

Monitor

Making the health sector
work for patients

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



This document contains non-confidential representative bodies' 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, providers, clinical commissioning groups, 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.

Representative bodies

Please click on items in the list below to jump to the submission you require.

- [Action on Hearing Loss](#)
- [British Medical Association](#)
- [Diabetes UK](#)
- [English Community Care Association](#)
- [Medical Protection Society](#)
- [Men's Health Forum](#)
- [National Children's Bureau](#)
- [NHS Alliance](#)
- [NHS Partners Network](#)
- [NHS Services Pharmaceutical Services Negotiating Committee](#)
- [Pharmacy Voice](#)
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- [Royal College of Nursing](#)
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- [Rutland Parent Carer Voice](#)
- [Sense](#)
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Submission of evidence

Monitor: Call for evidence on the general practice services sector in England 1 August 2013

About us

Action on Hearing Loss is the new name for RNID. We're the charity working for a world where hearing loss doesn't limit or label people, where tinnitus is silenced – and where people value and look after their hearing.

Our response focuses on key evidence that relates to people with hearing loss. Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss and tinnitus, including people who are profoundly deaf. We are happy for the details of this response to be made public.

Introduction

Action on Hearing Loss welcomes the opportunity to submit evidence to Monitor about the general practice services sector. Hearing loss affects over 10 million people in the UK – one in six of the population. This rises to 71% of over 70 year olds, who make up a large proportion of patients accessing general practice services. As our population ages this number is set to grow and, by 2031, there will be more than 14.5 million people with hearing loss in the UK¹. Our response provides evidence in two areas: firstly issues faced by people with hearing loss accessing GP services, and secondly the need to improve diagnosis, referral and management of hearing loss by GP services.

Contact details

Chris Wood, Senior Research and Policy Officer
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¹ Action on Hearing Loss *Hearing Matters* 2011

Access to GP services for people with hearing loss

One in six people in the UK have some level of hearing loss and GP surgeries will have a high proportion of patients with hearing loss in their surgery every day. When using GP services, it is vital that people with hearing loss have the same level of access as hearing people. The Equality Act 2010 requires service providers to make reasonable adjustments to ensure that their services are accessible for people who are disabled, and states that they must anticipate and promote these adjustments rather than make them on a responsive basis.

In January 2013 we published [Access all Areas? A report into the experiences of people with hearing loss when accessing healthcare](#), based on a survey of 600 people with hearing loss. We found that:

- Many patients with hearing loss had left an appointment with a GP feeling unclear about information provided, including more than one-quarter (28%) who were unclear about a diagnosis, 26% who were unclear about health advice and one-fifth (19%) who were unclear about their medication.
- The main reasons for patients with hearing loss feeling unclear after a GP consultation were the GP not facing the patient (64%), the GP not always speaking clearly (57%) and the GP not making sure the patient had understood what had been said (51%).
- There was a marked difference between how patients with hearing loss currently contact their surgery to book appointments and how they would prefer to – the majority (72%) contact their GP surgery by phone, while many would like to use other methods such as email.
- Just under half (44%) of respondents said their GP surgery had a visual display screen, and one in seven (14%) had missed an appointment because they had missed being called from the waiting room.

The findings suggest that where communication barriers resulted in patients being unclear about information, they could easily be addressed by practitioners making simple changes to improve communication. These include providing deaf awareness training for all staff, so that they know how to communicate with people with hearing loss in person and

over the phone, and extending the use of technology such as visual display screens, loops and email. All staff should be trained to use these technologies.

We also surveyed British Sign Language users about accessing their GP. 68% of respondents said they had asked for a sign language interpreter to be booked for a GP appointment but did not get one, and 41% of respondents had left a health appointment feeling confused about their medical condition because they couldn't understand the sign language interpreter.

We are concerned that BSL users are not being provided with fully qualified interpreters in healthcare settings. It is imperative that sign language interpreters used by healthcare providers are fully qualified to deliver interpreting services in a healthcare setting. This ensures accurate communication of medical information. Furthermore, a patient's hearing loss and preferred method of communication should be recorded on their medical records so that communication support can be booked and any necessary adjustments made.

Improving diagnosis, referral and management of hearing loss

Diagnosis and referral rates of people with hearing loss are very low. Based on prevalence and population data, we estimate that there are four million people in the UK who do not have hearing aids but could benefit from them. Current research suggests it takes people an average of 10 years to seek help for their hearing loss, which means they delay receiving services and support that could help them with their hearing loss, and they take longer to adjust to their hearing loss².

Research also suggests that GPs fail to refer up to 45% of people reporting hearing loss for any intervention, such as a referral for a hearing test or hearing aids³. This causes an unnecessary barrier to patients receiving support. GP services should be referring all people with a hearing loss for assessment by hearing services. GP services could also become more patient-centred, through greater outreach and

² Action on Hearing Loss *Hearing Matters* 2011

³ Davies, Adrian et al 'Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models' *Health Technology Assessment*, Vol II: 42, 2007

information provision, as well as more accessible referral routes, which would encourage more people to seek help.

There is a need for improved awareness of the impacts of hearing loss, as well as the significant benefits that hearing aids and other interventions can bring. GP services could be at the forefront of providing information about hearing loss, encouraging people to seek help for their hearing loss, screening and checking people for hearing loss, and working in an integrated manner with Audiologists to ensure that all people who could benefit are being assessed and provided with hearing services.

Paul Dinkin
GP services Call for Evidence
Monitor
133-155 Waterloo Road
London
SE1 8UG

1st August 2013

Dear Paul

Call for evidence on the general practice services sector in England

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 152,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

The Association welcomes the opportunity to respond to Monitor's call for evidence on the general practice services sector in England.

Broadly speaking, we believe that the current model for delivering general practice works well, with high levels of patient satisfaction and the ability in most areas for patients to choose between different practices. Improvements in patient access to services and patient choice should be based on need and will frequently be best pursued through increased investment in existing providers.

Choice of GP practice & GP access

Patient choice is important. Many patients value continuity in the provision of their general practice services and, if personal circumstances allow, stay with their family practice all their lives. The 'cradle to grave' care offered by the local GP practice and the development of a strong relationship between GP and patient is invaluable to the delivery of high quality services, in particular for the rising number of patients with complex long term conditions.

The results of the NHS England annual GP patient survey – a survey of patient satisfaction with GP services - are generally very favourable in relation to access to GP services, including patients' experience of making an appointment and surgery opening hours¹.

In urban areas, patients who need or choose to change their practice rarely encounter problems. Patient addresses are usually covered by several practice areas and the regulations on patient registration mean that practices need a reasonable, non-discriminatory reason for turning down registration applications. Choice is more limited in small towns and rural areas. However, additional practices will generally develop where there is a clear patient need for them, for example as a result of a major new housing development; creating additional practices simply to allow further choice for patients would clearly be impractical and a waste of scarce resources.

Patient choice can be limited by the closure of practice lists. However, this happens very rarely and will generally be due to reasons such as insufficient funding to allow practices to expand their staffing, or limits on premises space. Practices have to go through a defined, formal process before closing their lists, which includes approval from NHS England.

¹ Details of the results are available here <http://www.england.nhs.uk/statistics/category/statistics/gp-patient-survey/>

Chief Executive/Secretary: Tony Bourne

Investment in general practice

The consultation document refers to the £7 billion that practices are paid each year to provide services to patients. While this is a significant figure, the £7 billion quoted is a relatively small proportion of overall spending on the NHS, and the proportion of funding to general practice has been falling year on year since 2006. Increases in investment in general practice have also been low; for example, the increase from 2010/11 to 2011/12 was just 0.57%² and not all of this funding reaches GP practices. Changes made to the GP contract for 2013/14 will reduce practice funding further³, and the uncertainty caused by yearly GP contract changes is a disincentive for practices to plan and invest in the future. Funding for GP-led premises expansion has also been extremely low in recent years.

Large numbers of existing providers in general practice would very much like to provide more extended services for their patients and take over some of the work carried out in secondary care. However, they are often unable to do this due to a lack of funding both for provision of care and investment in premises. Relatively small increases in GP funding for both services and physical capacity would transform practices' ability to expand their services and improve patient access to services. This would be a very cost-effective way of expanding the general practice services available to patients and ultimately offering greater choice.

Competition

The consultation requests evidence of particular issues that act against the interests of patients. One such an issue is the commissioning of time-limited APMS contracts. While such contracts are put in place to encourage competition, their time-limited nature does not encourage long-term investment in practices or the long-term commitment of doctors to them, which has a negative impact on patient care and continuity of service. There could also be a negative impact on the cost-effectiveness of the NHS as a whole; a recent paper in the British Journal of General Practice suggested that the probability of visiting outpatient specialist services is significantly lower among patients with a long-term relationship with their GP, compared to those with a shorter relationship.⁴

Linked to the above, there is a danger that large providers may have the capacity to put in cheaper bids for an APMS contract than their smaller competitors. If contracts are awarded solely or mainly on price, this could unfairly advantage larger providers. The key criterion should be the ability to deliver high quality patient care. There is also a risk of such bids being loss leaders, driving out smaller providers resulting, ultimately, in less choice.

The BMA response to Monitor's review of walk-in centres highlighted some of the risks of pursuing patient choice without regard for local patient need and existing services. The walk-in centres were established, following the recommendations of Lord Darzi's Next Stage Review report of October 2007, to provide primary care services to registered and unregistered patients. Every PCT was required to commission at least one walk-in centre. This resulted in 152 new GP-led walk-in centres spread across the country, including many areas where there was no evidence of unmet need justifying this investment. Many of these walk-in centres have now been closed⁵, suggesting that they were either not cost effective or duplicated existing services.

This policy undoubtedly increased patient choice in primary care, yet analysis by the King's Fund suggests

² *Investment in General Practice 2007-08 to 2011-12*, Health & Social Care Information Centre
<http://www.hscic.gov.uk/catalogue/PUB07472>

³ Details of the impact of the 2013/14 changes on practices are available here <http://bma.org.uk/working-for-change/negotiating-for-the-profession/gp-contract>.

⁴ British Journal of General Practice: *Continuity of GP care is related to reduced specialist healthcare use: a cross-sectional survey*, July 2013

⁵ This trend is highlighted in Monitor's review of the provision of walk-in centres in England <http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-40>

that the introduction of walk-in centres resulted in supplier-induced demand⁶. This conclusion is based on evidence of a substantial growth in emergency activity in recent years with disproportionate growth in the numbers of patients accessing emergency services for minor emergencies⁷. The exception to this finding is where walk-in centres are co-located and integrated with A&E departments⁸. This supports the anecdotal evidence from members that that outside these settings, patients often use these services inappropriately as patients are encouraged to attend much earlier, often with self-limiting illnesses.

Commissioning from general practice

CCGs have a statutory duty to assist NHS England in improving the quality of primary care. The commissioning of community based services from GP practices will be an important lever to create locally responsive and high quality services, and allow CCGs to adopt a whole system approach to the commissioning of care for their population. It is important, therefore, that CCGs implement robust mechanisms to manage potential conflicts of interest where they are commissioning services from member GP practices.

The BMA has recommended that CCGs should consider the formation of an external scrutiny committee, possibly shared between CCGs, to provide an extra mechanism to guard against conflict. This body could include lay members, representatives from member practices, clinicians from other CCGs, public health doctors, the Health and Wellbeing Board and the NHS England Area Team. CCGs could share a Scrutiny Committee to ensure external and independent input into decision-making, a robust approach across geographies and to avoid duplication⁹.

GP practices are often limited in bidding for Any Qualified Provider (AQP) or competitive tender contracts. For smaller practices, taking on the staff and investing in the equipment needed to compete for these contracts, in the hope that these costs will eventually be recouped by subsequent service provision, is extremely risky. This issue is particularly pertinent in the case of AQP – qualification as an AQP provider is a lengthy and complex process, with anecdotal evidence from GP practices estimating that the application process itself can take approximately 40 hours. These contracts offer no guaranteed income, but pay providers retrospectively for services delivered. This clearly disadvantages smaller practices who may be less willing to risk investment of time and resources in qualifying as an AQP provider, with no guaranteed return on this investment. Larger GP practices are on the increase¹⁰ but this increase has been steady rather than dramatic, leaving most practices with GMS and PMS contracts at a competitive disadvantage when bidding for these contracts. Similarly, it is possible for practices to work together under larger collaborative structures or federations to compete for contracts, but many practices are not yet in a position to do this, partly due to a lack of capacity and resource to do so, again leaving them at a disadvantage. It should be practical for practices to remain smaller if they choose to do so, as this provides patients with a choice between different types of practices.

