

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



This document contains non-confidential providers' 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, local medical committees 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.

This document includes responses from:

- GPs
- GP practice managers
- Nuffield Health
- Other providers

Please click on items in the list above to jump to the section you require.

GPs

Dr Nazaff Adam

One of the biggest issues is increasing demand and lack of investment into primary care.

GP's are taking on more and more work; looking after more complex cases than we have ever done in the past—this with no real term investment in primary care is having a major adverse effect.

Older GP's are feeling very stressed/work satisfaction and moral is low/and the continuous negative press certainly does not help.

Younger and newly qualified GP's are waiting and biding the time as they watch what all the changes in the NHS will result in.

Until there is an appreciation of all this general practice will slip down a slippery slope

I fear for the future of primary care in UK

Dr Daniel Albert

Thank you for inviting evidence on this important, but neglected, topic.

In this letter, I will describe how General Practice in England has suffered from a profound lack of innovation over the past few decades. I will discuss the detrimental effect this failure to keep up with medical developments is having on patient care and the strains it puts on the rest of the NHS. I will also suggest ways in which the current contracting mechanisms for primary care are maintaining this unfortunate situation, and how they can be altered simply to allow primary care to achieve its potential

In doing this, I realise that I stand out from the crowd of typical GPs. Certainly, the submission from my local LMC (Leeds) is entirely at odds with what I am saying, and I believe the response you receive from the RCGP will also extol the ***status quo***.

My Background

I have been a GP for 19 years. During this time, I was a partner in a practice for 12 years and worked in a variety of salaried roles for the remainder. I have also had leadership/ commissioning positions as PCG Chair and PCT PEC Chair. I am currently a non-executive director of Leeds South and East CCG. In addition to General Practice, I have an interest in Emergency Medicine; an interest which has allowed me to also see things from a hospital perspective. I am a member of the

Royal College of General Practitioners and an Associate Fellow of the College of Emergency Medicine. The views expressed in this letter are entirely my own.

Changes to General Practice over the years

GPs often complain that more and more hospital tasks are being transferred to them, without the funding following. Whilst the economics of this is probably valid, clinically the opposite is nearer the truth. GPs, of our parents' generation, were part-time obstetricians, anaesthetists etc as well as full-time family doctors (day and night). Patients with Heart Attack, Stroke, Pneumonia etc were looked after in their own homes. GP surgeries in the 1960's had more medical equipment in them than do the purpose-built health centres of today.

As medicine and medical technology has advanced, rather than embrace the changes, GPs have handed the new developments over to the hospitals, and retreated into a cosy environment where the main currency of General Practice is less diagnosis and treatment and more the "consultation" – an exalted conversation. The fact that so much General Practice can now be conducted over the telephone, or internet, suggests that very little practical is actually going on. This is not altogether a bad thing. Helping patients to make sense of their own health and of the health service is a noble and useful activity, but the diagnosis and treatment of conditions of intermediate severity – needing more than a few tablets, but less than an A&E department, has no place in which to be conducted. Unfortunately, these are the very conditions that are on the increase, as more of us live longer with our chronic conditions. Primary care could, and should, do much more. This has been widely recognised for many years, but attempts to enable this modernisation have largely stalled. Lord Darzi had this issue in mind when he proposed GPs getting together to form poly-clinics where economies of scale would make more modern medicine possible. The concept changed so much, during the contracting process, that the new centres provided a service that was less than mainstream general practice, instead of more – as intended.

Clinical Gaps in Primary Care

Since there is no absolute definition of what "primary care" consists of, it is somewhat a matter of opinion where the primary/ secondary line should be drawn. The line has certainly moved in the direction of lower acuity conditions over the years. This has been particularly the case in urban areas, but rural medicine has not escaped. Many, perhaps most, GPs do not carry emergency equipment and drugs with them any more. They have allowed their skills in this area to fade to the extent that they take advice from paramedics with much shorter (and cheaper) training. Hospitals have absorbed much of the work that used to be dealt with in the community. Minor injury units, clinical decision units etc are devices for treating patients AT hospital, but not really IN hospital. Increasingly, patients are being sent to hospital for investigations and opinions to determine if they need hospital

treatment. Sometimes, this makes sense – where a CT scan is required, for example – but X-rays and blood tests have been around long enough, that they can be provided effectively and cheaply in community settings.

The other problem in GP surgeries is access. In the A&E department, access is determined by clinical severity and urgency. In general practice it is more about understanding the local system and telephoning at a particular time. This applies as much to GP out-of-hours services as to surgeries themselves. Whilst booked appointments are convenient for those seeking planned reviews, if you are ill the distractions of work, shopping etc are precluded anyway and you might as well sit and wait. Which is why many patients “vote with their feet”, and make their way to the only place with the lights on all the time.

What are the contractual blocks to modern primary care?

There are two restrictive practices that mitigate against development.

1. **A closed-shop of immortal contracts.** GP practices, for the most part, enjoy open-ended GMS or PMS contracts. As GPs can appoint their own successors, the practice becomes immortal. When this is combined with restrictions on setting up new practices, all competitive incentives are removed. In theory, practices might compete for each other’s patients, but few have the financial backing to invest heavily for a return in many years time. It is far more attractive to draw the profits and enjoy a comfortable lifestyle in the knowledge that your business is almost totally secure.
2. **Protection of Primary Care from “Commissioning”.** From GP-fundholding to the present, arrangements have been in place for GPs to re-design services to suit the needs of their patients better. The only services that they were not permitted to redesign were their own GP practices. Investing in primary care was prevented for reasons of “probity”. It would be too much like putting money in your own pocket. Yet massive development of primary care is precisely what is needed to avert the current crisis of too many A&E attendances and too many admissions. By keeping “commissioning money” separate from “practice income”, the treasury can be satisfied that GPs are not pocketing public funds inappropriately (there is good evidence that many will try, given half a chance). Unfortunately, the policy prevents not only fraud, but innovation as well.

The way forward

GMS, PMS and APMS contracts should be abandoned. There should be a new contract for GP practices to enter into. It might be called New PMS (standing now for Primary Medical Services). Companies as well as individuals will be eligible to apply to take on these contracts, so long as they can demonstrate robust clinical leadership. The contracts will require arrangements to be in place for, *inter alia*:

1. Current GP work
2. 24/7 walk-in access to minor injury/ moderate illness service
3. 24/7 multi-disciplinary home visiting service for the housebound and terminally ill (to replace GP OOH and District Nursing)
4. Community paediatric service to include health visitor and paediatric support
5. Arrangements for transport of those who are not housebound, but cannot make it to the walk-in service and/or ECP visiting service.
6. community basic radiology and laboratory services.

This list is probably not comprehensive, but is intended to give an idea of what a complete primary care service might look like. Contracts for parts of the service should not be issued. Small practices will clearly need to sub-contract aspects of their service. There will be business opportunities both for taking on large primary care contracts and for setting up support organisations that enable smaller practices to survive.

I hope you find the above information helpful. Please feel free to contact me for further clarification etc.

Dr Helen Alpin

It is with disappointment that I find the call for evidence is taking place for an extremely short time over the summer months when many will be on annual leave. This gives the impression that there is little commitment to genuine consultation and that this could be seen as a "tick box" exercise.

The underlying motivation of this process seems to be the opening up of general practices services to the private sector. There is no evidence that competition will improve the quality of health services. There is significant scope for "cherry picking" and tendering on a lost leader basis. Both these corporate games will have a detrimental effect on the provision of an integrated, comprehensive, affordable health SERVICE for the population.

Speaking as an inner city GP primary care appears to be one of the most accessible services for people who struggle in their access to other services. There is choice of practice and no barrier to people switching practice as they wish. The current contracts are restrictive in the fact they are based on a capitation basis whilst this is cost efficient and limits the costs of primary care they have the perverse incentive that the more service that is provided the higher costs of providing the service and lower profits.

The current organisational structures of the NHS inhibit the development of commissioning primary care as it is widely thought that CCGs commission primary care which of course they don't, they commission hospital services over which they can have little influence. The evidence on commissioning suggests that GPs would have most impact if they were to commission primary and community services.

GPs are currently working beyond sustainable capacity. As funding is cut this situation will get worse. Further investment in primary care would allow GPs to provide new services. GPs are a flexible adaptive resource who will innovate if given the right conditions.

To improve general practice there is an urgent need to invest in this sector including increasing the number of GPs.

Dr Utpal Barua

I am a retired GP with 35 years experience . I am also a Public governor at the local hospital. My particular concern is that there appears to be a recent trend in GP

practices to abdicate the traditional role of continuation and supervision of care management and follow up by a first contact GP. Such a practice results in inconsistent patchy care to patients as very few busy doctors review recorded notes. Patients are unable to see their preferred GP, & on many occasions shunted to either a locum or a Registrar. One of the common complaint by patients is ' -doctor was not interested in my problem , he was only making notes in his computer.'

Also there appears to be a tendency among many GPs to decline any advice if the patient was suffering from more than a single complaint.

In hospital practice ,if the client is identified with multi system (some time related) care needs , patient must return to their GP for multiple hospital reference resulting in delay & longer suffering.

Such repeated visits are undoubtedly expensive and inconvenient to patients and avoidable.

Dr David Chilvers

I saw the link on monitors e-mail trail. I suspect that the way in which the question was phrased would be much more likely to attract the attention of the disgruntled and single issue respondent so I thought that I would add in my thoughts.

I am a GP and also a chair of a CCG. I have seen General Practice change beyond recognition over the last couple of decades. The workload has changed and indeed

increased. We all complain about how busy we are, whether we are or not. However I would comment that I remember my colleagues were able to take breaks, lunches and even go home for a while during the day. Gradually these have whittled down and they are now having sandwiches at desks and going home late.

In spite of this GP access remains extremely challenging. Patients consistently tell me that they like a choice in ways of contacting me. We offer walk in surgeries, telephone appointments, bookable face to face appointments, e-mails and nurse clinics. We are a hugely low earning practice as a result, spending over a hundred thousand pounds a year over and above the national average so that we can offer this level. However whilst we have a growing list we still have queues and disgruntled people who want more. Moreover we have one of the highest access rates for ED.

