencies (or other innovations in the reimbursement system) would be able to include core GP services when many providers are already reimbursed for these under GMS contracts.

Joined-up commissioning

A number of GPs and CCGs highlighted the importance of NHS England area teams, CCGs and local authorities working effectively together to ensure that their separate commissioning decisions result in joined-up solutions for patients. For example, it was pointed out that unless appropriate agreements are reached between commissioners, a shift of care from acute to primary or community settings could result in a saving for CCGs but a cost for NHS England area teams, which may in turn frustrate such a shift even though it would deliver overall benefits to patients. Similar issues were raised in relation to social care provision.

Others pointed to existing flexibility which allows commissioners to work together. Legislation already allows NHS England and one or more CCGs to jointly carry out NHS England commissioning functions. In addition, the Department of Health is currently exploring the potential to introduce changes (through a Legislative Reform Order) which would make it easier for NHS England and one or more CCGs to jointly carry out a CCG commissioning function.⁵¹

Monitor is supporting the exploration of issues affecting joined-up commissioning through the integrated care pioneers programme.⁵²

2.2.3 Information sharing

The timely transfer of information between providers is important for maintaining high standards of co-ordinated care for patients who are receiving treatment across more than one setting. GPs that we heard from suggest this is not always working well, with, for example, failures by some secondary care providers to deliver comprehensive discharge information and delays in GPs receiving pathology results. We also heard from patients who provided examples of missing test results, incorrect referrals to secondary care and clinicians who were unaware of the previous treatment their patients had received.

A number of patients, healthcare providers and commentators also stressed the need for better and smarter use of information within general practice, as well as the

⁵¹ See launch of legislative reform order consultation to allow joint committees:

www.england.nhs.uk/2013/11/28/bulletin-for-ccgs-issue-47-28-november-2013/#lro

⁵² 14 pioneer areas were selected by NHS England, Monitor and other national partners to explore the development of more co-ordinated models of care. A number of these are exploring new ways of working with general practice. See: www.monitor.gov.uk/regulating-health-care-providers-commissioners/enabling-integrated-care/integration-pioneers

need to share information to ensure effective patient care (including self care) and better use of resources. Some providers, for example community pharmacists, indicated that their inability to access patient records acts as a barrier to offering services to patients and relieving pressures on GPs.

NHS England is currently developing nationally-held summary care records, which detail a patient's medications, allergies and adverse reactions⁵³ and will provide timely, accurate information to patients, clinicians and commissioners. The aim of the summary care record is to make better use of the information in medical records to improve the quality of patient care. NHS England has asked for views about giving community pharmacists access to summary care records as part of its call to action for community pharmacy.⁵⁴

Providers incentivised and able to work together in ways that benefit patients: proposed further work by Monitor

5. Achieving greater scale in general practice: Monitor will provide guidance on the regulatory implications of different approaches to providers achieving greater scale in general practice, including mergers, federations, “super-partnerships”, networks and multi-practice organisations.

6. New contractual and organisational models to support the delivery of integrated care: Monitor will work with NHS England to examine different contractual and organisational arrangements that could support the delivery of more integrated care to patients. This will include an analysis of alliance contracting and population-based risk sharing arrangements across different providers of primary, community and secondary care.

7. Information sharing between primary and secondary care: Monitor will review whether NHS foundation trusts are meeting their requirements under the provider licence to share information with GPs in a timely manner and seek to understand any barriers to their doing so.

⁵³ See www.nhscarerecords.nhs.uk/. So far about half the population of England have a summary care record: www.nhscarerecords.nhs.uk/havescr

⁵⁴ See www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pharm-cta/

2.4 Conclusion

There is a significant amount of work taking place to help address the current challenges facing general practice, including activity by providers, commissioners and national and representative bodies.

What we have heard from responses to our call for evidence suggests that Monitor can support this work in three main ways:

1. By undertaking research to gain a better understanding of variations in access and quality of GP services and the factors which limit patients' ability to make choices about their care;
2. By doing research to gain a better understanding of the factors that limit commissioners' ability to enable high-quality providers of GP services to invest in expanding their services, or for high-quality potential providers to begin offering GP services, especially in areas with currently low levels of access and/or quality; and
3. By offering regulatory clarity and guidance that the sector is seeking to enable and facilitate efforts to provide more integrated care where this is in the best interests of patients.

3. Summary of proposed further work

As noted under each of the three major headings in Section 2, we intend to conduct further work in the following areas:

Variations in access and quality

1. We will carry out analysis of the nature and extent of supply and demand of GP services to gain a better understanding of variations in access and quality across England and how these may be addressed.

Demand for GP services

2. We will conduct research into the factors that prevent or restrict patients from choosing their provider of GP services.

Supply of GP services

3. As part of ongoing research into improving the NHS capital funding regime, Monitor will work with NHS England to consider how the capital funding regime for general practice could better support investment in premises and the delivery of high quality out-of-hospital care.
4. Monitor and NHS England will continue to promote awareness and understanding of guidance on managing conflicts of interest during their ongoing engagement with the sector about the Procurement, Patient Choice and Competition Regulations.
5. We will research the regulatory implications of different approaches to providers achieving greater scale in general practice, including mergers, federations, super-partnerships, networks and multi-practice organisations.
6. NHS England is conducting research into the different contractual arrangements that could support the delivery of more integrated care to patients across general practice and other health and social care services. This includes the potential for greater use of contracts that hold groups of providers collectively to account for outcomes across a population.

We will support this work by advising on application of the regulations on procurement, patient choice and competition, and by considering how the pricing system can support these arrangements where they are in the best interests of patients.

7. We will research whether NHS trusts and NHS foundation trusts are meeting their requirements under the provider licence to share information with GPs in a timely manner, and any barriers to them doing so.

3.1 Further chance to comment

We aim to make significant progress in carrying out this work during 2014.

We welcome further comments on this discussion document or on the work that we propose to take forward.

If you would like to comment, please email us at: gpservices@monitor.gov.uk

or write to:

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



Making the health sector
work for patients

Contact us

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

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.monitor.gov.uk

This publication can be made available in a number of other formats on request. Application for reproduction of any material in this publication should be made in writing to enquiries@monitor.gov.uk or to the address above.