In some situations it may be entirely appropriate for CCGs to commission services from GP practices through a single tender procurement, for example, where a service requires a registered practice list. It is vitally important that CCGs are absolutely clear when a competitive tender is necessary and when a single tender could be justified. This would help avoid unnecessary, complex and costly competitive tenders entered in to due to unfounded concerns about the threat of legal challenge under competition law or Section 75 of the Health and Social Care Act. While we welcomed the publication of Monitor's substantive guidance on the Procurement, Patient Choice and Competition Regulations, we raised concerns that the vagueness of the wording on competitive tendering would leave commissioners open to challenge. We would encourage Monitor to issue clearer advice to CCGs in order to allay concerns about the threat of legal challenge.

⁶ The Kings Fund John Appleby: *Pressure on accident and emergency services accessed 11 June 2013*
<http://www.kingsfund.org.uk/audio-video/john-appleby-pressures-accident-and-emergency-services>

⁷ The Kings Fund *How is the healthcare system performing?* Quarterly monitoring report June 2013

⁸ The King's Fund *Urgent and Emergency Care, a review of NHS South of England 2013*

⁹ Transparency and Probity: BMA Guidance of Conflicts of Interest (2013): <http://bma.org.uk/practical-support-at-work/commissioning/ensuring-transparency-and-probity>

¹⁰ This trend is highlighted and explained further in the Centre for Workforce Intelligence [GP In-Depth Review Preliminary Findings](#)

British Medical Association
bma.org.uk

We hope that our submission is useful. Please do not hesitate to contact us for more information if required.

Yours sincerely

A handwritten signature in black ink that reads "Vicki Chapman". The signature is written in a cursive, flowing style.

Vicki Chapman
Director of Representational and Political Activities

Response to Monitor call for evidence on GP services in England

From

Diabetes UK

Contact: [

What Monitor would like to know

Information about aspects of the provision and commissioning of general practice services which may not be working in the best interests of patients

Parts to which Diabetes UK can contribute to

Patient ability to access GP services

and

Any new form 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

Background information

Type 1 diabetes develops if the body cannot produce any insulin. It usually appears before the age of 40, especially in childhood. It is the less common of the two types of diabetes. It cannot be prevented and it is not known why exactly it develops. Type 1 diabetes is treated by daily insulin doses by injections or via an insulin pump

Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). Type 2 diabetes is treated with a healthy diet and increased physical activity. In addition, tablets and/or insulin can be required.

Diabetes is a complex long-term condition, and the management of diabetes in primary care falls into several areas:

Type 2 Diabetes:

- Identification of those at risk of Type 2 diabetes and prevention
- Early identification and diagnosis of Type 2 diabetes and prompt initial management
- Referral to structured education and support for self management
- On going management including the carrying out of annual review that includes the 9 key care processes as set out by NICE guidance

- Referral to intermediate or specialist care when necessary, eg in the event of the development of complications or the development of co morbidities that require specialist input and care

Type 1 Diabetes:

- Awareness of the signs and symptoms of type 1 diabetes at presentation, in order to ensure the prompt diagnosis of children or young people with diabetes is managed effectively and that they are not in the life threatening condition of Diabetic Ketoacidosis (DKA).
- **The on going management of Type 1 diabetes is not typically carried out in primary care, however within the new NHS there are areas where it is being proposed that people with type 1 diabetes are ‘discharged’ from secondary specialist unit care to the care of their local primary care services (see below).**

Children and young people with type 1 diabetes

Children and young people are managed by specialist paediatric diabetes units which, since April 2013, have been required to meet the paediatric diabetes best practice tariff in order to ensure the provision of the minimum standard of care.

Examples of barriers to good care and elements that may not be working in the best interests of patients in primary care and general practice

The diagnosis of type 1 diabetes – the national paediatric diabetes audit reported in 2010/11 that nearly a quarter of all children diagnosed with type 1 diabetes were only found when they were already in DKA, a life threatening condition where too much glucose has built up in the blood, and which can lead to coma and death. There is an urgent need for primary care healthcare professionals (as well as parents and others who have contact with children) to recognise the signs and know what to do. Diabetes UK has campaigned for this as part of its Children and Young Person’s Campaign in the [4Ts campaign](#). The campaign includes a simple GP [pathway](#) for the diagnosis of type 1 and urgent referral to specialist care.

Proposals to ‘discharge’ people with type 1 diabetes from specialist care into primary care – some CCGs have already published plans to move the care of people with type 1 diabetes into primary care. This is of concern to people with type 1 who are currently under the care of their specialist team, due to the fact that GPs and other primary care healthcare professionals may lack the knowledge and experience of how to effectively manage type 1 diabetes, or that there are not significantly robust procedures or services in place to ensure the rapid referral to intermediate or specialist care in the event that it is required. Other concerns include the ability or willingness of GPs to prescribe the quantities of blood glucose testing strips that people with type 1 may need in order to manage their condition on a day to day basis.

Management of complications in people with type 2 – through Diabetes UK’s [Putting Feet First Campaign](#) we have publicised how up to 80 per cent of diabetes-related amputations in England

each year are preventable. Two of the key campaigning calls are to ensure Local health services provide an integrated foot care pathway providing the right treatment at the right time in the right place, and that healthcare professionals are more aware of the risk of diabetic foot disease and provide annual checks. For primary care, anecdotal evidence has shown that some GPs continue to try to manage on going foot problems in people with type 2 diabetes rather than referring them to their local specialist foot care team, which can directly lead to prolonged problems and amputation as the only option for treatment. They may also not refer patients at increased risk of developing foot problems to the foot protection team for preventative measures, which also increases their risk of developing complications leading to unnecessary amputation.

Prevention and early identification of diabetes – whilst this is of the utmost importance for identifying people with type 2 before they begin to develop life threatening complications, and preventing diabetes in those at risk and increased risk in order to help curb the number of people developing diabetes, GPs do not get incentivised to do this and therefore do not see it as their role. This is clearly not in the interest of people at risk, and current indicators such as the Quality Outcomes Framework only reward GPs for the people with diabetes that they have on their register, not for identification of those at risk or for proactive prevention.

The consideration of integrated care that meets NICE standards

There already exists a comprehensive range of guidance on the development of integrated care for diabetes, the most recent of which is [Best Practice for Commissioning Diabetes Services – an Integrated Care Framework \(NHS Diabetes 2012\)](#). This sets out how now is the opportunity to utilise the new arrangements in the NHS to commission diabetes care that has people with diabetes firmly at the centre and which is truly integrated and comprehensive. This includes specifically identifying what needs to happen to ensure working in an integrated way between primary care and specialists and in partnership with social care and other providers, who all make up the integrated team.

The goal of commissioning and delivering integrated care for diabetes in a structured model is to ensure effective delivery of services, clear roles and responsibilities and a system of care to support self management and effective outcomes. Therefore, to be effective, a comprehensive, fully integrated diabetes service from screening and prevention, through to the management of complications and complex cases to in-patient specialist care and end of life should be commissioned. Paramount to this is that services meet the requirements of the published NICE standards for diabetes, in particular the delivery of the 9 care processes, in the on going management of people with diabetes, with monitoring of the results of these processes to ensure proactive management.

The integration and co-ordination of care across primary and specialist services is crucial - this is not about primary care and GPs restricting access, but facilitating it and ensuring it happens as part of the integrated care pathway. Further to the example above, evidence is increasing from reports to Diabetes UK that patients are either being withdrawn from specialist care services (despite needing access to it) and patients being informed that they will in future be managed by general practice without the necessary processes in place to support and link with specialist care. There are also

examples of expressions of concern from GPs who feel that they are not prepared or feel 'safe enough' in their knowledge of type 1 diabetes to take these patients on without proper services and resources being in place.

The successful integrated diabetes care pathway has to be co-ordinated and include effective communication between all elements of care. It also requires all involved to be competent in the delivery of diabetes care and to be aware of what other services to refer to. [Best Practice for Commissioning Diabetes Services – an Integrated Care Framework \(NHS Diabetes 2012\)](#) defines how delivery of an integrated diabetes service is more than commissioning the individual components of care as part of a care pathway. Key components of a well-commissioned diabetes model will address the following 'pillars of integrated care':

Integrated IT - essential for the efficient running of a geographically disparate service and should enable timely communication between members of the team and allow accurate tracking of the movement of patients throughout the organisation

Financial incentives - This is the most difficult part to commission and involves moving beyond 'payment by results' and QOF, by which providers are incentivised to deliver activity, to a system which incentivises providers to deliver care centred around the patient. Good practice would involve commissioning whole pathways of care. Components of diabetes care (care pathways and the 9 care processes) should not be commissioned individually. Finances should be aligned with the outcomes required and providers encouraged to engage in partnership working in order to deliver these outcomes.

Personalised care planning - Care planning is a process that allows people with diabetes to have active involvement in deciding, agreeing and owning how their diabetes is managed. Care planning recognises that although healthcare professionals might have knowledge and expertise about diabetes in general, it's really only the person with the condition who knows how it impacts on their life. For example, the annual review, which currently often just involves tick boxes to show that tests have been taken, becomes a genuinely collaborative consultation by providing a real opportunity for people to share information with their healthcare team about issues and concerns, their experience of living with diabetes, and help with accessing services and support that is needed. Both the person with diabetes and the healthcare team will then jointly agree the priorities or goals and the actions to take in response to this. Year of Care is an excellent example of implementation of a care planning process – see [Year of Care](#)

Clinical engagement and leadership - All successfully commissioned integrated models of care have involved clinicians and service users at an early stage. Commissioners should consider how to facilitate engagement of clinicians and service users at all stages of the clinical pathway at an early stage of the development of a model.

Local operational diabetes networks are in a unique position to work across natural diabetes communities. Acting as the honest broker a local diabetes network will bring together and facilitate a range of stakeholders from different disciplines with a mix of expertise, knowledge and competencies to deliver high-quality, cost-effective care through the effective commissioning, organisation and delivery of services. See [Implementing local diabetes networks](#)

Clinical governance - Clinical governance in the context of integrated diabetes care is the whole diabetes healthcare community being responsible for the outcomes locally. Good communication, reporting and benchmarking will enable provider organisations to review variation in outcomes and target resources as appropriate.

This might include screening for diabetes where the prevalence is below expected. It may also include investing in an inpatient diabetes service in areas where the length of stay is high and patients have a poor experience of inpatient care. The governance allows the whole diabetes community to both be responsible for the outcomes locally and have the financial ability to address the local priorities.

Diabetes UK's report [Commissioning Specialist Diabetes Services for Adults with Diabetes - Defining A Specialist Diabetes UK Task and Finish Group Report \(Oct 2010\)](#) also outlines the requirements people with diabetes have from an integrated service. It defines and draws together the various components and roles to assist managers, commissioners and healthcare professionals responsible for the delivery of diabetes services, focussing on the fact that diabetes care is complex and touches upon every part of the health service, and diabetes is a condition which calls for a wide mixture of professional care from a variety of professional disciplines.

A key model for integrated care outlined in the above report is that of community specialist diabetes teams linked to hospitals, which offer people management that is close to home, with the facilities available for rapid referral to community based intermediate or specialist care, between service providers that are integrated and fully coordinated in that persons care. This model in particular is a good example of utilising the joint working potential and expertise across primary and specialist care to implement services such as structured education that meets national standards.

For more information on this evidence or if you have any specific queries, please contact

[X]

Monitor

Call for evidence on general practice services sector in England

Response from the English Community Care Association (ECCA)

1. Introduction

- 1.1 The English Community Care Association (ECCA) is the leading representative body for community care in England. Our members provide a wide range of services for adults with care and support needs including residential and nursing settings, homecare, housing and community-based support. Our members also deliver specialist care home services such as rehabilitation, respite, palliative care and mental health services.
- 1.2 ECCA welcomes this call for evidence from Monitor. A good GP service for residents in care homes enhances quality of life and ensures that care home staff are supported to care for people in the care home setting and reduce emergency admissions to hospital. Many homes receive a good service from their GP practice but this is not universal and there is a feeling that the gap between good and poor practice is growing. There has been a concern for some years that GP services for people in care homes vary both in quality and accessibility and that residents in care homes do not receive the same level of service as people in their own homes. The same can be said for the wider primary health services eg continence services, eolc, podiatry, tissue viability services. People living in care homes are entitled to the same services as other people in the local community who live in their own homes and the local GP service should ensure this happens.
- 1.3 Dr Finbarr Martin on the launch of the BGS report on GP services in care homes entitled '*Quest for Quality*' June 2011 said
- “No Model of co-ordinated healthcare has been developed to meet the needs of care home residents”, and that “traditional general practice in many areas does not appear equipped or supported to fill this void.” He continued, “Healthcare support to care homes has been a low priority for commissioners and planners.”
- 1.4 NHS responsibilities for NHS care to residents in care homes must be clarified and, delivery of that care regularly monitored and action taken if residents are not receiving the care to which they are entitled, to ensure residents in care homes are not disadvantaged.