I believe we need more GP's. Possibly not as many as the RCGP is advocating but many more than the current task force is suggesting. Meanwhile, since 2004, patients have lost the 24 hour cover from an individual person. This lack of continuity means that education is not undertaken and they lose the ability to self manage.

I also believe quite strongly that no-one ever goes to work wanting to do a bad job. The youngsters I see coming through training want to make a difference. The question about whether GP's are operating in the best interest of patients was, to my mind, inflammatory and unhelpful. We need all branches of the health service to avoid getting into such situations and to try and work together. There is no easy answer to our current predicament so we must go forward as a team or we risk impotence through infighting.

Dr Tim Cotton

Please find my comments in response to your request for feedback. These comments are made without prejudice and are my own rather than WHCCG opinions. That stated, I would like to think that they are in tune with my fellow commissioners and GP colleagues. I will take each point in turn

- the ability of patients to access GP services, including their ability to switch practices;

In West Hampshire the feedback from patients completing the patient satisfaction surveys indicates that the vast majority of patients are satisfied with access to GP Services. 96% of member practices in our commissioning group took part in Patient Reference Group activity under the auspices of the Patient Participation Group Direct Enhanced Service.

[✂]

My own experience suggests that patients can easily switch practices if they live within the practice designated boundary. Most practices have extended their boundaries in the last year

- the impact of the rules for setting up and/or expanding a general practice;

Expansion, merger, collaboration and confederation are cited by many as the way forward for a sustainable general practice of the future. If this truly is the way forward then the rules will need to facilitate these processes.

- the impact of the different contractual terms under which practices operate;

I believe that these can lead to disparity in service provision for NHS patients, depending on which contract is held by the practice they are registered with. PMS and APMS practices often negotiate to provide very useful and affordable services, but if a local GMS practice wants to provide a similar service they cannot under GMS. There may be a work around with Locally Enhanced services in some circumstances.

My personal opinion is that PMS and APMS are very much 'political' contracts and that GP practices who are not prepared to change from a GMS contract are disadvantaged and in turn patients registered with them are disadvantaged.

Again my personal opinion is that none of these contracts lend themselves toward innovation.

- 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;

GP's are able to expand the scope of services they provide but only within the limited NHS budget for primary care.

Expanding a service costs money, whether it is in setup costs or running costs. General Practices in West Hampshire are actively piloting new services, and employing new care pathways through money that has been sequestered from QOF.

My personal opinion is that NHS General Practice is currently existing by virtue of the goodwill of GP Partners who are in many instances finding themselves in considerable financial difficulty. These GP Partners are taking home far less than a GP locum or a salaried GP. If services and resources are diverted from NHS General Practice I believe that the NHS GP will become extinct and that will have disastrous results for secondary care and the NHS as a whole. I firmly believe that

General Practice is the lowest tier of a NHS house of cards and that GP tier is not looking very robust. In my personal opinion this is the most serious concern.

- the process for commissioning new services from general practices, the factors that influence these commissioning decisions and any challenges that commissioners face;

The current model of commissioning new services from general practice is limited by the existing GP Contracts and by the current funding streams and lack of money to pay for these. There are local innovative projects promoting integrated care with community based consultants and GP Fellows providing better NHS services for frail elderly, but as and when these projects prove to deliver better services and better care for our patients, it will be impossible to roll these projects out across the CCG patch because the primary care budget would not stretch that far. It is difficult to predict (if recent research is to be believed) whether or not efficiency gains in the secondary care sector might arise from these projects and without resources being reallocated from secondary care there will not be resources to fund these services for all NHS patients. It will take bold commissioning decisions to effect change.

Procurement and the legal issues surrounding services that are provided by a GP with a list and services where a procurement exercise is required

- factors that affect potential providers' willingness or interest in providing new services;

Financial viability, infrastructure set up,

- 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.

There are local innovative projects promoting integrated care with community based consultants and GP Fellows providing better NHS services for frail elderly. I am in active discussion with local GP's discussing collaboration, confederation and mapping a route to a future General Practice where integrated care is the norm. The RCGP paper The 2022 GP –A Vision for General Practice in the Future NHS outlines some of the constraints now and the developments in terms of human resource and training that will be required in the future. I think it paints an accurate picture

Dr Relton Cummings

You are seeking evidence on the effectiveness and accessibility of Primary Care in England. Whilst I have no data to back up my comments they are based on 31 years as a GP, 11 years as LMC Chairman and 7 years as chair of first a PBC group now a fully authorised CCG.

Primary Care in England has struggled with increasing demand and expectation of both the public and politicians. The change to the GP contract in 2004 has been both a blessing and a distraction. A blessing in that it did result in more investment in Primary Care at the time with a focus on rewarding a series of markers relating to clinical and managerial good practice, and a distraction in that ever since then there has been little further investment and much political 'hay-making' most recently in blaming the new contract for the crisis in A&E.

Throughout this General Practice has continued to provide, in the main, high quality care and is well respected by patients and public. That the QoF framework rewards process rather than outcomes is true as is the fact that other things not in QoF may not be prioritised. What is not appreciated is the things that cannot be measured by QoF, like continuity, cradle to grave care and a level of personalised service unmatched elsewhere in the world. Investment in alternative providers like the Darzi Equitable Access program have sometimes improved access but more often simply created another point of access without significantly helping with workload and at a much greater cost than conventional GP practice. One of our Darzi practices has closed due to poor patient recruitment and the other has enough patients to support one WTE GP but mostly by taking other GPs patients rather than taking previously unregistered patients and in hindsight, had the same level of investment been put into mainstream GP it is my belief we would be seeing a much better outcome emerging.

As the population ages and Long-term conditions affect greater numbers, the workload on Primary Care has risen exponentially. This, coupled with greater expectation on behalf of the public, sometimes fuelled by politicians seeking re-election, has created a near-unsustainable level of demand. Recently several organisations have produced suggestions for a new model of Primary Care organisation, notably the RCGP, the Kings Fund and the Nuffield Trust. A move away from the small business model towards Federations or other larger structures seems inevitable but with it needs to go a recognition that 9% of the total health care spend is no longer enough to deliver what is required of General Practice. If more is to be done in the Community and less in hospital then serious investment in Premises and infrastructure particularly IT, needs to be undertaken.

Average registered list size, which when I started in 1980 was around 2000, has fallen to around 1600 but it is arguable that in order to deal with the complexities of modern General Practice, the average list size may need to fall to closer to a 1000. Given that list size is a proxy for income, I am not arguing for a cut in income but more recruitment, training and possibly even a move to a salaried service must be considered, despite its unpopularity in some GP quarters. What we do not need is another Government quick-fix like many other 'bolt-on' solutions, that applies to small sectors of the country, like central London, but which have little relevance elsewhere. There is, without doubt, variation in the quality of practice in different parts of the country and even within my own CCG and tackling this variation is a priority. It is also

a truism that some GPs, given financial investment in their practices would prefer to translate that into profits rather than healthcare delivery, so some form of ring-fencing would be necessary to ensure the public gained the benefit of any further investment. Deprivation can be a major factor in how successful GP practices are in reducing health inequalities and some practices struggle manfully to hit targets and achieve coverage of QoF whilst some do manage to achieve good quality care. We need to balance investment in deprived practices with ensuring that they are trying to achieve better outcomes and not simply using the mantra of 'deprivation' to excuse poor performance. CCGs and Area Teams are ideally placed to drive up the quality of primary care but also need the flexibility to invest in it as well.

One must also acknowledge the role of other team members in General Practice, particularly practice nurses who deliver the majority of LTC management with no additional investment or resource. Community nurses, being employed in the main by other providers, can have variable degrees of integration and role sharing with practice nurses and pooling the nursing resource under the direction of the Primary care team has distinct advantages.

British General Practice has been the 'Jewel in the Crown' of the NHS and GPs have generally coped with the myriad of reorganisations and changes imposed by successive governments and retains the highest level of trust of any professional group. Some parts of the DoH seem to view GPs as part of the solution to the NHS problems, hence CCGs, and others view them as part of the problem, to be brought into line, competed with, increasingly regulated and made to jump through more complex hoops to achieve funding.

The DoH needs to understand what it has before it is left to wither on the vine.

(These views are personal and not representative of NNECCG)

Dr Ah Esteki

I am a GP who is also intensely involved in the commissioning and also working as Quality and Productivity Lead but also Prescribing Lead and RCGP Clinical commissioning champion and I wish to give you a balanced opinion about the impact of the changes that we as GP experience.

It is to my regret that GP have been forced to act as agent to "cost cutting" for the DoH and also risking the long term relationship with their patient. Since the new commissioning group have taken over the work from the PCTs I have seen not only a significant increase in my workload but also have been subject of abuse by the Heath Secretary.

I have been working for over 15 years in the NHS and have never felt so patronised despite the excellent work I have been consistently offering at the same time being

blamed for repeated failure of the Secretaries of State for Health in successive governments.

This is at the same time where the Secretary of State has arbitrary changed the quality and outcome framework mono-laterally and failing to engage with the BMA and the DDRB recommendation.

One has to have a short memory not to remember the data that were collected in US and published in 2008 that showed the GPs in the UK not only have the highest knowledge worldwide but also have the highest patient satisfaction a head of US and Australia.

Also the policy maker should not forget that we negotiated a new contract in 2004 because the retention and quality of primary care had a significant decline and only after the new contract we managed to attract highly qualified and enthusiastic team of people that have driven the care so highly. One example is mapping obesity that is unique in the world.