- 1.5 We are not convinced primary care for local populations pays sufficient, if any regard, to the health needs of care home residents, which will be greater than others living in their own homes in the community.
- Over 20,00 care homes in the UK and 320,000 people over 65 plus care for in care homes
 - Number of people with dementia will increase to over 1m by 2025
 - People with learning disabilities needing care and support will increase by 50% by 2018
 - Average age of residents in care homes is 85 years old and they are often very frail

2. Access

- 2.1 CCGs and care homes need to work in partnership to promote the best health, social care and dignity for care home residents which would ensure GPs and other primary healthcare services provide;
- Promotion of a healthy lifestyle and nutritional advice
 - Falls prevention advice
 - Access to community health services, including district nursing, specialist nursing and allied health professionals
 - Continence advice and supplies
 - Support in the assessment of the resident's care plan including end of life care
 - Planned regular reviews of residents assessing healthcare goals and clinical changes, including medication and weight loss with nutrition and hydration intake reviews
 - Medicines management and review

All of which should be backed up with robust systems of communication between the care home, the GP and other primary healthcare services.

- 2.2 Residents need access to a wide range of medical services, including mental health teams, dietetics, occupational therapy, physiotherapy, podiatry, continence, falls and tissue viability (dealing with wounds, pressure sores and ulcers). These are not always available to residents, or if they are, require residents to wait a long time during which their health deteriorates.

3. Choice

- 3.1 People living in care homes are entitled to a choice of GP. This is not always easy to manage however.

4. Retainers

- 4.1 There has been a long tradition of GPs charging some care homes retainers for services. These services should be over and above what GPs are required to provide as part of their GP contract – **although this is not always clear to**

homes and members have recently reported retainer requests for services the home would have expected anyone to receive if they are in their own home ie general medical services. ECCA published two reports on this issue, '*Can We Afford The Doctor*' September 2008 and '*PostCode Tariff*' July 2009.

4.2 The reports made a number of recommendations

- NHS Leaders should play an authoritative and strategic role in ensuring that GP practices in their locality adhere to the regulations and terms of their contracts
- NHS Leaders should develop nationally agreed and implemented guidelines on what services constitute 'enhanced services'. Situations where a care home would require a level of GP service beyond that provided by a GP under the terms of the GP contracts should be clearly outlined and defined.
- NHS Leaders should work with the British Medical Association to produce guidelines on appropriate and transparent costings for 'enhanced' services to care homes

"It appears that fees for GP retainers are calculated in a largely arbitrary manner and there does not appear to be any standardised approach to costings".

Can We Afford the Doctor? English Community Care Association, 2008, p.4

4.3 If retainer fees are to be paid by a care home, a fair tendering process should be followed. *Can We Afford the Doctor?* found that "retainer fees are almost always sought by the GP practice concerned; it is not standard practice for care homes to procure retainer services through a tendering process". Promoting a tendering process would mitigate against arbitrary and often exorbitant charging by GP practices.

4.4 The issues raised in the ECCA 2008 and 2009 reports are still relevant today and in seeking member views for this paper it is clear that GP retainers vary significantly in cost and that there is no real logic to why a charge is made, what is charged and how that is determined. In effect, such costs are likely to be recouped in charges to self funding residents, the funding council or the NHS.

5 Staff Inoculations

5.1 As part of the central funding of the NHS, NHS staff will receive the necessary inoculations eg flu, hep B to ensure they can carry out their work effectively and safely. There is no such funding for staff in independent care homes where the employers are required to pay for such preventative health measures. As with retainer fees above this cost will need to be recharged to self funders and councils/NHS funders (though public sector underfunding means these costs are not always able to be recovered) and residents are again disadvantaged

simply because of where they live in comparison to people living in their own homes. This is a public health issue that should be funded centrally for the benefit of all citizens receiving care and support.

6 Good Practice

6.1 The Coastal Locality Commissioning group (Teignmouth and Dawlish GPs) have developed a care home plan to ensure there is a good strategy for support of care homes and with the aim of reducing urgent care admissions. The plan covers

- GP medical support
- District nurse support
- Medicines Management
- Dashboard
- Training
- Care Home Forum
- Use of care homes in intermediate care
- Facilitating early hospital discharge and
- Engagement with stakeholders

ECCA 22nd July 2013

For more information contact

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Consultation Response GP services in England



July 2012

MPS's response to Monitor's call for evidence on general practice services sector in England

About MPS

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

We are a mutual, not-for-profit organisation offering more than 280,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal-accident inquiries.

Fairness is at the heart of how we conduct our business. We actively protect and promote the interests of members and the wider profession. Equally, we believe that patients who have suffered harm from negligent treatment should receive fair compensation. We promote safer practice by running risk management and education programmes to reduce avoidable harm.

MPS is not an insurance company. The benefits of membership are discretionary - this allows us the flexibility to provide help and support even in unusual circumstances.

General Comments

MPS would like to offer thoughts around the factors that influence commissioning decisions and the challenges that commissioners may face.

GPs now have the responsibility to both commission and provide services. Therefore, situations will arise when GPs own judgment as NHS commissioners could be, or could be perceived to be, influenced by their own concerns, interests and obligations as healthcare providers. Equally, if not more challenging, is being placed in the position of the patient advocate but also the budget holder and commissioner for the services those patients will need and the potentially damaging effect this may have on trust in the doctor-patient relationship.

Patients need to feel reassured on both these fronts. They need to be confident that their GP is using their influence on the commissioning process appropriately, for the benefit of patients and not for their own interests. They also need to feel confident when they visit their GP that decisions about their care,

and about which services they are referred to, are made in their best interests and not inappropriately influenced by their GPs concerns or responsibilities as a commissioner.

The importance of overcoming these issues should not be underestimated. A recent survey by MPS revealed that 59% of GPs and Practice Managers see conflicts of interest as the main concern surrounding the introducing of CCGs (the only things they were more concerned about were budget restrictions and time constraints).¹

To protect the patient-doctor relationship CCGs must have clear and robust governance structures and processes in place to ensure real and perceived conflicts of interest are dealt with in an open way. This requires declarations through registers of interest and codes of behaviour when commissioning decisions are made. It will also be important to communicate with patients and explain that the structure of commissioning NHS services in the reformed health care system means that conflicts of interests will arise but that conflicts of interest do not in themselves amount to impropriety. Careful communication with patients can also reassure them that decisions about their care are taken in their best interest and not unduly influenced by GPs new role in the system. Without this, patient and public confidence in the NHS could be undermined.

¹ Dr Simon Abrams, 'The power is in your hands', *Practice Matters*, Vol. 1 Issue 1 (MPS: April, 2013). <http://www.medicalprotection.org/uk/practice-matters/issue-1>. Based on survey conducted by MPS of 1091 UK MPS members between 8 and 18 February 2013. 34% of respondents were GP Partners and 39% were Practice Managers.

CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

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

The Men's Health Forum is submitting this response following the invitation issued to strategic partners of the Department of Health, NHS England and Public Health England which stated that Monitor would be pleased to accept submissions by the end of September 2013.

We focus on the call for evidence paper's requests for information on access to GP services and on new forms of primary care.

Summary

Commissioners and GPs must address men's under-use of GPs. This under-use is not the result of men's failure to access the services but the failure of GP services to operate and market services in a way that meets the needs of men.

Men's use of services

In England in 2008/9, general practice consultation rates for females were higher than those for males. The biggest difference between men and women was in the 20-40 age group where women attended general practice twice as oftenⁱ.

Age band	Total Consultations (count)	Consultation rate per person year
Female		
20-24 years	800443	5.53
25-29 years	893351	6.15
30-34 years	854571	6.32
35-39 years	905593	6.02
Male		
20-24 years	298353	2.21
25-29 years	327386	2.33
30-34 years	354468	2.55
35-39 years	437007	2.80

Women have higher consultation rates for a wide range of illnesses, so the gender differences cannot be explained simply by their need for contraceptive and pregnancy careⁱⁱ.

An analysis of men's use of GP services shows the potential impact on men's health and the healthcare systemⁱⁱⁱ. The data is compatible with a scenario in which men are reacting later to severe symptoms than women with the result that they are more likely to be hospitalised or die.

This research was based on a total of 35.8 million contacts with GPs and 1.2 million hospitalisations in Denmark in 2005. (Like the UK, Denmark has free access to primary and hospital healthcare.)

This is also consistent with UK and Europe-wide data on malignant melanoma which shows that while women are more likely to develop this type of cancer, men are more likely to die from it^{iv}.

In contrast to GP services, over half, 50.5%, of those attending A&E are men^v.

The barriers

Despite higher rates of premature mortality, men face a number of practical barriers in accessing GP services.

These include the demands of long working hours and problems with accessing primary care services near the workplace due to the system of registering with a single GP practice^{vi}. The vast majority (87%) of men work full-time compared to about half (57%) of women^{vii}. Even a majority of health professionals recognise that working hours were a “significant” factor affecting GP visitation^{viii}.

Proactive workplace health interventions are value for money. A health programme by Royal Mail Group, a major employer of men, was analysed by the London School of Economics. The programme saved Royal Mail Group more than £227 million over three years. The LSE calculated that using Royal Mail Group’s approach in the 13 worst performing sectors in respect of absence rates would be worth £1.45bn to the UK economy^{ix}.

The NHS Health Check programme offers another example of how GP services can overcome these barriers. GP practices write to men *inviting* them to come in for the NHS Health Check. Community pharmacies operate NHS Health Checks and commissioners such as the local authorities in Dudley and Lambeth are working with providers to run NHS Health Check drop in days in town centres and in local facilities such as libraries.

Conclusions

Even though men have poor health outcomes, the barriers to men’s effective use of health and related services have not yet been systematically addressed by the NHS and other organisations. Services are not routinely delivered in ways that take proper account of men’s attitudes and behaviours.

This suggests that many providers are failing to meet their duties under the public sector equality duty, with similar requirements in place since 2007 under the gender equality duty.

Services may not be sufficiently good value for money if they are not meeting the needs of half the population which then use more expensive A&E services or delay seeking treatment.

GP led walk-in services provide extra flexibility in terms of time and place. For some men dual GP registration may be an answer. Men’s poor use of GP services suggest that the extension to GP hours has not been adequately implemented or marketed to men and that low awareness or low expectations persist.

The NHS Health Check programme offers an opportunity for creative thought about service delivery, not least because this is a programme of particular value to men given their high levels of morbidity and mortality from cardiovascular disease. Many areas are already delivering the programme in ways that could provide lessons for improving access to traditional GP services.

About the Men's Health Forum

The Men's Health Forum, a charity, is the voice for the health and wellbeing of men and boys in England and Wales.

Our goal is the best possible physical and mental health and wellbeing for all men and boys. There is one premature male death every five minutes and far too many men and boys suffer from health problems that could be prevented.

The Forum works across a number of health and related issues. Our work focuses particularly on those groups of men with the worst health and we are striving to ensure that we take account of the diversity of men and their needs.

The MHF was founded by the Royal College of Nursing in 1994 and became an independent charity in 2001. In 2013 we were appointed as a strategic partner of the Department of Health, NHS England and Public Health England. This programme sees us working alongside government to help health providers and third sector organisations improve the health of men and boys.

For more information see www.menshealthforum.org.uk.

ⁱ Information Centre, Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch® database. <https://catalogue.ic.nhs.uk/publications/primary-care/general-practice/tren-cons-rate-gene-prac-95-09/tren-cons-rate-gene-prac-95-09-95-09-rep.pdf>

ⁱⁱ Bajekal M. et al (2006), Focus on Health.

ⁱⁱⁱ Juel K., Christensen K. (2008), 'Are men seeking medical advice too late? Contacts to general practitioners and hospital admissions in Denmark 2005', Journal of Public Health 30(1):111-3.

^{iv} NHS (2007), Cancer Reform Strategy

^v Accident and Emergency Attendances in England - 2011-12, Experimental statistics. <http://www.hscic.gov.uk/catalogue/PUB09624>

^{vi} Men's Health Forum (2008), Improving male health by taking action in the workplace: A policy briefing paper. www.menshealthforum.org.uk/sites/menshealthforum.org.uk/files/pdf/MHW08policydoc.pdf

^{vii} ONS, Labour Market Statistics www.ons.gov.uk

^{viii} Making Methods Matter (2013), 'Why are men reticent to visit their GP?', Exeter University

^{ix} David Marsden and Simone Moriconi, London School of Economics, Centre for Economic Performance and Department of Management (2008) The Value of Rude Health

Call for evidence on general practice services sector in England

Response from the National Children's Bureau



About the National Children's Bureau

The National Children's Bureau (NCB) is a leading charity that for 50 years has been working to improve the lives of children and young people, reducing the impact of inequalities. We work with children and for children to influence government policy, be a strong voice for young people and front-line professionals, and provide practical solutions on a range of social issues.