We truly do not appreciate the fact that this government though very inexperienced does not wish to listen to those who have been improving the care of population year on year and instead deciding to bring in an arbitrary increased workload for every GP in the country. Be reassured this only harming the patient as the doctors are swamped with inappropriate tick boxing exercise and the valuable time is spent to satisfy government consortia reshuffle and restructuring. This is particularly harming the elderly whose only champion we have always been always. This is because the we do not have any sufficient clinical time left after so much work to dedicate any time to them thanks to new enforced QOF and consortia workload. We also should be clear about the fact that most of these works are neither remunerated nor appreciated by the current government.

To make things worse in a surgery the size of ours a financial loss of almost due to enforced new QOF workload is around 70k (enough to make two health care assistant and one full time nurse redundant) and it is predicted for the new year and this means job losses and service cut to the most vulnerable part of our society such as mental health patients and the elderly. This on the top of pension increases above 13 % that is almost if not the highest in the public sector. Neither judges nor MP themselves or Police pays such high contribution as we do and this has to be made fairer.

I wish to remind the reader that when we provided out of hours care before 2004 the quality was much higher and the cost significantly less than the current insufficient and fragmented out of hours service. I am struck by the lack of understanding on the side of the policy maker why they could not see this can consequently lead to increased A&E attendances and admission. Is this not the evidence in itself that the policy maker should let us run the services as they are needed not as they are

wished by the secretary of state for vote winning exercise-this does backfire often when locked at Darzi centres and the creation of the PCTs itself.

My whole heated plea is to let us do what we have always done best not only here but worldwide and remove the increase workload or remunerate it so we can offer even better services. If this did not materialise then be prepared to have even worse situation for the A&E then currently we experiencing

Finally, there is always a choice and this is you either pay for the good quality work or you don't get it. I hope the policy maker DO get it right for the benefit of the patient and reduce our workload and pay us the decency that we deserve

Dr Mary Hawking

I am Dr Mary Hawking, until 31.3.13 a GP partner at [X] and with a continuing interest in the NHS, general practice and health informatics.

My views are my own.

In response to Call for evidence on general practice services sector in England – and despite the very short time allowed for comment and lack of publicity about the existence of the call, I would like to make the following observations:-

1. General practice, as you rightly observe, is and has been under increasing pressure: the factors involved include:-
 - a. Annual changes in the GP contract which appear to be based on a desire to get more work for less money leading to a need to concentrate on conditions covered by the QOF or DES rather than patient care.
 - b. A steady decline in practice income since 2005 associated with rising expenses and patient demands.
 - c. Unresourced transfer of work from secondary to primary care e.g. the majority of post surgical wound care, most care of diabetes, COPD and other LTCs (in my practice the majority of practice nursing hours are now used for this rather than the care for which we are/were funded) and even in some areas pro-operative assessments.
 - d. Little or no investment in practice premises over the past decade or longer: in Dunstable it is recognised that GP practice accommodation is only 60% of that needed for current services: we have been trying to develop a Dunstable Medical Centre since 1998: plans have almost been completed three times, when changes to the NHS organisation have meant that they have been aborted: I suppose the only good thing is that GPs have not suffered financial

consequences – unlike in areas where the private finance risk was borne by the individual practices.

- e. Because of a combination of inadequate premises or other space and the continuous changes in the contract it has been impossible to develop our services as we would have wished: the same applies to the majority of practices in the vicinity.
- f. The situation has been compounded by the demands placed on GPs to attend numerous meetings called by the PCT previously and now by the CCG, many of which involve a considerable amount of travel time.

2. Patient access and choice:-

- a. All the local practices have open lists: we certainly accepted patients who lived within the practice boundaries but had decided to change from other practices, and as far as I am aware, the other practices in the area do the same.
- b. There is a constant tension between same day, emergency and pre-booked appointments: this was discussed in individual practices and as part of QP 6-9 last year. My practice – and most of the others – ran a mixed economy which could be varied according to demand and number of appointments available. For many patients, especially those with LTCs, those needing help in getting to the surgery and those with other commitments such as work or family, being able to book an appointment in advance is important.
- c. Continuity of care – having one team or individual responsible for care – is very important to many patients especially those with chronic or multiple conditions or who are somewhat fragile: this aspect has suffered from the general lack of resources (including resources previously supplied by the community trust: the district nursing cover has been reduced, macmillan nurse services reduced and apparently will be withdrawn, community matrons – a service we valued highly and with excellent patient outcomes – reduced and under threat, Health Visitors no longer allowed to take direct referrals and so it goes on) and increased demands on the time of GPs, practice nurses, practice managers and other non-clinical staff by the current PCOs (PCTs->CCGs).

3. APMS and new entrants into general practice

- a. APMS contracts are usually won by large organisations: the whole process is designed to prevent small entrants, and the financial reserves demanded before any application will be considered effectively prevent GPs bidding for failed practices: however, there have been examples of the private winner of the contracts abandoning their contracts – and in the case of general practice,

this appears to transfer the patient load without any transfer of the resources or funding.

- b. New entrants require support from the PCO and for this to be affordable there does need to be a need: the previous PCT closed down the last single-handed practice to lose its GP (list size 2900 odd) rather than continue it or use it to attract a new entrant. I would not have thought that increasing the number of practices would be vfm. When the supply is already adequate.

4. Over regulation?

- a. It looks as though general practice will now be regulated and controlled by Monitor, CQC, NHS England, LATs, CSUs, CCGs, Las, HWB, PHE and many other bodies: no doubt all of these will be demanding paperwork and incompatible form filling. Just preparing for CQC diverted a vast amount of time from patient care – with the numerous regulators now involved with general practice, what proportion of time and resource will be taken up by preparing the paperwork for the regulators?

I hope this is of use: as I said, the lack of publicising your Call and the very short time will limit the input – especially from practices and patients.

If you had received “over 40” responses from various organisations by the time GP ran its story, could I ask for the details of your consultation advertising procedures?

Philip Horsfield

I write in response to your request for feedback on GP Services.

[X] is a long establish GMS practice with just under 10000 patients in North Tyneside. We have nine permanent GPs and also train GP registrars and foundation doctors.

In her podcast on your website, Catherine Davies asks for views in three areas. On behalf of the partners of this surgery, I respond below:

1. How easy is it for patients to access GP services or change practices?

This is a two part question.

- In relation to changing practices, moving from one practice to another is relatively simple. Patients simply register at their new practice (with no need to tell the old one), and records are then transferred via NHS England. The system could be made better if every IT system talked to each other, and records were able to be transferred electronically. There is a weakness in the system currently, as administrative and clinical staff are obliged to re-enter

data onto medical records whenever a patient moves. This could definitely be done better.

- How easy is it to access GP services? I imagine you will get a myriad of responses to this question, and many factors will be specific to patients' individual practices. In our practice we have a sophisticated appointment system which offers "book in advance" and "on the day/urgent" options. We rarely run out of appointments, so in general we feel the system works. However, patients may not get to see their first choice (favourite) GP if they book at the last minute, and this is often hard to reconcile.

Of greater concern in the current environment of the "A&E crisis" is the access to urgent care (or "walk in services"). GP practices are not commissioned to deliver this type of service, unlike the deeply unpopular Darzi centres. Our suggestion would be that local GP practices would be willing to deliver a similar service (across seven days) if they were paid a similar additional payment. We are aware of how much our local Darzi centre costs the NHS each year, and for the same money the other 29 local practices could be paid to have an extra "walk-in" GP with locally coordinated nurse led services as a back-up, and this could be added to the NHS 111 Directory of Services. Local GPs, with their greater knowledge of the patients, would also refer less of them on to secondary care.

2. How easy is it for GPs to set up a new practice or introduce new services?

It is very difficult to set up a new practice or even set up a new service in a current GP practice. The torturous process of doing a business case and getting it past commissioners is simply too much for any normal GP practice. The process has now been made even harder as general practice is now commissioned by three entirely separate paymasters; NHS England, Local CCG's, and Local Authorities. This is a retrograde step, and is stifling innovation.

The new "Any Qualified Provider" contracts which are being commissioned by CCG's and local authorities are not designed to allow GP practices to sign up easily. Old style Local Enhanced Services (LES's) required little more than a signature and the capacity to deliver the service. AQP accreditation is beyond the reach of most GP practices, unless they federate and apply as part of a larger organisation.

3. The primary care sector is changing. Is there anything stopping it changing for the better?

The Department of Health is perceived as the enemy of general practice. The Secretary of State, Jeremy Hunt, has mounted a huge media campaign aimed at tarnishing the image of GP's in the eyes of the public. We see this as a precursor to introducing private providers into "the market". In reality, general practice offers

excellent value for money and provides safe high quality patient care week in week out.

Is anything stopping change for the better? Yes. If local services which are traditionally delivered by GPs are “taken to the market” and put out to private tender, there will be a gradual destabilisation of hundreds of practices, and the core day-to-day work will be compromised as teams are downsized to reflect lost income. Patients will lose the one stop shop, and be forced to receive care of each illness according to who put in the cheapest bid. Private providers from our experience cherry pick the easiest services to provide, but in provision of that care will routinely exclude difficult to manage patients (for example mentally ill, obese & young children) who are routed back to their own doctors or to A&E.

Commissioners need to be directed back down a path of involving general practice in the development of new services. This is not the case currently.

General Practitioners are keen to remain relevant in the new NHS. However, they feel increasingly marginalised by the Department of Health, which is taking forward a privatisation agenda in order to (allegedly) drive down cost.

The current NHS commissioning infrastructure is designed to exclude GP surgeries and encourage private providers. That is a huge barrier to change for the better.

Dr Daniel Hughes

As a working GP I think general practices needs to change significantly to met the challenges ahead in delivering systematic excellent health care to our practice population. QOF has gone some way to make us becoming proactive rather than reactive but there is a way to go.

Recent changes introduced through the health and social care act have been massively destabilising to planning and delivering service change, vast swathes of organisational memory have been lost at a PCT/CCG and I feel a lot of time we are recovering ground form 18 – 24 months ago.

Innovation in practices need to be supported and championed...it is incredibly complicate to try and set up new services and navigate the rules associated with this, for instance I think it would not be unrealistic for my practice to replace an out going GP partner with a consultant geriatrician...but I haven't really been able to find anyone who could explain to me how to do this...it would be useful if the was a group of people you could go to with these ideas to tell you how to do this.

Primary care is swamped...increasing work load, falling income, falling moral, difficulty in recruiting not only into GP post but also nursing, HCA's etc...we can't get our noses of the grind stone to look at different ways of working...the analogy of trying to fix an aeroplane whilst it is in the air has been used. Support us with tools /

time / money...why has no one made the NICE pathways into useable protocols on the common GP IT systems?...why is common work such as protocol/template development being done a 1000 times in each individual practice across the country?

If core hours are increased this does not mean I will be able to see more patients, if I am forced to work nights and weekends this will mean I will have less availability during the week. Given the highest percentage of users of general practice are the elderly, children and mothers with young children it makes sense to concentrate our availability during the working day...though I admit there would be a strong argument for going to 7 day working...I would strongly resist night time working this tends to be more urgent care and hence may need more services than a gp can deliver... or is not urgent and can wait till the next day.

Which brings me onto patient expectations...currently my "urgent surgeries" are mostly taken up with young adults or children with self limiting illness which often means that the more needful elderly housebound patient with multiple co-morbidities is left waiting. We need to be honest about what the NHS is there for and what we can do for patients.

Finally...get the media off our back...celebrate the good thing about primary care.

[✂]

Dr Lakhveer Nall

I learnt of your call for evidence only today after a general email was sent to all north east GP practices by a colleague whom out of concern, that as a significant target group from whom you were hoping to get responses from, we appear to have not been informed. This raised concerns about the quality of the evidence you are hoping to collect and furthermore undermines work which otherwise appears to be very important.

Looking through your document I thought of specific responses. However I note that the Leeds LMC has written a response to yourselves and have to say that I would echo the statements made by my colleagues there.

As a GP my main concerns are chronic underfunding of primary healthcare services as can be seen when looking at the proportion of the healthcare budget that it comes from, variation in practice as a result of APMS contracts that were trendy under the recent Labour regime and create a degree of unfairness without necessarily demonstrating value for money or improved patient care.

Knowing what our patients value most from our own surveys appears to be access to a GP and continuity of care with the same GP. We have maximised access by

providing same day, open access, pre booked, telephone consultation and extended hours services. Interestingly enough, demand for Saturday mornings was not as high as expected and appears to be a way of us managing the weekly demand as a whole rather than specifically in a period where patients desire and I suppose that culturally most patients still appreciate that there is a fundamental difference between access to primary care services and urgent healthcare services. This raises another concern that diminishes the traditional qualities of primary care that patients most value – in that more and more secondary care services are being placed within a primary care setting and where the demand is met by intermediate care services, the fall back still places excess demands on the primary care providers.

During the Out-of-Hours period a private company has been contracted to look after our patients and the GPs who work for this company are in the vast majority locally established GPs who know their patient population and local clinical pathways very well.

Our CCG is proactive in establishing new services through locality based needs assessments, that as commissioners, we are taking an active role in seeking and establishing what we want to produce – delivering better patient healthcare experiences for our patients here in Sunderland.

Dr Liam O'Hara

Your inquiry into the 'Fair Playing Field' is opportune.

Let me initially describe the playing field as i see it.

GP practices are independent private businesses.

GP's contract the services of their businesses to a commissioner.

The commissioner can be anyone who wishes to purchase their services.

Commissioners may be state organisation(s), private organisations or individuals.

A contract is the nature of securing a relationship with a commissioner.

Thus a provider commissioner relationship is created.

In the case of Primary care medical services, the providers may be perceived as a monopoly⁽¹⁾, the commissioners in the case of the NHS as a monopsony⁽²⁾.

This relationship has served the NHS well since 1948.

The advantages of a monopoly-monopsony relationship are economies of scale, security and efficiencies.

When a market agenda is brought into the relationship, the advantages of the previous relationship may be lost.

The business of Primary Care (GP) is no different to any other business, it has a duty to secure its existence.

(1) <http://en.wikipedia.org/wiki/Monopoly>

(2) <http://en.wikipedia.org/wiki/Monopsony>

The duty of care to commission services in a society rests with its political representatives however they wish to derogate this duty. The duty to provide a service is borne out of a contractual relationship between a provider and a commissioner.

The nature of the contract between a commissioner and a provider and how that benefits the consumer is your brief.

A contract by its nature is a two way negotiated abstract.

The current contract contains many anomalies. These anomalies have persisted in sight of the monopoly-monopsony relationship. They have, up to a point, been a 'grace for favour' bond.

The change to a market model ruptures what precedes it; the perceived advantages and 'grace for favour' anomalies made redundant. A market is a market is a market.

What are these anomalies and what other observations from a provider perspective act as an innovative drag in a market based framework?

1. The restriction upon GP practices to offer private services to citizens upon its NHS register, outwith the minor schedule 11 concessions, yellow fever vaccinations etc. In essence if a commissioner has not commissioned a service which may be provided, the provider cannot offer to privately provide it to those it is contracted to provide General Medical Services under its NHS contract.

Contractualized hand-cuffs if you will.

It will be apparent that new providers in a fair, level and open market would balk at this clause.

A market provider presented with such an anomaly would find its business model difficult to establish de novo.

A market distortion, disturbing innovation and novel models of service delivery.

If the aim is innovation and new modern models of service delivery this clause has to be addressed fundamentally, best removed.

2. Service provision de facto requires premises, the anomaly of a 10% rule on business turnover with a private (non-NHS funded) contribution of $\geq 11\%$ has the ability to invoke a clawback of rental income (rental paid by the NHS to support premises and practices) by NHS England.

In a market attempting to cultivate innovation and the 10% rule and creativity of service delivery (1.) serve as a disincentive to new entrants as well as those existant.

3. Ordinary private business trades with 'good-will', primary care is not allowed to trade this abstract. An open market approach will find this restriction a disincentive 'to do business'. It would need to be removed across the board.
4. The blizzard of regulation (Juridification⁽³⁾) introduced into primary care and its effect upon its business model is suffocating. The agents of its genesis afflicted by Parkinson's Law⁽⁴⁾. Information governance, CQC,

⁽³⁾ <http://www.eurofound.europa.eu/emire/UNITED%20>

[KINGDOM/JURIDIFICATION-EN.htm](http://www.eurofound.europa.eu/emire/UNITED%20KINGDOM/JURIDIFICATION-EN.htm)

⁽⁴⁾ http://en.wikipedia.org/wiki/Parkinson's_law

Revalidation etc, are from a legal statutory sense meritorious, however, when imposed upon a small business they have the potential to demoralize and introduce a fiscal drag. This drag and effect upon morale has the potential to stifle innovation and creativity, the necessary ingredients upon which your brief sits.

5. The achievement of AQP and IgSOC in order to be commissioned is a hurdle 'small' finds more difficult than 'big'. By their nature GP practices in a business sense are 'small' their amalgamation to achieve 'big' is the only route open to them. The network of association (Metcalf's Law⁽⁵⁾) allowing them to have greater power in negotiation than their sum.

The discipline of History implores us to heed its lessons

lest ignorance repeat its follies. Hitherto FHSA/PCG/PCT's, and now the current political incarnations NHS England and CCG's are the agents of commissioning, the imperative of effective and efficient communitarian health care delivery is their brief. The practice of extending contracts to 'big' existent (Foundation Trusts) players distorts the playing field if 'new/novel' entrants are to be attracted. The interaction of business and its commissioning in Healthcare is indeed the 'new' Jerusalem.

⁽⁵⁾ http://en.wikipedia.org/wiki/Metcalfes'_law

The tapestry of business revolves around trust and reputation, there is no greater trusted profession in the general public's eyes than the Medical profession. If innovation of service delivery is to be cultivated it needs to be wisely nurtured.

Dr Dermot Ryan

Having read your document, it seems that once again an organ of government, which has little understanding of primary care, is once again proposing to tinker with it.

There is no room for competition between doctors or practices when there are insufficient GPs to provide services in the first place (which is one of the reasons why poorly performing GPs continue to work).

QoF targets, many of which lack clinical relevance and made more difficult to achieve by the "enlightened" Mr Hunt, serve to distort service provision even further: those disease areas which do not attract funding will assume a lower priority. The QoF targets chosen are the wrong ones and may be damaging, such as the new target for blood pressure in the elderly, which may lead to better stroke outcomes but achieved at the costs of more falls and fractured hips or the drive to detect those with dementia, when we do not have the medications to effect a cure (or even an amelioration) let alone the social services support which is the key to management of this condition.

Political whims constantly altering pathways of care and raising public expectations to a level which is unsustainable.

An exhausted demoralised primary care work force, which dreads opening the newspaper every day in fear of what the government briefing against them is today.

Primary care staff being laid off as ten years of successive resource cuts in spite of very significantly increased demand.

What needs to be addressed is the chronic underresourcing of primary care, the most efficient and effective part of the NHS, accounting for over 90% of patient contacts with less than 10% of the budget. The knowledge and skills deficit also needs to be addressed by providing high quality refresher courses, locally (within 100 miles where possible) which are incorporated as part of the working week.

The tone of this discussion document is discouraging and disheartening: the fact that the targets chosen are not those which would have been chosen by those on the frontline delivering the service, confirms that decision-makers have little regard and

less understanding of primary care, out hunting for more nails to place in the coffin of primary care, leading us down the road to US style health care where twice the money buys much poorer outcomes than we have in the UK.

What is needed?

1. A realistic appraisal of the capacity of primary care to deliver the proposed packages need to be made.
2. Support in terms of education and training need to be established to ensure that training and skill levels are both optimised and refreshed.
3. Fewer points of access to patients need to be made (Multiple choice of access equates to no choice as people do not know where to turn)
4. Investment in the infrastructure of the community in order to provide care closer to the patient needs to be made.
5. Integrated care pathways can only be developed if the perverse payment incentives currently deployed are moderated to ensure that these can be developed.
6. Consultation times need to be longer (at least 15 minutes) to reflect the growing complexity of consultations undertaken by an ageing population with multiple morbidities.
7. Judging clinical excellence by adherence to single condition guidelines is dropped: clinicians should be encouraged to use the guidelines to inform clinical decision making, not be coerced particularly when such an option may prove injurious to the patient for example the administration of a beta blocker for angina to the patient with asthma
8. Sustained investment in primary care including capital investment.