For more information visit www.ncb.org.uk

This submission draws on NCB's report *Opening the door to better healthcare: Ensuring general practice is working for children and young people*¹, published in June this year.

1. The concept of 'out of hours'
 - 1.1. A key barrier to access to primary care is the times at which a G.P practice makes its services available. It is of concern that the current standard contract enables GP practices to choose what hours their services are available outside of 'core hours'. While the majority of practices offer some extended hours, they are only paid for a minimal number of extra hours each week, determined by their practice population size.^{2,3} It is hard to see how this approach fits with a system of commissioning services according to an assessment of local need, which is what is expected, even if not yet a reality, with regards to other health and social care services. Ian Kennedy, in his 2010 Government-commissioned review of child health services was particularly critical of the 'out of ours' concept:

"It is so utterly focused on the world, the needs and concerns of the professional. Children, young people and their parents/carers do not understand the notion of being ill or needing help 'out of hours'. They recognise the idea of the routine and the unusual. And the unusual happens when it happens. And help is needed when it happens."⁴

¹ Available from <http://www.ncb.org.uk/policy-evidence/policy/thematic-policy-reports>

² Department of Health (2009), *GP Extended Opening Hours July 2009*

³ NHS Employers, NHS England and British Medical Association (2013), *2013/14 extended hours directed enhanced service guidance*

⁴ Ian Kennedy (2010), *Getting it right for children and young people Overcoming cultural barriers in the nhs so as to meet their needs*, p65

It indeed results in a flawed system for children and young people. Nearly all practices close at 6pm on most weekdays and many GPs have no involvement in the provision of 'out of hours' services.^{5,6}

- 1.2. These arrangements mean that parents of younger children will be confused about where to go to when they have concerns about their child's health, encouraging them to resort to A & E unnecessarily. There does indeed appear to be an increase in the rate of children attending A & E during evenings.⁷ A & E is not likely to be the best setting for meeting these children's needs (see contribution to pressure Accident and Emergency units, below). Working parents may particularly struggle to take their child to surgery during its normal opening hours for less urgent appointments and default to A & E when they finish work or the child's condition deteriorates.
- 1.3. For school aged children, the number of appointment slots available outside of school hours in the early evenings and at weekends is also reduced by these arrangements. This means that children are more likely to have to take time out of school even for routine or non-urgent appointments. A spell of illness or a long term condition requiring several such appointments could mean several missed lessons that a child may not be able to catch up on and, ultimately, avoidable harm to their educational outcomes.
- 1.4. Getting services delivered at the times at which they are most needed may not be challenge unique to general practice – concerns have also been highlighted about the availability of consultant paediatricians at times of high demand in acute settings.⁸ We note however that hospitals are generally open, at least, 7 days a week.
- 1.5. **A system which distinguishes 'out of hours' services using nationally set parameters that bear no relation to local demand is a particularly striking obstruction to delivering the best primary care for children and young people, and may serve to compound the challenge for other services in meeting demand.**

2. The size of practices vs the need for expertise in child health

- 2.1. It is of course well established that children's anatomies and communication needs vary from that of the wider population. We welcome the Department of Health's support for extended GP training which will allow for more experience in child health. This will take some years to work through, however, and there is a need to ensure appropriate expertise in child health through continuing professional

⁵ National audit office (2006), *The Provision of Out-of-Hours Care in England*, cited from: The King's Fund (2009), *General Practice in England: An Overview*

⁶ Royal College of General Practitioners (2010), *RCGP Child Health Strategy 2010-15*, p11

⁷ Ian Kennedy (2010), *Getting it right for children and young people Overcoming cultural barriers in the nhs so as to meet their needs*, p21

⁸ Royal College of Paediatrics and Child Health (2013), *Back to Facing the Future: An audit of acute paediatric service standards in the UK*, p24

development and child health 'leads' as well as initial training. We are concerned that this may be obstructed by the configuration of practices.

- 2.2. The extent of expertise in the general expertise setting will affect where families go for health support and ultimately children and young people outcomes. Children who have a long term health condition and/or disability will often go straight to their consultant paediatrician for their health concerns. Some of these encounters with the hospital paediatrician will be for ailments such as coughs and colds that affect all children and young people and may not necessarily require such specialist attention. Three quarters of parents of disabled children surveyed by Contact a Family in 2011 said that their child's GP had no role in their care.⁹ This can mean such children and their families having to travel further than they should to receive support. In some cases, children will be taken to A&E. It can also present challenges when a young person turns 18 no longer has access to paediatric care, as this role in coordination of care must then be passed to the GP, who, as a result of having little prior involvement, will have limited knowledge of the patient.
- 2.3. Dealing with relatively common mental health concerns among adolescents is a particular area where the right expertise may not exist amongst all GPs. A research review found that young people with mental health problems felt that many GPs lacked understanding, awareness, empathy and interest, and were reluctant to provide certain types of support.¹⁰ The Kennedy Review stressed that "there are significant shortages of professionals trained to care for young people with mental health problems at a time when an epidemic of such problems lies beneath the surface of society."¹¹
- 2.4. Having considered these challenges, the Children and Young People's Health Outcomes Forum made a number of recommendations including that all general practices that see children and young people should have a named medical and nursing lead.¹² These leads would be able to help maintain the expertise of each practice and ensure that procedures remain in line with the latest regulations and guidance, for example on safeguarding, coordinating health and special educational needs services or use of medicines. The System-wide Response to the Forum sets out the Royal College of General Practitioners' support for this recommendation and

⁹ Contact A Family (2013), *Making GP practices more welcoming for families with disabled children: Information for GP practice teams*

¹⁰ Lavis, P. and L. Hewson (2010), "How many times do we have to tell you? "Young Minds Magazine **109**: 30-31. Cited from *Listening to children's views on health provision*, p34

¹¹ Ian Kennedy (2010), *Getting it right for children and young people Overcoming cultural barriers in the nhs so as to meet their needs*, p13

¹² REPORT OF THE CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM, p54

<https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results>

their commitment to NHS England, the Department of Health, the General Pharmaceutical Council (GPC) and others to consider this proposal in more detail.¹³

- 2.5. It is understandable that identifying a medical and nursing lead for children and young people would be particularly challenging for smaller practices, but it is apparent that the size of practices may not be determined by the needs of patients.
- 2.6. While there may be many advantages and disadvantages to different sizes of practice, the main advantage of smaller practices is that in areas of low demand, such as rural areas, they can be more spread out allow for patients to access the surgery without travelling long distances. One would expect, therefore, for the proportion of single and double-handed practices to be higher in rural areas. The map included in the evidence pack for NHS England's current consultation on GP's services, however, shows that if anything, the reverse is true.¹⁴
- 2.7. This suggests that the size of practices is may not determined by demand or informed commissioning decisions. As a consequence the ability of General Practice to meet children's needs through the existence of practice medical and nursing leads is unnecessarily hindered**

3. Contribution to pressure on Accident and Emergency units

- 3.1. Nearly a quarter of all those attending A & E are aged under 16 and the number of attendances (figure 2) have risen nearly 35 per cent in 4 years.¹⁵ There has also been a significant increase in emergency admissions for children.¹⁶ While the causes of this must be complex and multifaceted, it is likely that the flawed commissioning of GP services are contributing to or compounding this, and that well configured primary care must be part of the solution. A recent study of emergency admissions for children aged under 15 has found an increase of 18% for conditions where higher rates of admission are associated with poorer primary care.¹⁷ Admissions of less than one day for acute infections virtually account for the entirety of this increase.
- 3.2. 'Out of hours' arrangements mean that parents of younger children will be confused about where to go to when they have concerns about their child's health,

¹³ Department of Health (2013) *Improving Children and Young People's Health Outcomes: a system wide response*, p40

¹⁴NHS England Analytical Service(2013) *Improving General Practice – a call to action Evidence pack*, p40

¹⁵ In 2012 23% of A & E Attendances were for children under 16. The total number of attendances for this age group has risen 34.5% on 2008 figures. Health and Social Care Information Centre (2013,) *Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data - April 2012 to December 2012*

¹⁶ Gill PJ *et al* (2013), "Increase in emergency admissions to hospital for children aged under 15 in England, 1999-2010: national database analysis", *BMJ*, Volume 98, Issue 5.

¹⁷ Gill PJ *et al* (2013), "Increase in emergency admissions to hospital for children aged under 15 in England, 1999-2010: national database analysis", *BMJ*, Volume 98, Issue 5.

encouraging them to resort to A & E unnecessarily. There does indeed appear to be an increase in the rate of children attending A & E during evenings.^{18,19}

- 3.3. There is much variation in A & E attendance and admission that cannot be explained by the relative economic disadvantage of areas.²⁰ This suggests that there may be local variations in configuration of services, including in primary care that should be further investigated.
- 3.4. As suggested above, failure to commission the right configuration and size of practice could impair attempts to ensure there is good child health expertise present in all practices. Families' perceptions of where the best child health expertise exists can also influence where children go for treatment, regardless of the severity or the complexity of the complaint. Three quarters of parents of disabled children surveyed by Contact a Family in 2011 said that their child's GP had no role in their care.²¹ This role will often end up being taken by a hospital paediatrician on a routine basis, but the lack of an established positive relationship with a GP will mean that trips to A&E for minor conditions are more likely. It is also worth noting the observation made by the Child Health and Maternity Partnership in 2011 that some of the areas with the highest rates of emergency admissions are areas which have standalone children's hospitals.²²
- 3.5. A & E is not likely to be the best setting for meeting the needs of children with relatively minor conditions: They may have to wait hours to be treated; Doctors do not have same ease of access to medical records; It can unnecessarily risk harm to the child involved, including from hospital acquired infections and distress from the A & E hospital environment; It distracts the health professionals at the hospital from tending to more acutely ill children; and it costs money that could be spent on more appropriate interventions.²³

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30 September 2013

¹⁸ Ian Kennedy (2010), *Getting it right for children and young people Overcoming cultural barriers in the nhs so as to meet their needs*, p21

¹⁹ Andrews (2011), *Fundamentals of Commissioning health Services for Children*, Child Health and Maternity Partnership

²⁰ Cheung R (Ed.). NHS Atlas of Variation in Healthcare for Children and Young People. 2012. NHS Right Care p74

²¹ Contact A Family (2013), *Making GP practices more welcoming for families with disabled children: Information for GP practice teams*

²² Andrews (2011), *Fundamentals of Commissioning health Services for Children*, Child Health and Maternity Partnership, p8

²³ For example, based on 2010 figures from NHS West Sussex of £1,000 for an emergency admission and £53 for primary care cited from Andrews (2011), *Fundamentals of Commissioning health Services for Children*, Child Health and Maternity Partnership

NHS Alliance

Response to Monitor's 'Call for evidence on general practice services sector in England'

Thank you for the opportunity to respond to this call for evidence.

We are very interested in this review and your focus on whether general practice services are working in the best interests of patients. The NHS Alliance has broad membership across primary care providers, including general practices as well as a wide range of other providers, including many that are developing new models for delivering better care in the future.

We have thought carefully about submitting 'evidence'. We have recently produced two major pieces of work relating to this are:

- 'Breaking the Mould' that looks at access to general practice as part of the wider challenge of delivering urgent care
<http://www.nhsalliance.org/?s=breaking+the+mould> prepared with the Primary Care Foundation. You may also want to look at the Primary Care Foundation website for a wealth of information on improving access to care
<http://www.primarycarefoundation.co.uk/>
- Breaking Boundaries
<http://www.nhsalliance.org/?s=manifesto+for+primary+care%3A+breaking+boundaries> laying out a progressive vision for the future of primary care that includes a range of material that touches on all three of your key areas, but particularly the potential for introducing new models of care outside hospital.

[✂]

NHS PARTNER'S NETWORK RESPONSE TO MONITOR'S CALL FOR EVIDENCE ON GENERAL PRACTICE SERVICES SECTOR IN ENGLAND

The NHS Partners Network, (NHSPN) which represents independent sector providers (“for profit” and “not for profit”) of NHS care across all sectors except mental health, is a self-governing network of the NHS Confederation, working with the other members of the Confederation and fully committed to the values of the NHS Constitution. More information about the network can be found on our website at www.nhsconfed.org/nhspartners.

The NHS Partners Network welcomes this opportunity to comment on Monitor's consultation on to focus on GP services. GPs are the gateway to the rest of the NHS system as well as themselves providing a large proportion of care. Patients have experienced growing difficulty in accessing GP services. Independent sector providers have also experience issues with the "gatekeeper" role of GPs when it comes to the implementation of policies like AQP and the exercising of patient choice.