Dr Kashif Sarwar

With regards to General Practice, as a GP I feel the workload capacity for most GP's is at a tipping point, we are over stretched and working hard with all the NHS and political demands put on us. If you want the best for the NHS and patients you need to invest more in Primary Care and fund and train more GP's and Nurses. Do not fragment Practices and Privatise it, that will lead to poor quality of care and increased costs.

Dr Kadiyali M Srivatsa

Dear Mr Bennett

I read your comment in The Guardian and so visited your website and learnt what you do.

I am a doctor who worked in acute paediatrics in major hospitals since 1983 and GP surgery since 2000. When I started working as a GP Locum in various surgeries in and around London, I was very disappointed because I felt the care and management of patients was very poor. I believe doctors primary role is to diagnose illness early and make sure patients do not develop complications. I am making this comment because I have meticulously read notes. My mission was to help reduce patients visit doctors or visit A&E to help reduce cross infections and antibiotic abuse. I felt the quality of care offered by doctors and some nurses (Independent Nurse Practitioners prescribers and consultants) was so poor, I refused to return to work as a doctor in the surgery I was employed to work and want to live in Germany so that we don't have to depend on the NHS.

I have collected datas and conducted independent study to help bring in changes to reduce wasted consultations. GPs working in UK will not admit they are offering appointments to patients who do not have any serious medical problem that require doctors input. I was passionate about NHS and believed this was the best healthcare system in the world, and so worked all my life. I would have gone to USA long time ago if I knew the NHS will be commercialised.

Please read the attachments and let me know how you can help me move forward in my project or give me an opportunity for me to be a member of your team and bring in innovations to help sustain the NHS. I am in London and will be happy to visit and explain how my project will bring in the changes every one is crying for. Doctors and nurses blaming poor quality care due to shortage of staff is one that I am sick and tired of hearing. If the doctors and nurses do the job well, then there is no need to increase star but you may be able to reduce and help save NHS for patients who need doctors help.

Please let me know if I could join your team and help you bring in changes to make sure the care and treatment offered by members of my profession is the best and not one that makes me uncomfortable (so un-ethical) because patients who trust us are suffering pain and rapidly loosing faith.

Please Read: **[Why Systemize Health care In UK Is Essential?](#)**

The reason I did my research started in 2003 when I worked as a Salaried GP in a "Pilot GMS Nurse-led Practice" and monitored patients who visited "Walk-in-clinic".

This work was to help reduce wrong doings that was highlighted in Mid-Stafordsire Hospital Enquiry.

Dr Jackie Wakeman

Views for consideration.

I am a GP partner and list below a snapshot of the challenges currently faced.

Workload -12 to 14 hour days not unusual for partners plus catching up with e-mails at weekend, plus revalidation portfolio, plus reviewing Trainees portfolios also mostly done at weekends.

Steadily increasing practice list size but increase in capitation funds always 6/12 in arrears.

Despite increasing list size and work load, partner income has been static/falling.

Recycling of income streams eg QOF domains to DES's with no reciprocal expectation that work previously funded ceases. Effectively more work required by same people and realistic likelihood that income diminishes. Similar example includes cuts to funding for extended hours.

QIP - good idea in theory but more recycled money with numerous hoops to jump through in tight timescales (so tight that required audits at end of process will be almost impossible to acheive within year).

NHS structural reorganisation - last 4 months, our management have spent time trying to re-learn who is responsible for what as PCTs have gone and CCGs and other NHS organisation now up and running. In particular difficulties tracking down missing payments. (Even people working in the new organisations don't seem to be clear and a lot of really good knowlegable folk have been lost altogether - one reorganisation too many in their professional lives!)

NHS health checks = extra work funded at "break-even" money and generating additional, effectively unpaid, extra work in terms of reviewing resultant abnormal results and follow-up communication with patients.

Would like to plan ahead with regard to expansion of medical and nursing capacity but insecurity of income (because of recycling of funds) makes this challenging.

Underfunding of some services (eg IUD fitting) making us wonder whether we can afford to continue to offer an accessible and comprehensive contraception and sexual health service that meets local demand.

We have skills and staff to initiate GLP1s for practice patients. Insulin initiation is funded but GLP1 initiation isn't and despite enquiries, doesn't look like it will be.

There are other services we could consider offering but no guarantees that they would be funded.

Practice staff working under pressure (increasing demands/expectations of patients). We've increased reception and clerical staff numbers to try and cope but we need more clinicians too.

We have a flexible appointment system in terms of same day and book ahead access and telephone call back but demand is always in excess of supply.

Staff sickness - a run of genuine ill health in staff - further pressure on practice budget as we pay sick pay and pay for cover.

Concern for the future, looking at age of staff and now no set retirement age, that this pattern will increase.

This is only a brief list of just a few of the issues.

We pride ourselves on doing a good job with the resources at our disposal. We work really hard to provide an accessible service to patients and to try and keep our patients out of A&E and hospital as far as possible but we can't keep doing more and more without additional resources.

Now need to spend the rest of my Sunday afternoon on portfolios!

Dr Alistair Walling

I write to submit a view in regards to your recent call for evidence. I am aware of large representative organisations submitting information to you including my CCG and Leeds LMC both of which I support.

I firstly say I find this entire process unusual and I am not clear how this fits in the remit of monitor in any way. I also find the requests given to be of a very negative approach- specifically looking for negative aspects- this is not the way a normal and unbiased assessment of need for change would be conducted. As others have mentioned, a one month consultation period in the summer holiday period is highly suspect especially when there is then an almost open ended (if at all) deadline for the statement.

You are correct in stating that general practice is under increasing pressure, with the financial reductions on practice income in recent years, the need to undertake more and more arduous tasks with little clear patient benefits to maintain targets and income directed by the DOH. Increasing patient demand certainly has an impact on general practice with more complicated consultations, patients presenting each more times per year, DOH directives requesting us to call more patients for more frequent review, the shift of work from primary care.

This service is provided to a high standard on a small and shrinking proportion of the NHS budget- around 6%. Patient trust and satisfaction with GPs continues to be one of the highest levels of any profession.

Certainly there are significant challenges to come in the increasing elderly population and life expectancy, the increase in populations with chronic disease, advances in medicine and the need for monitoring of patients and shift of work into the community. These problems need to be tackled and one way to look at this would be to ask for examples of where things are working very well (something quite noticeably lacking in your call for evidence). We need increased numbers of general practitioners (a fact accepted by the department of health, rcgp and others), increased support and funding in the community. There certainly are new ways of working and improvements to be made, but I think it would be very dangerous to threaten the aspect of the nhs which provides greatest value for money, is very well liked by patients and is the main aspect examined by the rest of the world. The change to CCGs is already a significant one and the suggestion of any further change seems a crazy idea which could destabilise the entire NHS at a vulnerable time.

There are no issues for patients choosing practice in my area, all practices have open lists and patients can simply walk into any practice and register, there are 3 practices within 100m from where I sit now.

Again I must say this call for evidence seems to have a very clear agenda and I have to say if someone in my practice had submitted a similarly worded and targeted request to identify and develop a need for change they would be sent back to redo the entire thing to look for open and clear responses identifying both best and worst practice and looking to develop improved ways of working. I apologise I have not referenced my statements but with the tight timeframe to send in the response I have been unable to list the appropriate sources, I am sure others will have been able to give the appropriate details if needed.

Dr Tim Walter

Sir, I have at this late stage had my attention brought to this exercise.

As a working GP I would like to bring it to your attention that

GP is deemed by many to be a bottomless pit, every news article ends with "and if you are concerned, contact your GP" Whilst it is a role we have the burden is unbearable.

GP is usually the last to hear. Press releases are distributed far and wide and we are often "behind the curve" when new ideas and procedures are produced.

News articles are often nationally publicised, and are based on local activities or initiatives, yet there are no corresponding national services, meaning there is a mismatch of expectations for patients and availability locally. If the NHS publicises a service nationally it should be a national service.

111 service is pandering to the need to consult on everything, just a phone call away. The effort we have put in to educate and inform patients regarding self care is being eroded by the "just in case" culture.

There seems to be a fallacy that once something is "embedded" in QOF that this item can be removed and a new target added. This results in a reduced service for patients as we are unable to keep working harder and harder for patients. A patient with a particular condition should be looked at in their entirety and funded appropriately for the care for that condition. If you wish to focus care for the condition specifically then funding can come from that domain (at the expense of other care processes for the condition) but you should not reduce funding for one condition because another one has caught your attention.

I have no idea if this is what you are looking for and I have little time to continue my contribution but hope you might consider this.

Patients are not actually helped by the level of change and constant reorganisation occurring in the NHS

[✂]

I understand Monitor wants to know about barriers preventing patients from securing access to the best possible care and also what barriers prevent their doctors from providing it...