The market

Underlying the various issues facing GP services at the moment is the context within which they operate. Whilst they are private businesses they do not operate in a free market. Most importantly there is no real competition for primary care and whilst patients have in theory been given choice of GP in the NHS Constitution, GPs are still allowed to block this choice.

Primary care is therefore operated like a franchise. A GP practice is given an area to operate in. It is true that area boundaries may overlap but in reality competition for patients is actively discouraged by the NHS and GP groups. Moreover, in many cases where a patient tries to change their GP, the GP actively discourages this. We have anecdotal evidence of GPs still citing NHS restrictions including boundaries and claiming that each patient has to register with the GP in their specific area.

NHSPN believes that the improving GP services can only really be achieved by the development of:

1) A competitive market:

Providers should be able to establish practices at their own discretion. They should be allowed to identify areas of low or poor provision and assess whether to invest in those areas. NHSPN is very confident that the market itself can and would provide the most effective solutions for such areas. Investors would be interested in filling the

gaps where there are perhaps poor facilities or inadequate open hours, insufficient services or poor patient feedback/ CQC reports. The history of where independent sector providers opened walk in centres supports this view. It is policy and commissioning decisions combined with the reluctance of traditional GP practices to go into some areas that has left some areas without the necessary provision.

2) Patient choice:

Patient choice in GP services is specifically supported by the NHS Constitution. However, we have anecdotal evidence that it isn't really happening and some practices continue openly to adhere to their old tradition of having mutually agreed patient catchment areas. For example, in one borough we know of a small practice that refused to accept a patient when they moved 0.5 miles away from where they use to live (previous house being 0.2 miles to the practice). However, another much bigger practice providing many more services was more than willing to accept a patient 1.5 miles away and out of their normal boundary.

It is important to note that patient choice is not important only as a theoretical or ideological concept or right. It is of course in part a matter of convenience and preference. But patient choice underpins continuity of care, ease of access and drives quality .

3) Support for investment:

Establishing and running high quality modern GP practices requires investment, so it is important that the way the system works gives confidence to investors. Generally investors are more comfortable with the workings of consumer markets, than with sometimes politicised and arbitrary commissioning decisions. However, even a shift towards more patient/consumer driven primary care services will not be enough. For investors to enter a market it is also necessary that they can see how to exit it on fair and reasonable terms. This is especially (but not only) true of small practices where GP partners have invested in the property and assets - tangible and intangible - but need eventually to be able to release their investment profitably including the "good will" that is such an important element in healthcare services. Moreover current financial incentives for drug prescribing and reducing hospital admissions are local, variable and short term. This can feel too uncertain and undermine investment decisions.

Access

The current system has failed to respond to the different ways in which patients want and indeed need to access GP services. There is a disturbing tendency to regard patients who do not wish to fit into traditional GP opening times and access arrangements as tiresome and unhelpful. The reality is that working hours across huge swathes of the economy are now quite different to what they were even 20 years ago. Moreover the emergence of a truly multi-cultural society means that there

are substantial groups of citizens who for a variety of entirely proper reason need and are accustomed to accessing primary care in different ways. That needs to be respected and responded to, not dismissed as a nuisance. The whole saga of Walk-In Centres perfectly illustrates this, Walk-In Centres were often set up in the face of resistance by conventional GP practices, succeeded despite this, and precisely because they responded to changing social and lifestyle patterns, but in too many cases are then the first services to be closed down by commissioners with too strong a bias towards conventional GP services as soon as financial pressures start to bite.

One of our staff members had to access GP services recently and fortuitously this allowed us to "map" the entire sequence of events. Her experience perfectly illustrates the difficulties that patients can face at the moment and the inadequacy of conventional arrangements. With her full permission we attach a flowchart showing what happened at Annex A .

There is of course no good reason why Conventional GP Practices cannot look at different models of provision including: opening longer hours, weekend access, and extended offer of primary care within the practice including for example diagnosis. It would be quite wrong of us not to acknowledge that some are doing so. But without the stimulus of patient-driven competition in the sector the incentives to change are too weak and the response will continue to be inadequate.

In order for this to happen we consider that it will also be vital to need to have fewer, but larger practices. At the moment, we have a system with too many small practices unable to respond to what patients really want. See for example the map at Annex B showing practices, by size, in Leicester:

Contracts and Commissioning

NHSPN believes that APMS contracts are usually too restrictive: they should focus on outcomes not activities. As they currently stand, they do not support innovation in triage and treatment streams and the activity based approach tends to reinforce established methods of working rather than incentivising the new approaches discussed above.

We also believe the "Carr-Hill formula" no longer adequately represents our society. APMS contracts can make a business in a deprived area financially unviable. Whilst we believe that issues such as age are still very relevant to payments, we think that other factors - for example deprivation and ethnicity - should be added to the weighting of payments.

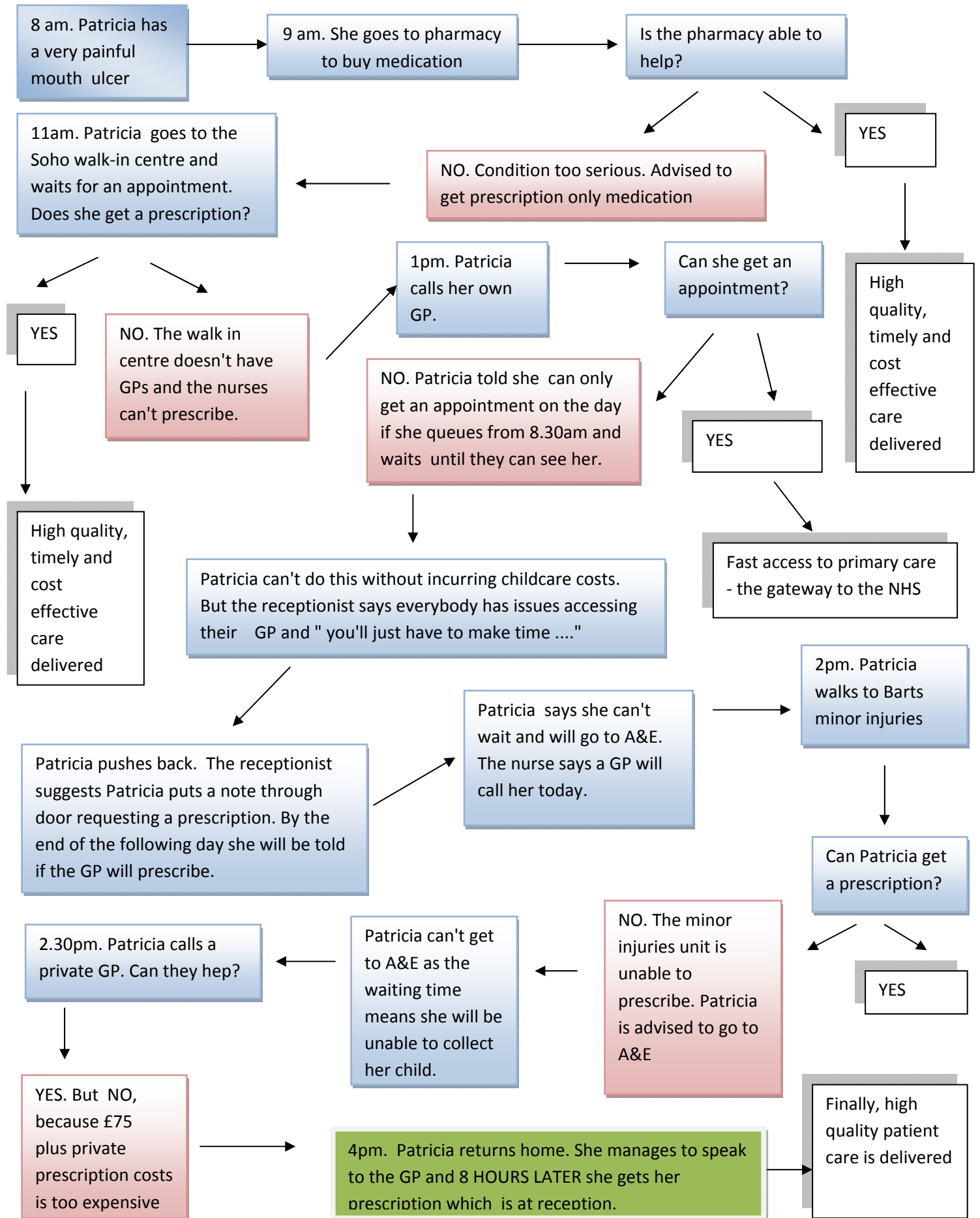
An inevitable conclusion to be drawn from much of the above is that a significant "rethink" is needed about primary care commissioning. The move of primary care commissioning from the old PCTs to NHS England provides an opportunity for this, not least because the new Regional and Area teams will be in a position to develop a level of focus on the issues and the expertise that PCTs were too often lacking. We

are firmly of the view that commissioners need to become more sophisticated and more open both to commissioning services differently and to commissioning a wider range of services within primary care, either from GP practices or other providers.

NHSPN

August 2013

ANNEX A: Patricia's progress. The blue pathway shows what actually happened. Red boxes are where the sensible option was "blocked". White boxes show the best - but unavailable - option at each stage.



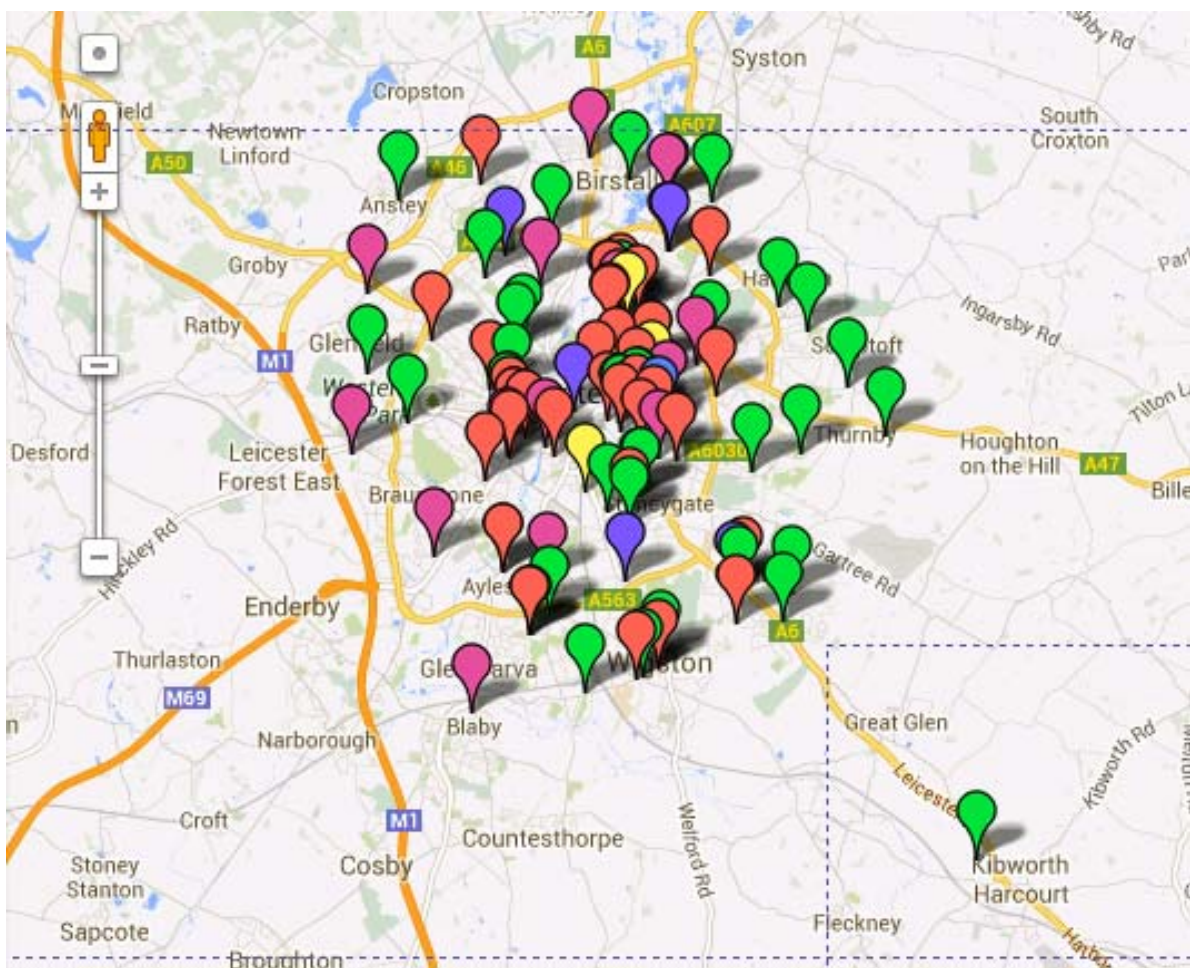
ANNEX B

PRACTICES IN LEICESTER, BY SIZE

(image from

<https://www.google.com/maps/ms?vps=2&hl=en&ie=UTF8&oe=UTF8&msa=0&msid=202179206231773498408.0004d50d823cd7f922ee6>)

Red	Less than 4,000 patients
Green	4,000 to 10,000 patients
Purple	10,000 to 15,000 patients
Yellow	Over 15,000 patients





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Monitor Call for evidence on general practice services sector in England

By email
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31st July 2013

Dear Sir / Madam

Submission of points to the Monitor Call for evidence on general practice services sector in England

PSNC promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors. Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

NHS services are stretched more than ever before at the moment under the combined pressures of financial constraints and increasing demand for services. And with the patient base only set to expand further as the population ages and long term conditions become more prevalent, the challenges are not set to go away.

PSNC believes that the NHS can, and must, meet these challenges. But it will not happen without radical thinking and a commitment from all healthcare professionals to play their part. We believe that it will not happen unless community pharmacy is used effectively to play a key role in supporting patients to lead healthy lifestyles and make the most of their prescribed medicines and the care available to them. By reshaping the community pharmacy service, large savings in NHS resources and improvements in health outcomes can be made. Our ideas on how this can be achieved are described in 'The vision for NHS Community Pharmacies – the path to improved patient care' which accompanies this submission.

We highlight below a number of examples of ways in which the current approach to contracting and operation of general practice can sometimes frustrate the provision of community pharmacy services, which can be to the detriment of patients.

Information and IT

Community pharmacies currently do not have access to shared patient records or GP records. This can frustrate the effective provision of services, such as management of long term conditions, by community pharmacies.

The GP record frequently acts as the central coordinating record for the care of an individual and as such it is important that health professionals outside the GP practice are able to submit clinically significant information to be included in this record, for example the results of an NHS Health Check.

This is not easy to achieve in an effective manner as IT systems across primary care are not configured to allow this. Such problems can lead to an uneven playing field, particularly where community pharmacies may be competing to provide services against GP practices or other providers with access to shared patient records. We believe all health

care professionals should have relevant role-based access to shared or GP records where the patient consents to such access.

Incumbency advantages

The central role of some incumbent healthcare providers, for example general practitioners, frequently requires their cooperation with other, potentially competitor, providers. This could, for example, relate to information sharing, as described above.

In such circumstances it can be possible for an incumbent provider to block the provision of new healthcare services by another provider, by preventing effective multi-disciplinary collaboration. At times the blockage may simply occur due to a lack of incentive for the incumbent provider to work collaboratively with other providers, rather than a desire to prevent the provision of services by other providers for anti-competitive reasons.

Commissioning of seasonal influenza vaccination illustrates this point. A great many pharmacies already provide this service on a fee paying basis, but NHS commissioning of the service from community pharmacies has been relatively limited. There is evidence of community pharmacies being able to increase vaccination rates in at-risk groups, where the service is offered over and above the incumbent NHS provision by GP practices.

Local experience suggests that the service has not been widely commissioned from community pharmacies, despite the positive evidence of increased vaccination rates achieved, due to negativity from GP practices about the increased competition which would result from pharmacy provision and the need for GP practices to annotate their patient records when a community pharmacy administers a flu vaccination. We believe that this service would be more appropriately commissioned by NHS England using an any qualified provider approach.

Tendering and commissioning behaviours

The new healthcare commissioning structures present many new opportunities for community pharmacies; however we are concerned that appropriate governance measures are put in place in all of the new organisations in order to ensure a fair and transparent commissioning process is applied. Clinical Commissioning Groups, the Boards of which are dominated by GPs, are of particular concern due to the theoretical potential for the constituent GP practices to exert undue influence on commissioning decisions for services which the constituent practices may themselves wish to provide. This influence could manifest itself as the development of service requirements that favour the constituent practices over other potential providers.

In a similar vein, because the GP-patient relationship is one in which there is a presumption of undue influence, the governance arrangements for GPs should require that they do not, and are seen not to be making recommendations as to potential providers a patient may wish to select. We believe it is particularly important to protect patients' rights to choose to use the pharmacy that they feel best meets their needs.

If you require clarification on any of these points, please do not hesitate to get in touch with me.

Yours sincerely

Alastair Buxton FRPharmS
Head of NHS Services

Consultation response

Monitor

Call for evidence on general practice
services sector in England

1st August 2013

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Members of Pharmacy Voice



Pharmacy Voice welcomes the opportunity to contribute to this call for evidence.

Positive community pharmacy/general practice relationships are important to the future of both professions, and will underpin any move towards seamless patient care. We have no doubt that general practice is under pressure, but we would suggest that one of the solutions to increasing demand, is to direct patients to those parts of the wider NHS system, including pharmacies, most appropriate to dealing with them. GP services should not be dealing with the 57 million consultations a year pharmacists are capable of managing, as just one example¹.

Although recent developments in professional practice have yet to deliver a universal step change through closer collaboration between the professions, good practice in follow up to Medicines Use Reviews (MURs), engagement through the New Medicines Service (NMS), models supporting supplementary prescribing by pharmacists, and repeat dispensing, where it has been implemented, show the way forward.

Access to primary care services

The 11,200-plus community pharmacies in England² dispensed 885million prescription items in 2011-12. Community pharmacies are located where people live and work; 96% of people can get to a pharmacy within 20 minutes by walking or using public transport (99% by car)³. They are open longer than GP surgeries, in the evenings and on Saturdays; many are now open on Sundays. Pharmacies are located on high streets and in deprived estates where people are more likely to have multiple long term conditions. Over 400 million visits will have been made to a pharmacy for a health-related reason last year.

Community pharmacists are, therefore, the most accessible healthcare professionals, available without appointment and typically seeing patients more frequently than any other healthcare provider. As such, they are increasingly used as a focus for improving the public's health by tackling the poor health behaviours of the "well".

Pharmacies sit where health and social care meet, supporting the frail, disabled or housebound, and carers with the administration of medicines. This frequent contact means pharmacy staff can be the first to notice when things are amiss; this informal monitoring can be transformed into a formal role when linked to other health and social care providers. For example, shared care systems for substance misusers link the pharmacy, key worker, patient and prescriber to the benefit of patient care.

¹ *Building on strengths, Delivering the Future*. Department of Health 2008

² *General Pharmaceutical Services in England: 2002-03 to 2011-12* HSCIC
<https://catalogue.ic.nhs.uk/publications/primary-care/pharmacy/gen-pharm-eng-2002-03-2011-12/gen-pharm-eng-2002-03-2011-12-rep.pdf>

³ *High Quality care for all, now and future generations: Transforming urgent and emergency care services in England*. June 2013. NHS England

The recent report on general practice by The King's Fund and Nuffield Trust⁴ highlighted the importance of shared electronic records to underpin scaled-up primary care networks, and enabling the coordination of care. We agree with the authors that such records need to include community pharmacists, as well as the community health services and social care, if true integration of care is to be possible".

Patient safety

Recent audits have demonstrated how community pharmacies improve outcomes for patients. A recent audit⁵ of the supply of high risk medicines in 2,773 pharmacies in England and Wales found that just under 14% of people taking methotrexate, lithium or warfarin were not receiving the blood tests used to check they are receiving the right dose. In the course of the audit, 425 patients were referred back for examination of possible signs of toxicity. Evidence from the first audit in this series, undertaken in 2011/12 and looking at pharmacist interventions⁶ in over 4,400 pharmacies, suggests that community pharmacists query almost two million prescription items each year with prescribers, including 44,000 incidents that could have resulted in serious harm. We believe this is the first time that community pharmacy's day-to-day contribution to medicines safety has been measured on such a scale.

Maximising the potential of community pharmacy to improve the use of medicines further, to support self care for both common self-limiting conditions and long-term conditions, and to deliver public health services will reduce the demands on GPs.

Pharmacy support for self care

Self care includes the actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital⁷.

There is growing evidence to show that supporting self care leads to improved health and quality of life, a rise in patient satisfaction, and better symptom management, including reductions in pain, anxiety, depression and tiredness. It can have significant impact on the use of services, with fewer primary care consultations, and reduced visits to outpatients and A&E. Some 57 million consultations with general practitioners each year are for

⁴ *Securing the future of general practice: new models of primary care* July 2013 Kings Fund and Nuffield Trust <http://www.nuffieldtrust.org.uk/publications/securing-future-general-practice>

⁵ *Practice Based Audit 2012/2013* Pharmacy Voice July 2013
http://www.pharmacyvoice.com/images/press/PBA_final_report.pdf

⁶ *Local pharmacies intervene on two million prescriptions every year* 2012 Pharmacy Voice
<http://www.pharmacyvoice.com/press/local-pharmacies-intervene-on-two-million-prescriptions-every-year>

⁷ *Self care* The Proprietary Association of Great Britain <http://www.pagb.co.uk/selfcare/home.html>

illnesses that people could manage through self care¹. Support, not just information but including feedback and follow up, is key.

A 2011 survey for the Department of Health⁸ found that 74% of people with a long term condition have used their local pharmacy at least once in the previous 6 months. Aviva have found that up to 40% of GP time is spent with people who do not need to see their doctor⁹. There is growing interest in services designed to use the capabilities of pharmacists in what are known as “minor ailments services” – Scotland has a nationally commissioned service. Wider commissioning of these sorts of services by CCGs, and consistent information to improve public awareness of the capabilities of pharmacists, would enable more patients to self care, and reduce demands on GPs.

NHS Health checks

The Secretary of State, Jeremy Hunt, said only last month “More than 650 lives a year could be saved if simple NHS Health Checks were offered throughout the country and taken up.” Community pharmacies – identified as partners for delivery¹⁰ – should be commissioned as providers of NHS Health Checks to increase the likelihood of any target for lives saved being reached.

Healthy Living Pharmacies

The Healthy Living Pharmacy (HLP) concept was developed by NHS Portsmouth PCT, working with the Hampshire and Isle of Wight Local Pharmaceutical Committee (LPC), to enable pharmacy team activity to reduce health inequalities through delivering consistent and high quality health and wellbeing services, promoting health and providing proactive health advice and interventions. Interest in the concept is high; it is being rolled out across a number of other areas, increasingly with support from local authority public health leads.

HLP programmes are characterised by the development, within pharmacies, of a number of key enablers, which deliver both a framework and a focus for the delivery of behavioural change wellbeing services and high quality health services. The enablers include an appointed and trained Healthy Living Champion (previously Health Trainer Champion) to support the HLP’s health and wellbeing role, and leadership training for managers so they can support the development of the team as it moves to proactive health intervention.

HLPs are characterised by the provision of healthy living advice at every opportunity – when dealing with over the counter requests, during prescription interventions, and as

⁸ *Long term health conditions 2011* survey for Department of Health April 2011

⁹ *Aviva health of the Nation* report 2011

¹⁰ *NHS Health Check implementation review and action plan* July 2013 Public Health England
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224538/NHS_Health_Check_implementation_review_and_action_plan.pdf

part of services such as MURs and NMS etc. This approach is consistent with the “making every contact count” agenda.

An evaluation of pathfinder sites across England was conducted in 2012¹¹. It found that 21% of the 1,034 people who accessed health and well-being advice and/or an NHS service at an HLP would have done nothing if the service had not been available. Sixty per cent said they would have gone to their GP.

Greater use of the knowledge and skills of community pharmacists and their teams will enable patients to access care at a time and place best suited to them, and alter demand on GP services so that GPs can do more of what they are uniquely qualified to do. In the longer term, these new methods of working should be supported by greater alignment of the GP and pharmacy contracts to avoid duplication of payment and promote integrated service provision in the interests of improved patient care.

Medicines optimisation

Medicines are second only to staffing in the NHS resource league table. If the specific challenges faced by the NHS in tackling some of the challenges around medicines – it is widely estimated that 30-50% of medicines prescribed in long-term conditions are not used as intended and 5-8% of hospital admissions are caused by preventable adverse effects of medicines – then effective engagement of pharmacists is essential.

The national pharmacy contract includes two advanced services which support better use of medicines– Medicines Use Reviews and the New Medicine Service. These patient-centred services are designed to enable patients to make the most of their medicines.

An MUR is a simple review with the patient (or carer if appropriate) of all the medicines (including over the counter and complementary medicines) a patient may be using. Identified issues are addressed, and GPs informed as necessary. The NMS follows initiation of a new treatment for a long term condition, and is designed to address patient concerns or questions that arise once the medicine is being taken. The service is based on proof of concept research which demonstrated improved adherence and understanding among patients at three months¹².