- patients may want to 'see their regular doctor at times that suit them' but this expectation is unreasonable given the fact that doctors do not work 24/7 and take holidays from time to time. Also, other patients who want the same doctor at the same time will also not have their expectations realised. Expectations need to be balanced with the real world we live in and the higher the government and Dept of health raises expectations, the greater the discontent they will produce. The current stress that GPs are suffering as they hear news items demanding personal care 24/7 is affecting patient care. Doctors are choosing to reduce their hours (I personally know 2 full-time male GPs who are reducing to 3/4 time simply to ensure their survival till retirement They are in their 40's)

- patients need to expect telephone triage by a clinician. This ensures that those who need (not want) to see a clinician quickly actually manage to do so. This will ensure high quality care for those who need it. Again, however, expectations need to be modified.
- primary care is hugely underfunded and this can effect the quality of care patients receive. Money gets sucked into the hospital system via payment by results....when GPs take on extra work by default, money rarely follows. The old PCTs were expected to pay the hospital trusts first and then the residual went to primary care, with the result being that it was community services that were axed. Currently, the hospitals are offloading more and more patients from in-patient and out-patient care (as the CCG's endeavour to stay in budget) and we are expected to perform as 'community house officers' chasing up their results and tests for them. There needs to be equity of funding across primary and secondary care to ensure best possible care.
- Dropping average GP income is affecting recruitment. I know of two practices locally who have been unable to appoint new partners. Reasons given include the low practice income compared with opportunities elsewhere, and the uncertainty regarding contracts and political direction.
- GPs need the support of secondary care doctors when dealing with complicated patients. I would strongly advocate the return of the 'general physician'. For example, I currently have a patient who has vague symptoms which cannot be attributed to a single system. He has seen 5 specialists and I am being advised to refer him to a sixth...Specialisation can be a barrier to best possible care.
- Constantly changing services is a barrier to good care. For some less common conditions, a GP may only refer once every few years. Complicated pathways and endless specialised forms makes referrals overly-complicated.
- Remember that doctors are there to deal with all the problems that do not fit nicely into a flowchart. We need to be allowed to use our intelligence and professional acumen and not be straight-jacketed by regulations and rigid referral guidelines. We are at risk of generating a generation of clinicians who cannot think for themselves (or dare not for risk of censorship) All this is a barrier to best possible care.

I think that is enough food for thought. Your comments would be appreciated (ie I hope someone reads this)

[X]

Suspicious as to your motives for issuing this call for evidence on 1st July and not advertising it widely. Who did you advertise this to? What evidence are you seeking? And who from?

With those caveats, as a GP who works in perhaps the most rural practice in England, I feel it crucial that your attempts to influence policy do not do further damage to what is good about UK primary care. Encouraging patients to act as consumers and change practices regularly, as they might their allegiance to a supermarket, is fundamentally damaging to continuity of care. There is plenty of evidence for the benefits (economic as well as medical) of personal continuity from a small team. Access is another consumerist concept because it places the wants of the demanding above the needs of others; nevertheless, our patients have access they are very largely satisfied with. If Monitor truly wants to improve matters it will look at the way expensive and unhelpful services like 111 are imposed and help enable funding from that to be channelled to primary care instead.

New practices cannot be established, new services cannot be developed by those on the ground. The existing NHS contract and cost control systems dictate both, as they do the form the process takes when opportunities do arise: set up for companies with large bidding and contracting departments.

Blocks to change are the determination to fragment rather than enhance the existing model. With more help (and funding) GP surgeries are quite capable of being more dynamic, as proven during the fundholding years. The main issue concerns the DOH imperatives that seem still to be determined to break up primary care and create an internal NHS market for a small cohort of profit-making multi-nationals.

[X]

[X] However as a full time GP I would like to reassure that there is no issue with registering with a GP in the Leeds area. The benefits of having a named GP service rather than a multi access service is immense. Should however a patient wish to change GP practice locally there is ample scope to do this. There is no need or wish for new providers in general practice. Start putting the money where the work is done and British general practice will continue to be the envy of the world.

[X]

As a provider of GP PMS services for 11000 patients for 20 plus years I feel in a position to make a contribution to this debate .In the last 7 years we have as 5 individuals invested £3.5m via a bank loan to build a state of the art medical centre in our rural market town. This has allowed us to massively expand our services and try to offer a one stop shop. As a result our patient population has grown and so too

have our doctor and nurse levels. At present the biggest obstacles facing better patient care are one) the time spent on bureaucracy eg QOF, CQC, LES, DES and reams of pointless data recording. Two) the huge difficulty of recruiting new GPs and Nurse practitioners (over a quarter of GPs in Suffolk are over 55 yr). Three) the difficult accessing hospital services, their lack of a holistic approach, the lack of functioning as a team and sorting out patients at first admission ie the present revolving door system. Four) the lack of our own social worker who is directly accountable to patients and the practice.

We are looking at new ways of working including amalgamating with other practices, but there seems to be little recognition of the recruitment crisis in general practice and the causes of it or the huge benefits of the current self employed system which offers good value for money to the patient and taxpayer.

If I were to propose a new system I would be very wary of destabilising the current one without good reason and I would also want to pay attention to what is affordable in terms of accessibility.

[X]

I am seriously considering a career break from UK general practice in the hope that in few years time things will look a little brighter. Being a GP principle in the current climate is increasingly unappealing; I have a family and want to see them.

[X]

I am a GP [X].

I am really concerned about the way in which this discussion has been framed. It looks very much like big business exerting influence on regulators in order to help them get a foot in the door by claiming that more competition will free up the market for them. Having said that I am equally clear that the current model has probably had its day and needs to change. That needs to happen quickly and I worry that the current incumbents in the system do not have the skills or the desire to change as required.

I think the independent contractor model at individual practice level is no longer fit for purpose. We need larger more efficient primary care organisations and I'm not sure that individual GPs should have a profit share in that beyond performance related pay. Patients would be better served by a salaried workforce motivated for reasons other than simple finance and organised across a larger footprint.

They will not be better served by more competition however which will be inefficient but not drive the improvement needed as all the evidence already tells us they don't move now even from bad practices when they can. It is also still very difficult to define good and bad general practice (even the King's Fund failed when it tried a

couple of years ago). Continuity is hugely important to patients and especially those with long term conditions even when they have an acute problem. The system is designed for single episodes of illness in otherwise well patients. That is fine for most children and young adults but they actually make up a small proportion of our workload. We need to get more responsive to their needs (both in terms of quality and speed of response to prevent them going to A&E instead) but we also need real continuity for the frail elderly. These two need different models to support them as they are in conflict with each other.

Primary Care tries to be all things to all people and does a remarkably good job (though it is currently breaking GPs and their families to achieve this). We need to consider splitting it more clearly and rewarding the different facets in different ways to ensure the best models of care for different patient groups (and therefore the more individualised service the politicians talk of).

I hope that helps as a starter for ten.

GP practice managers

Martin Bell

As a practice manager, I'd like to feed in the following comments:

1. Very interesting that this consultation exercise has had little publicity amongst GPs/ general practice. Key participants need to be engaged in mature, meaningful dialogue if true transformation is to be realised: rather than a top down 'dumping' of someone else's ideas onto practices.
2. RE Patient Access to services - everyone needs to stop knocking GPs: we haven't got it 100% right 100% of the time, we know that, our patients tell us this regularly, but we are trying to take steps to continually improve access. If the DoH wants us to open 24 /7, then pay us properly to do so. Stop expecting primary healthcare on the cheap: staff costs alone, for example, would need to be fully covered.
3. Rather than asking the question as to how easy is it for GPs to set up on their own, start talking to us about how we can federate and what support we need to do so: we need to work more cooperatively and collaboratively both as providers **or** commissioners, and as providers **and** commissioners. We need to bring primary care providers together in ways that builds organisations that possess the scale, the impetus and the autonomy to make decisions in collaboration with our patients and other stakeholders, at the lowest possible level to where the patient services need to be delivered.
3. There needs to be a new relationship between primary and secondary care, and not simply on the basis of vertical integration. We seem to have lost a sense of the 'national' in national health service, and what appears at the ground level is competitive localism between primary and secondary care. This must end, for the good of society's health. We must build a health economy that integrates the vast array of competent and professional providers along the basis of both vertical and horizontal integration: Integration needs to be a balance of 'and' rather than a two dimensional 'or'.
5. Engage, communicate and involve Practice Managers; we are a professional, competent bunch of people - enter into dialogue with us. We run the business on a daily basis, we know better than most the strengths and weaknesses of the system at a local level. If any transformation of primary care is to succeed, then it must be owned and driven by primary care, in conjunction with others, and built around the patient. To ensure primary care fulfils its part,

practice managers - as the lynchpins of the business - need to be actively involved and supported to be involved

Glennis Walling

I have worked in General Practice for 33 years and have been a practice manager for 23 years. I am totally demoralised with the way general practice is heading – RCGP certification/Productive General Practice Programme/CQC/Reduction in QOF points/increased Enhanced Services/volumes of extra paper work.

The GP's are also fed up with the continual changes, reduction in resources and pressures put on general practice – If this continues newly qualified doctors' will opt for other specialities or emigrate abroad as general practice will have very little to offer as an incentive to join.

One of our GP's is on the LMC committee and recently reported that the general consensus from practices is that practices managers 'have had enough'! Three experienced Practice Managers/Office Managers have left general practice since April of this year in our town alone.

The service and quality of care that is provided by most GP practices is taken for granted and the public and MP's have no idea of the quality and quantity of work and care that is provided by general practice. Is a pity that this is not more appreciated either by the public or MP's.

[<]

Currently within our Practice a Patient can see any GP within 24 hrs, be triaged by a Nurse Practitioner this morning to be seen today if the urgency requires it, or may have to wait up to a week or so to see their preferred GP. As I only have one of each GP this is unavoidable and a lot better than the vast majority of other services run by any sector.

We open 8.00am to 6.30pm weekdays and Saturday mornings. To run any later or earlier than this we would have to spread our available resources much thinner, to the point they were unsafe, due to lack of support staff, or we would have to have funding and staff willing to work the hours.

We are not a supermarket who affords to stay open later by selling product to people in those later hours, therefore making more money. We cannot charge for our services.

Out of hours a patient is triaged as soon as they get through on the telephone and is either given advice, seen by a Nurse, seen at a health centre or seen if appropriate on a visist. This is an amazing service, just because it is not the patients own GP

does not make it any worse. They would not necessarily see that GP for up to a week or more in hours. They are still seen and their needs are dealt with.

Patients can transfer Practices at the filling in off a very short form, and this happens every day. How difficult is that? The only time I have known a difficulty accepting a patient within a Practice is either when the Practice is so full it has to close it's books for safety as well as Practicality issues, or when a patient has been consistently violent with all the Practices in the area.

Expand services - ha, ha, ha!

We are lacking

- Room space
- Personnel
- the size to cope with the regulations involved
- Time (already taken up with seeing patients, paperwork, red tape, CCG work, extra services already lumped on us, etc.)

What we should be doing is making sure that we do the tasks we are designed to do, be a frontline care provider and gate keeper for secondary care.

If you want secondary care demand to decrease, you should start to look at demand management on a National Scale, as opposed to making it more local so the blame can be spread and a bigger post code lottery is made.

We are not a cheap provider of secondary care services. The reason they have higher costs is that they have the support systems in place for when things go wrong.

The New Commissioning service for General Practice - we have gone from one perfectly satisfactory commissioner of services within the Practice, to three different and rather confused providers. Surely there are easier ways to provide integrated care than confusing all who work within the system?

If you want to Commission General Practice from a SuperMarket, that is fine, as long as you bear in mind that

- They are also out to make a profit, so will only chose areas that it is likely they will make one.
- If they can cherry pick services they will. Who picks up the rest?
- If you start providing many different providers in one area the price remains the same, but people get confused and there is the potential for greater errors.

- The cost in the end will soar or the service will deteriorate e.g. continuity will reduce, there will be more use of triage as opposed to Doctors seeing people, etc. We can do that as well, but I would rather have a National Directive, as I don't want to be the only one in this area doing it as until I'm a monopoly it would be business suicide.

What are the main obstacles to us doing more

- Time,
- Money
- Staff
- Premises

Dear Mr/Mrs/Ms Monitor, why on earth do you have to always be looking for issues rather than praising work being done already.

Like everyone else in the health service and many other services, we work flat out every day we are at work. We get tired as well you know. Then to openly look to find 'issues' ("we would particularly welcome submissions that include evidence that a particular issue acts against the interests of the patients.") is particularly demoralising.

How many inspectors do we need to be able to tell us that a tiny fraction of services are not perfect, so therefore we will yet again put some draconian measure in place to 'FIX IT'!

Funnily enough the vast majority of us in the service came into it because it is about helping people. We want to do our best and do so within the resource constraints that we have. It's not perfect, are you? Do we meet the 'wants' of all the patients? probably not, do we meet the 'needs' of the patients? in the vast majority of cases yes we do.

Either continue to support us as we meet the needs of the patients or supply more resources to meet their wants, but whatever you do a bit of praise every now and then would be appreciated.

[✂]

Further to the paper just a few observations from running a practice and these are my personal observations

- Ability to recruit quality clinical staff - there is a problem with GPs and practice nurses locally but I also understand this is a problem that is becoming wider

spread. This makes it more difficult when practices are taking on large numbers of patients to be able to cope and continue to provide quality care

- Premises – in the current financial climate and with current funding models getting access to funding for new builds and extensions is becoming more difficult
- NHS pension scheme – the changes to this scheme mean that the current clinical staff are choosing to take early retirement in larger numbers as there is no incentive for them to remain paying into the pension scheme and often this makes it more beneficial to retire before the full changes impact, adding to the difficulties of recruitment
- Rising demand and expectations – this is making it busier and difficult particularly with the current funding model to meet the needs/wants as funding to general practice has fallen and will continue to fall. It may mean some practices will choose to restrict their services as a way of coping with the demand

[✂]

Firstly thank you for the opportunity to feedback my views on primary care services albeit we only got to find out about this opportunity today which is very disappointing as I need to also send to my patient group representatives for them to feedback to you too!

I will summarise my thoughts on various issues affecting day to day life in primary care which ultimately affects patients. I have been a practice manager for 13 years and have always worked in rural practice until three months ago when I joined a city practice in need of much development in Cumbria.

- 1 Patient demand – This has been growing steadily both in GP land and A&E and patients have very limited tolerance to minor ailments therefore seeking the opinion of doctors at a very early stage. I feel nationally this needs to be addressed and that public health campaigns / Education should be involved. Similar to A&E we need to concentrate more on the patients that need the time and reduce the timewasters. Mental Health has been an ongoing problem as a large proportion of society today can not cope and I feel that every practice should have a full time counsellor or ideally Psychologist attached to them. Drug and Alcohol services need to be made more available and waiting lists kept to a minimum.
- 2 Community nursing – All community nurses should be attached too and employed by GP practices so that equity of service is provided to housebound patients. I am astounded that I have found in two counties that housebound

our most vulnerable patients are second class citizens because we just don't have community nurses with the skills that our practice nurses have. There has been too much emphasis by PCTs on breaking down the relationship to separate community nurses from general practices and I fear that we have lost the integrated working that happened many years ago. In fact I would rather have the funding to employ more nurses who would then look after long term conditions of these patients and not be reliant on community nurses.

- 3 Health Visiting – What is a health visitor? I and three new docs have not met our health visitor there is no interaction what so ever. Since HV's were taken away from practices the relationship has become non existent. Surely joint working from all health providers is paramount to the family unit!
- 3 Workload – More funding for additional GPs and then the correct time can be spent dealing with case loads. As we see a more aging demographic of patients more time is needed to provide well meaning care plans. But instead GPs in my practice are often working until 9pm at night to do the best for their patients. It is not about the pay packet for them at the end of the day they just want to get it right for patients.
- 4 Development of more local services –Care closer to home I feel is disappointing, when I read the white paper I expected to see more consultants working in the community. Instead we have seen the rise of GPWSI services benefiting a minority of practices. We are due to move into new premises next year and I would like to see consultants working alongside GPs seeing patients in their own community.
- 5 Practice Development – limited time to spend on this as patients come first therefore the knock on effect is that development is slow and demoralising to staff and patients. The use of new technology is limited due to financial constraints of two partners retiring and no money at the CCG.
- 6 Recruitment and Retention – We have a major issue for recruitment in Cumbria this needs to be addressed and support given to more GP training. Retention is also an issue as GPs are becoming burnt out and often leaving the vocation as they just can't deal with the workload. We (the tax payer) have invested in these doctors for 10 years however we then don't support them because we just keep throwing more and more at them!

I could go on however I do feel that the six areas listed above are typical of frustrations felt by most practices' all of which have a knock on effect for patients. I believe in the future of general practice however we must change to accommodate new technology and the requirements of patients but not to the detriment of our hard working doctors and staff. I think culture needs to change in practices and that the support of the CCGs in practice innovation is important. I also think CCGs have a

very difficult job as they have adopted commissioned services historically and have their hands tied to make immediate changes.

[✂]

After listening to the broadcast on the monitor site, what interests me was the patient's ability to access GP Services, in Cumbria we have been able to give patients a good accessible service.

However recently there have been issues in recruitment and retention. A number of Practices have vacancies in the area and cannot recruit GP's though most have advertised on a number of occasions using the main magazines and local job shop publications. The problem has recently be exacerbated by the recent events at our local provider and the locality has lost three newly qualified GP's when their partners left the local hospital.

In the recent Class of VTS graduates only two newly qualified GP's stayed in the area.

Yet we are expected to undertake more work in the community and meet tighter and tighter targets and complete because of the CQRS/GPES systems duplicate monitoring returns.

CCG's need to be reviewing their workforce planning needs and communicating with GP's about what is happening on the ground, before their becomes a significant shortage of available GP's.

[✂]

Having only just been made aware of this call for evidence I respond as a Practice Manager , responsible for a four site practice and an area of 220 square miles, with a population of 9000 patients.

As I'm unsure of what you require I thought I would take the opportunity to submit some of my thoughts on general practice and the difficulties we face

Funding

Our funding has been reduced considerably over the past five years, resulting in a decrease in payments to the practice of over £100k per year. This inevitably led to redundancies [one nurse, one GP as well as support staff] which in turn led to us having to centralise some services instead of offering them at the branch surgeries as we had previously.

Practices are often encouraged to chase funding by signing up to Enhanced Service contracts, most of which are withdrawn within two / three years and replaced with

new enhanced services, while the practice is expected to continue with the work previously paid for under the previous enhanced service [eg - Choose and Book]

Premises Improvement Grants are also meant to be available to help with updating older premises to comply with ever new and changing legislation - this is impossible to get hold of and I'm currently dealing with a Local Area Team who tell me there is no money available. NHS England have yet to confirm as to whether this is the case and we are almost half way through the financial year. I have had to submit a FOI to NHS England after constantly being fobbed off.

There is a constant battle between provision of healthcare and availability of funds.

Costs

Practices, the same as any other business, have seen costs spiral to record levels

The introduction of CQC has led to extra expense within the practice - my practice had to pay £2000 as we have four sites [for the benefit of our patients]. There is another practice in our town with one site who pay £600. This is inequitable and unsatisfactory - we receive no extra income for providing the service into rural areas and yet are penalised for doing so. While I disagree with a payment to CQC at all, I absolutely despair that we pay 3.5 times the amount of a practice who provides a centralised service.

Costs to provide from NHS buildings are also set to rise with the introduction of the NHS Propco models of building management.

Pension contributions for locums changed in April, immediately increasing the cost of a locum by at least 14%

Recruitment

Because of our geographical location we are finding it more and more difficult to recruit clinicians as they see primary care as a bureaucratic and paperwork based - there are not the trained clinicians for practices to be able to pick and choose but as there is less money we cannot offer an enhanced payment for working sometimes 50+ miles from home.

CCG's

While we are whole heartedly behind our CCG we feel that there has been a stark change in the levels of responsibility compared to the old PCT. The PCT has run with a loss for years, yet year one of a new organisation has left the CCG with an almost impossible target to save money with a new team and less support from LAT and PCSA due to their own reduced staffing levels.

The responsibility for providing care within budget has fallen to the CCG's who are managed by the GP's in each locality - but in a rural area such as ours taking that much clinical time from the patients can also have a detrimental effect

Pressure

The constant pressure and flow of patients to Primary Care where there is no outlet or extra capacity has led to widespread increases in demand on A&E services. As the funding model changes for these secondary care attendances and they become tariff based then it is not in the interest of the A&E provider to turn patients away and risk a smaller income and increased chance of litigation.