Repeat dispensing

Repeat dispensing is a system whereby a GP can issue up to a year’s worth of prescriptions for a patient. The pharmacy of the patient’s choice holds the “master prescription” and dispenses in accordance with the GP’s instructions and the patient’s needs, checking on

¹¹ *An evaluation into Healthy Living Pharmacies (HLP) in England 2013*

<https://www.npa.co.uk/Knowledge-Centre/Resources/Press-Releases/HLP1/HLP/>

¹² Clifford, S., Barber N., Elliott R., Hartley E., Horne, R., Patient-centred advice is effective in improving adherence to medicines, *Pharmacy World & Science*, 2006 September; 28(3):165-170

each supply the patient's condition is stable and referring back if necessary. The service improves access, reduces bureaucracy, but maintains patient/professional interactions.

Unfortunately, service roll out of this service has been slow, anecdotally because of the slow roll out of the second version of the electronic prescription service (EPSR2), which makes the production of repeat dispensed prescriptions easier and enables recall of un-dispensed prescriptions if a patient's condition changes. Issues with EPSR2 need to be resolved, but GPs should be encouraged to use the repeat dispensing system as a solution to improving workflow in the surgery while reducing opportunity cost for patients.

Restriction of patient choice

Community pharmacy is one area of the NHS where patients have traditionally exercised a genuine choice over their provider. However, over the past few years, increasing numbers of GPs have taken a financial interest in a pharmacy, either as owners or part-owners or as landlords allowing a pharmacy to operate from the practice, with a levy premium rent linked to prescription volume.

There is evidence that, where these financial interests exist, some GPs and their staff are using their position as providers of medical services to restrict patient choice, so the pharmacy in which they have a financial interest gets the revenue associated with prescriptions that otherwise would have been dispensed elsewhere. These activities restrict patient choice and undermine fair competition between pharmacies, and action should be taken.

Pharmacy Voice

Pharmacy Voice (PV) represents community pharmacy owners with the principal aim of enabling community pharmacy to fulfil its potential in playing an expanded role as a healthcare provider of choice in medicines optimisation, long term conditions and public health. Its founder members are the Association of Independent Multiple pharmacies (AIMp), the Company Chemists' Association (CCA) and the National Pharmacy Association (NPA).



Royal College of
General Practitioners

Professor Amanda Howe MA Med MD FRCGP, Honorary Secretary of Council

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1 August 2013

Monitor call for evidence on general practice services sector in England

- I. The RCGP welcomes the opportunity to submit evidence to Monitor's review of the general practice services sector in England.
- II. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.
- III. We gratefully acknowledge the contributions of the RCGP Centre for Commissioning and RCGP Council members in formulating this response.

Our response

Overview

1. The RCGP welcomes Monitor's stated aim to better understand the challenges faced by general practice at a time when it is operating under increased pressure. **However, we**

would strongly caution against the assumption that the challenges faced by general practice are caused by a lack of competition, or that the best lever to reduce perceived variability in access and/or quality would be an increase in competition.

2. The primary challenge faced by general practice is workforce capacity. The Centre for Workforce Intelligence has concluded that “the existing GP workforce has insufficient capacity to meet current and expected patient needs”¹. In order for choice and competition to be meaningful it is necessary to have excess supply in the market; this is clearly not the case for many areas of general practice.
3. We note that the consultation paper states that there are more than 40,000 fully trained GPs working in England. However, this figure includes GP Specialty Training Registrars (GPStRs), who are still in training. Latest figures in fact show that there are just over 35,500 fully qualified GPs working in England and just over 31,500 full time equivalent fully qualified GPs².

Detailed response

The ability of patients to access GP services, including their ability to switch practices:

4. Firstly, we would note that GP Patient Surveys consistently show that **overall levels of patient satisfaction with general practice are high**. In 2012/13, 86.7% of patients rated their overall experience with their GP surgery as good, three quarters (76.3%) of patients reported that their overall experience of making an appointment was good and nine out of ten patients said that they had at least some level of confidence and trust in the last GP they saw³. The doctor–patient relationship is highly-valued; it is therefore to be expected that many patients choose not to switch practices as they are happy with the services that they receive at their current GP surgery.

¹ Centre for Workforce Intelligence (2013), GP in-depth review: Preliminary findings, <http://www.cfw.org.uk/publications/gp-in-depth-review-preliminary-findings>

² Health and Social Care Information Centre (2013), NHS Staff - 2002-2012, General Practice, <http://www.hscic.gov.uk/searchcatalogue?productid=10382&topics=2%2fWorkforce%2fStaff+numbers%2fGeneral+practice+staff&sort=Relevance&size=10&page=1#top>

³ 2012-13 GP Patient Survey Aggregated Wave 1 and 2 results, www.england.nhs.uk/statistics/2013/06/13/2012-13-gp-patient-survey-aggregated-wave-1-and-2-results/

5. Secondly, it is important to understand that the **existing general practice workforce has insufficient capacity to meet current and expected patient needs**⁴. Unless more resources are invested in general practice and action is taken to increase the GP workforce there will not be sufficient capacity in some areas to allow patients to exercise choice now or in the future. As well as increasing the number of new GPs who enter the profession, it is crucial also to take action to retain the existing workforce by increasing levels of support and resource, particularly in areas where GPs are under most pressure, and providing better support for returners.
6. There is considerable regional and local variation in the availability of GPs per head of the population. Deprived areas of England broadly tend to have fewer GPs per head⁵, yet these areas often serve patients with higher levels of physical and mental illness (commencing at a younger age than in more affluent areas), more multimorbidities and greater problems with self-care. Consequent to this mismatch of need and resource, consultations in general practices serving very deprived areas are characterised by: multimorbidity and social complexity; shortage of time; less patient enablement, especially of patients with mental health problems; and, practitioner stress. **In order to improve both quality and access in these areas it is vital not only that action is taken to increase the GP workforce overall, but that a substantial share of this workforce increase should go towards improving support for under-doctored areas.**
7. It should be recognised that local geography can have an impact on patient choice. Patients are generally less likely to encounter a problem in switching practices in urban areas. Where there are closed lists in these areas this is likely to be because: funding is not sufficient to allow practices to expand their staffing; there are limits on premises space; or, the practice has a desire to maintain a quality service based on a defined population. Choice of GP practice may be more limited in small towns or rural areas, but in many cases it may be uneconomic and impractical to commission additional practices simply to allow choice. It is also important to understand the potential quality benefits of reducing clinician isolation in small towns or rural areas, by encouraging partnerships rather than pushing single clinician practices purely for the purposes of choice and competition.

⁴ Centre for Workforce Intelligence (2013), GP in-depth review: Preliminary findings, <http://www.cfwl.org.uk/publications/gp-in-depth-review-preliminary-findings>

⁵ Ibid.

8. **We feel strongly that geographically defined GP practice areas should be maintained.** The abolition of practice boundaries would destabilise GP practices (as it would be far more difficult to plan to meet demand), impact adversely on continuity of care and would make it harder for GPs to deliver integrated care alongside local authorities, as these are organised on a geographic basis. Furthermore, it is likely that a number of rural practices would become unsustainable, as they would face losing significant numbers of their patients - typically younger, healthier commuters - and would be left caring for a greater proportion of patients lacking mobility and/or with complex, long-term conditions. This imbalance would rarely be viable in the long term and would thus ultimately reduce choice in rural communities, to the detriment of the most ill and vulnerable.

The impact of the different contractual terms under which practices operate:

9. We note that there has been an historic variation in funding between GMS and PMS contracts, but that this is being addressed by the Department of Health's plan to bring PMS funding down to the same level as the GMS average over a seven-year period from 2014. We would note that it is vital that funding released from PMS reviews is retained within the GP contract as a whole and is not simply removed from general practice to plug deficits elsewhere in the NHS.
10. Monitor should be aware of the risk of loss leading with Alternative Medical Services Contracts (APMS) bids, which in the long term could be anti-competitive.
11. Some sessional GPs report that they do not see APMS practices offering long term placements or career opportunities, and so the turnover of staff is high. This suggests that time limited APMS contracts may not encourage long term investment in practices or the long term commitment of doctors to them.

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:

12. GP workload is restricting the ability of many GP practices to expand their services. As outlined above (paragraph 2) the existing general practice workforce is under considerable strain, with insufficient capacity to meet current and expected patient needs. There is a worrying lack of recent substantive evidence on GP activity and

workload⁶. However, the latest available studies of GP workload point to a significant increase in workload pressure in recent years, with the number of consultations for the average patient per year rising from 3.9 in 1995 to 5.5 in 2008 and with the biggest increases taking place amongst those aged over 70 years⁷. Investment in the general practice workforce is urgently needed in order to allow GPs the time and capacity both to reflect on how to organise care for the future and to expand the scope of services that they offer.

13. Many existing practices are also limited by a lack of premises funding, which prevents expansion or the provision of additional services. One of our members told us:

“Our building does not have enough consulting rooms to cope with our patient footfall. Our patients numbers have increased in a decade from 7,200 to 8,200 and we have increased our WTE GP number to five, but we have had to turn back office rooms upstairs into consulting rooms which mean GPs have to go to a room downstairs to see patients who can’t climb stairs...we lack the funds to build a lift.”

14. While GP practices can bid for Any Qualified Provider (AQP) contracts, gaining approved provider status requires considerable investment of time and money. Most practices, and especially smaller practices, are limited by the short term nature and risk of setting up AQP contracts, which may involve taking on staff or investing in equipment with the aim of recouping costs through subsequent service provision. Commercial organisations are often far better placed in this process, leaving most GMS/PMS practices at a competitive disadvantage.

15. We are concerned that the new commissioning arrangements under the Health and Social Care Act may make it more difficult for GP practices to provide additional community-based services of the kind previously provided as Locally Enhanced Services (LESs). Current [guidance from NHS England](#) states that CCGs should commission such services through the NHS Standard Contract. This is a cumbersome, time-consuming and disproportionate process, particularly for small practices.

⁶ Centre for Workforce Intelligence, GP in-depth review: Preliminary findings, <http://www.cfw.org.uk/publications/gp-in-depth-review-preliminary-findings>

⁷ The Information Centre (2009), Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® database, <https://catalogue.ic.nhs.uk/publications/primary-care/general-practice/tren-cons-rate-gene-prac-95-09/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf>

16. There is also a risk that CCGs may feel under increased pressure to put LES contracts out to tender under the new arrangements. It is therefore vital that commissioning guidance clearly recognises that there are often distinct clinical advantages for patients when services are directly commissioned from holders of the registered patient list (i.e. the GP practice), as opposed to third party providers.

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

17. There is a real risk that regulations relating to procurement, choice and competition could discourage CCGs from directly commissioning from general practice, for fear of legal challenge. We already know of examples where commissioners have been deterred from renewing existing successful arrangements due to concerns about conflicts of interests, despite clear evidence of likely patient benefits. Legal advice, perhaps accustomed to competitive environments outside the NHS, has encouraged a risk averse approach. Unless greater clarity can be achieved, this inhibiting effect will damage progress in an area where there is significant potential for general practice to drive service transformation and improved patient care.

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:

18. There is a gradual move away from small independent general practice providers, towards larger regional or even national multi-practice organisations, ‘super partnerships’ (large-scale single partnership structures, operating from multiple sites) and federations (groups of practices working together to share back-office functions and educational and clinical services). This is largely being driven by financial pressures on smaller practices.

19. In the RCGP’s vision for general practice in the future NHS, [The 2022 GP](#), we foresee general practice teams working with groups of other practices and providers as federated or networked organisations. Such organisations would permit smaller teams and practices to retain their identity (through the association of localism, personal care, accessibility and familiarity) but combine ‘back-office’ functions, share organisational learning and co-develop clinical services.

20. It is important to achieve a healthy balance between competition, collaboration and ownership in the local community. While commissioners should be free to use choice

and competition to improve value for patients, Monitor should ensure that rules relating to competition do not restrain collaborative work by GP providers that is aimed at improving quality of care and providing and developing a greater range of services.

21. As the NHS moves towards greater integration between health and social care, for example between primary care and community services, it will become increasingly important for CCGs to work together with local authorities when planning and commissioning services. Local commissioners should also be given the flexibility to develop additional contractual components in order to reflect the needs of their community.

Additional Comments

22. Consideration should be given to the issue of supply induced demand (increased uptake as a result of increased provision of services), for example through the introduction of Walk In Centres (WiCs)⁸, and whether or not this reflects genuine need. Patients should be offered the best value healthcare to address their needs; where patients with self-limiting illnesses are attending WiCs this is unlikely to be an efficient use of NHS resources.