Patient Education

Patient demands and expectations have risen - patients expect to see a clinician on demand, regardless of their symptoms or requirements. This leads to a constant drain on available resource as unnecessary appointments are wasted on trivial and paperwork led requirements. Patients expect their surgeries to provide lots on non NHS support [travel clinics, medicals, insurance forms] with little understanding of the true workload, cost and time taken for each

This list is by no means exhaustive but the constant daily pressures of Primary care providers are felt across the nation - negativity from Monitor and recommendations for reductions in funding or changes to practice will only undermine a system still adapting the changes felt by CCG, NHS 111, A&E figures, Revalidation for GP's etc etc

1. Introduction to Nuffield Health

Nuffield Health is the UK's largest not-for-profit healthcare provider. We deliver expert, joined-up health, fitness and wellbeing services in over 300 locations around the UK. We provide access to 15,000 health experts through our 31 hospitals, 65 fitness & wellbeing centres, 200 corporate facilities and 41 medical clinics. These facilities allow us to provide services to help people get healthy and stay healthy, to understand and manage their personal health risks, and to get timely diagnosis and treatment for any problems which do arise. We are unique in that we join up medical, fitness and wellbeing services and promote preventative health above all else.

Each year we support over a million people directly with their health and wellbeing needs including half a million hospital patients, 295,000 fitness and wellbeing members and provide fitness, medical and screening services to over 1,600 companies. We work with half the FTSE100.

As the leading healthcare Charity in the UK, we have been providing many of our health services for almost 60 years. Our charitable aim is to improve the health of the UK population and, as we are independent of Government and have no shareholders, we are able to reinvest everything we make back into the organisation. This means we can continually improve our facilities, services and training and provide greater public health benefits.

2. Consultation Response

We welcome the opportunity to respond to this call for evidence in relation to the information about aspects of the provision and commissioning of general practice services which may not be working in the best interests of patients, including those raised during the course of the Fair Playing Field Review.

We set out our response in relation to a number of key health and wellbeing trends we consider to be critical:

- Global health trends and rising patient expectations will increasingly demand new models of primary care - this needs choice, competition and new contractual forms to help emerge to support diversity, different models and to enable a shift to support prevention and the proactive management of chronic conditions.
- The current approach has seen incremental change that has now stalled. Primary care contracting focuses on the old healthcare model which now emphasises commissioning, treatment and referral on to secondary care on not prevention of ill health and wellbeing.
- The current contractual approach protects the current model of care and a professional monopoly and contains many factors which favour the economics of monopoly such as central funding of property and information technology assets.
- GPs are the single largest private sector component delivering health in the UK, under contract, and therefore should be subject to the same competitive pressures as all other areas to ensure patient choice, contestability, quality of delivery and value for the state in terms of primary care contracting.
- The net impact of current arrangements are restricting new models and innovation. The current primary care commissioning policy is addressing the hospital interface and not underlying drivers of ill health. The unintended commercial impact is the super-sizing of the current approach which has minimal benefits.

- GPs are clearly under pressure in existing model both in terms of workload and the profitability and management sustainability of local bespoke approaches. With the predicted GP shortage in the future it would make sense to provide alternate models and support based on local patient preference and innovations that can be brought to the market.
- There is now an urgency to sort this out as this was a key area omitted from the recent round of reforms. We welcome an approach by Monitor and NHS England to suggest changes to the current approach.

We have concentrated on the specific points raised in your call for evidence:

- the ability of patients to access GP services, including their ability to switch practices;
- the impact of the rules for setting up and/or expanding a general practice;
- the impact of the different contractual terms under which practices operate;
- 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;
- the process for commissioning new services from general practices, the factors that influence these commissioning decisions and any challenges that commissioners face;
- factors that affect potential providers' willingness or interest in providing new services; and
- 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.

3. Discussion

Nuffield Health competes and collaborates in a number of markets in the UK with diverse customer segments. Broadly our main customer groups are private medical insurers/trust funds, corporate employers, NHS commissioners, and patients who choose to self-pay or use choose and book via their GP. Our market propositions cover private hospitals, fitness and wellbeing services, diagnostics and screening mammography, musculoskeletal services, occupational health, private primary care and preventative health assessments.

We therefore operate in several adjacent segments to primary care as a market and collaborate with local primary care in terms of referrals for over 500,000 episodes of care per year. We also respond as an interested party in terms of market entry for the alternate provision of expanded GP services in the workplace and for a preventative approach to chronic disease management.

At a headline level we consider there to be a strong need for changes to be made in terms of demographic of age and chronic disease and to reform a service model that was designed for the system, rather than the needs of patients as consumers. We believe there to be considerable unmet consumer need in terms of the quality, accessibility and demand for services. As a consequence of these unmet needs there has been rapid expansion of corporate paid primary and nursing care in the workplace to meet these workforce demands. We therefore consider there to be a strong case for workplace registrations for primary care and alternate delivery models in the community and return to work setting.

Further we consider there to be economic reasons for change. Workforce health and wellbeing has been identified by the World Economic Forums as the 4th pillar for economic growth. There is therefore the opportunity to liberalise primary care and release the central monopoly for contracting GP services.

Finally we suggest that new models of provision can be presented in the interest of the state (place capital requirements with providers) and increase in value both terms of service to patients and overall lower cost to the state. An alternate national network of GP services could be provided that excels in the workplace setting and concentrates on preventative wellbeing at its core.

a. *the ability of patients to access GP services, including their ability to switch practices*

We observe that there is strong interest in patients being able to select services and market research suggests that the trust and quality of service are highly valued by all patients in addition to availability of service hours and caring professional staff. Increasingly we are seeing demand for flexible care at several locations according to the patient's home and work circumstance.

These demands are increasing in the margins of state and private care including GP appointments, physiotherapy and stress management services. Broadly we estimate these unmet needs to be growing at around 10% per annum.

There is no mechanism to offer contestable choice in local GP provision and since the abolition of PCTs the routes to seeking alternatives have further diminished.

b. *the impact of the rules for setting up and/or expanding a general practice*

We understand that access to the primary care market is contracted and controlled via NHS England in addition to the necessary quality regime run by the Care Quality Commission. There appears to be no current mechanism to discuss local needs as these are controlled by GP commissioners. The contractual vehicles around General Medical Services, Primary Medical Services, Alternate Provider Medical Services, Specialist Primary Medical Services and Primary Care Trust Medical Services are difficult to understand and create pricing and therefore value discrepancies in terms of services to patients. There appears to be limited correlation between need and resources in a system that favours any historical arrangement.

c. *the impact of the different contractual terms under which practices operate*

The net impact of the contracting vehicles currently offered suggest that innovation will need to come from the value segment in terms of lower capitation payments. Whilst this would reflect the traditional triggers in other industries, it will be very difficult to offer primary care services with such discrepancies to existing contract holders.

d. *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*

There is strong interest in providing new models of care in terms of community provision or specific models of care. We highlight two for illustration:

- Workplace wellbeing - there is considerable aligned interest from employers and their employees to provide high quality wellbeing services in the workplace to recognise employee loyalty and make it easier to build preventative and rapid access healthcare into the daily routine.

Many employers and employees are choosing to pay for these services including six multinational companies we work with. We would welcome a debate on opening primary care services in conjunction with the state in the workplace to offer choice, drive productivity for economic growth and deliver integrated wellbeing for the promotion of preventative care.

- Community chronic disease management - there is considerable private demand for wellbeing memberships to our fitness and wellbeing centres to offer tailored programs for common chronic conditions such as osteoarthritis, diabetes, hypertension, cardiovascular disease and respiratory disorders. We would like to extend this to primary care providers to offer combined case management and prevention approaches for core groups to improve wellbeing, cardiovascular fitness, quality of life and meet the necessary pathway requirements set out by the quality and outcome framework and the national institute of health and clinical excellence.

We would like to offer new models with a model we have termed as the Nuffield Way with a personal health mentor provided to every patient to act as a proactive guide to link services and to proactively focus on wellbeing and prevention. All our services can potentially run with a range of skill mix professionals working as a team which includes physiology, physiotherapy, nursing, medical care, fitness professionals, and talking therapies.

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

We have experienced considerable difficulty, bureaucracy, time delays and cost in contracting in this way where a typical process will take over 12 months and contracts typically run to over 100 pages. The current approach is not attractive or affordable in terms of preparation, risk and bid costs and Nuffield Health currently does not bid for most offers to the market for these reasons.

- f. *factors that affect potential providers' willingness or interest in providing new services*

As a provider we consider primary care to be very attractive in terms of offering preventative healthcare to the workforce and community populations. We are completely willing to build fitness and wellbeing facilities at home and in the workplace at our capital risk. Clearly in a market that almost entirely lacks any competitive economic forces, innovative pressures or consumer choice we would welcome change and the ability for patients to make their own choices for service provision for all or part of their primary care by using vouchers or personal health budgets.

- g. *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*

Nuffield Health already provides private primary care in a variety of fitness and wellbeing locations across the UK and would be interested to expand these for the benefit of NHS patients.

We also operate over 200 onsite wellbeing services for corporate employers and would be interested to consider the expansion of NHS workplace wellbeing for primary care for the NHS.

We operate many fitness referrals in conjunction with local GPs.

4. Further information

For further information, additional comment or to meet up on this subject please contact:

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Other providers

Sandy [✂]

As there is such a huge increase in the public usage of A and E services which is now overloaded, there needs to be an ***increase in the standard and scope of GP 'immediate' or urgent services and GP out of hours services.*** This will be vital to ensure that hospital acute services do not collapse.

Publication, highlighting and marketing of GP services of every kind needs to increase. This could hopefully encourage minor cases NOT to go to A and E and NOT to unnecessarily call an ambulance.



Making the health sector
work for patients

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