The RCGP welcomes the opportunity to submit evidence to this review and looks forward to further dialogue with Monitor on this subject.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council

⁸ <http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing>

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

The Royal College of Nursing submission

1. The general practice services sector is for many their first and main port of call for health services. It is a gateway to many services and will continue to be a vitally important sector as the population is ageing and people are living longer with long-term conditions.
2. Our members work directly in general practice and many of our members also work in services that must work successfully with the general practice; from health visiting to palliative care nursing. The RCN is aware of the pressures in the wider health and social care systems and the importance of general practice services to help manage and realise the aspiration of the acute to community shift. Community and specialist nurses are also key to this shift in managing long-term conditions and reducing visits from medical professionals and admission to hospital.
3. However, community nursing is a workforce stretched to breaking point; and in some places in England, particular services such as district nursing are in crisis. The problems of historical under-investment are now being compounded as community service providers (like the rest of the NHS) seek to make “efficiency savings, resulting in chronic under staffing; whilst cuts to other essential services, such as social care, add to the pressure on nursing services.
4. To meet greater demand and assist in the shift away from expensive, acute care to care in the community, we have repeatedly called for greater investment in community and specialist nurses.¹
5. General practitioners (GPs) are the bedrock of primary care and crucial in preventing needs escalation and/or deterioration. The ageing population and increase in those who suffer from one or more chronic conditions has significantly increased demands on general practice. Nurses working in both primary and community care alongside GP colleagues can identify higher risk patients and develop team based approaches to support patients to manage their conditions and remain at or closer to their home. RCN members support and advocate for genuinely multi disciplinary team based approaches including colleagues in social care to meet increasing health demands outside of hospital.

¹ http://www.rcn.org.uk/newsevents/news/article/uk/a_and_e_pressures_critical,_says_rcn

6. The RCN believes that there are unexplored opportunities for nurses to work both within GP services and more broadly as part of community services and as nurse specialists and practitioners to help design, provide and co-ordinate services that will deliver the care that our communities need. This covers the full range of activities; from care homes to areas of specialist nursing care.
7. We are also aware of the risks of fragmentation from a wider range of providers being involved in delivering care. For example, many people will be aware of Virgin Care taking over provision of general practice services in Northampton, as covered by Dispatches, yet they have not been able to maintain the previous level of access or quality.²
8. RCN members firmly support closer collaboration and partnership working between all providers of health care across local health economies. Planning and delivering services based on the size and needs of the population can help in ensuring the delivery of safe, effective, accessible and affordable services. As part of this wider health economy collaboration we do believe there could be benefits from confederated working between practices and nursing would want to be involved in discussions to support the development of such approaches.
9. We will be interested in the results of Monitor's work.

² <http://bips.channel4.com/programmes/dispatches/articles/all/getting-rich-on-the-nhs-reporter-feature>



Royal College of Pathologists' response to Monitor's call for evidence on general practice services sector in England

Monitor call issued on 1 July 2013

This call seeks evidence that the provision and commissioning of general practice services may not be working in the best interests of patients.

These include

1. the ability of patients to access GP service
2. the impact of the rules for setting up and/or expanding a general practice
3. the impact of the different contractual terms under which practices operate
4. the ability for new or existing providers to expand the scope of the NHS services they offer, particularly the factors that may influence CCGs or local authorities in deciding whether to commission services from general practice
5. the process for commissioning new services from general practices, the factors that influence these commissioning decisions and any challenges that commissioners face
6. factors that affect potential providers' willingness or interest in providing new services
7. any new forms of primary care or integrated care that local health communities are planning or considering and any potential enablers or barriers that need to be considered.

The College presents the following evidence.

1. **GPs' use of pathology tests is highly variable and may not always be in the best interests of the patient.**
2. **Reconfiguration of pathology services by CCGs and commissioners is also variable and not always in the best interests of patients.**

None of the problems described are insurmountable provided appropriate professional intervention is permitted; examples of the effectiveness of such intervention are given.

GPs' use of pathology tests

There is a mature literature on this subject and a very large number of guidelines including some from NICE. Only the most recent studies will be cited to illustrate the varied and generally poor impact of guidelines on practice.

O'Kane et al (Ann Clin Biochem 2011;48: 155-158) reported on the requests for HbA1C (diabetes) and thyroid function tests in one year by 58 practices covering 284,609 patients in N Ireland. There was wide variability in test request rates and the practices with the highest request rates for these

tests were also the highest requesters for all other blood tests. There was no relationship between request rates for HbA1c and thyroid function and the known prevalence of diabetes and hypothyroidism respectively or with QOF scores used through the GMS contract to remunerate GP practices.

Driskell et al (Clin Chem 2012; 58:5906–915) examined 519,664 HbA1c requests from 115,730 patients, from January 2001 to March 2011. Only 49% of requests conformed to guidance; 21% were too soon and 30% were too late. Under-requesting was more common in primary care, in female patients, in younger patients and in patients with generally poorer control. The reverse generally was true for over-requesting. Publication of guidance (e.g., American Diabetes Association, UK National Institute for Health and Clinical Excellence) had no significant impact on under- or over-requesting rates. Prevalence of inappropriate requests varied approximately 6-fold between general practices.

Fryer et al have presented this year but not yet published an analysis of around 400,000 tests from three centres for HbA1C requested by GPs. The results are consistent across the three centres. The optimum re-test interval for this test is 2-3 months, with anything before 6 months giving the desired direction of change. Just over 40% of these tests were requested at intervals beyond 6 months, 12,000 beyond 18 months. These findings match the data from the same group published by Driskell et al in the paper referred to above. These data suggest there is a rush of QOF-related tests in March to fill the QOF quota. QOF guidance is a distraction because it is about making money in any one financial year rather than about how frequently a test should be done for best quality care.

Vaidya et al (Quality in Primary Care 2013;21:143–148) analysed 195,309 thyroid function tests (TFTs) for 148,412 patients (63% female; aged 16 years and over) done by two hospitals in south-west England at the request of 107 general practices during 2010. The number of TSH tests per 1000 list size varied widely across the practices from 84 to 482. Most of the variation was due to heterogeneity across practices and only 24% of this was accounted for by prevalence of hypothyroidism or socio-economic deprivation.

Atlas of Variation Data (not yet released for publication)

The data for this Atlas were obtained as part of a data quality audit and subject to strict governance protocols. Pathology messages to primary care were intercepted for a period of 23 days in June 2012. These were pseudonymised and processed to provide details of the compliance with the PMIP Pathology Bounded Code List (PBCL) and Laboratory Standard Representation (LSR) for codes and units of measure (UoM). In all 1.8m messages containing samples of 38 million test results for approximately 3m patients on 1029 tests from 152 NHS laboratory PMIP sources were analysed.

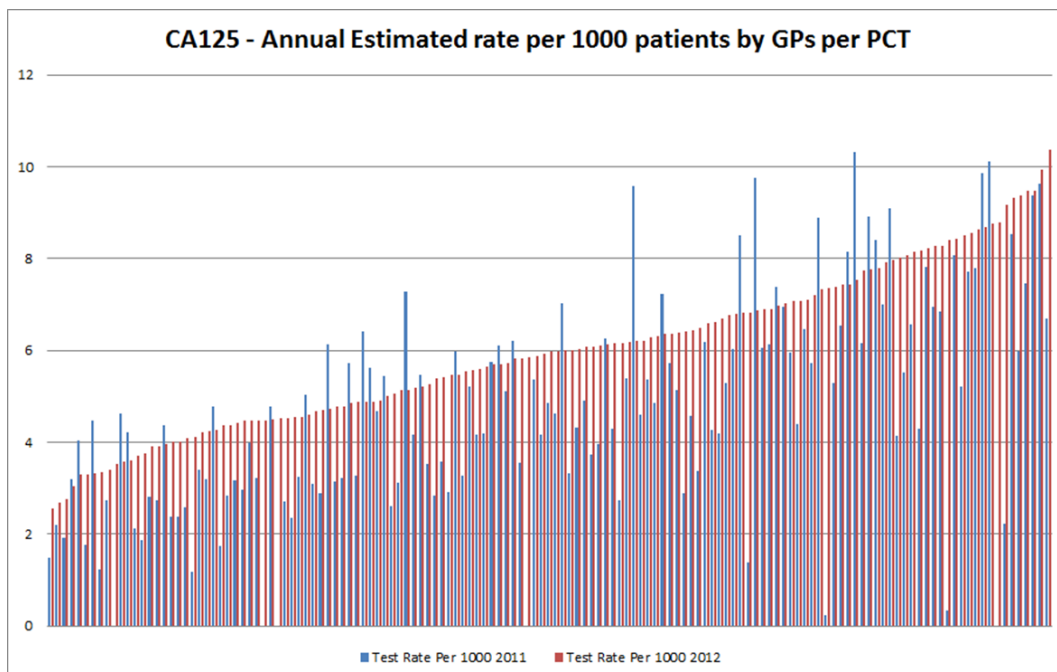
Data are presented as requests per 1000 patients per PCT in England and mapped geographically. To allow for spurious data the range of variation has been trimmed to exclude the bottom (least frequent requesters) and the top (most frequent requesters) and is given as both a range and with the highest trimmed rate as a multiple of the lowest trimmed rate e.g. 5 fold rate. Two tests are shown as representative of an overall pattern.

Carbohydrate antigen 125 (CA-125) is a protein found on the surface of ovarian cancer cells, and in some normal tissues, and it is a tumour marker for ovarian cancer. Traditionally, the CA 125 test has been used to monitor treatment for ovarian cancer; it can also be used to detect whether cancer has returned after treatment has been completed. CA-125 is also elevated in association with other ovarian pathologies. Most of the use for both of these tests is in the confirmation of a suspected diagnosis and in the monitoring of the response to treatment. Specialist units are the main users of these tests, although some testing takes place in general practice especially following NICE and DH recommendations. In 2011, a new policy for the use of CA125 for the early detection of suspected ovarian cancer in general practice encourages the use of CA125 in women if symptoms are persistent or frequent (e.g. more than 12 times a month):

- persistent abdominal distension or bloating;
- feeling full (early satiety) and/or loss of appetite;
- pelvic or abdominal pain;
- increased urinary urgency and/or frequency.

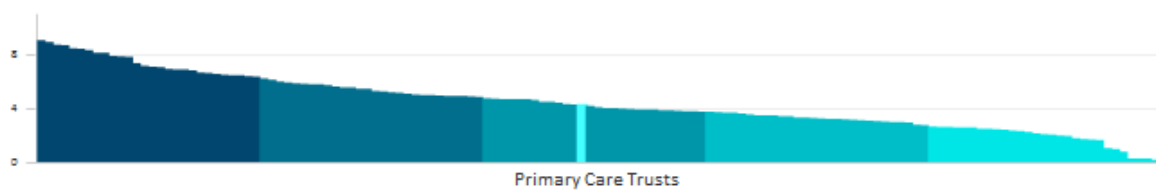
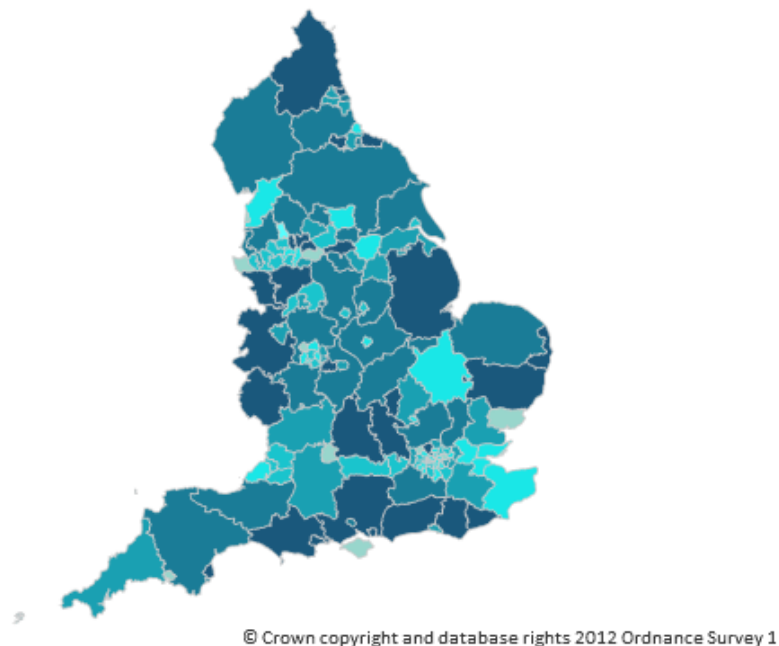
<http://www.nice.org.uk/nicemedia/live/13464/54194/54194.pdf> (accessed 02/06/2013)

Data at practice level are available but not for release under the IG rules governing this data collection. The pattern across PCTs is typical of their constituent practices, although at practice level the variance is even greater.



Note the overall low level of activity relative to the potential prevalence of at risk patients, the variance across PCTs and the small but significant increase in use between 2011 and 2012.

Estimated annual rate of use for carbohydrate antigen 125 (CA-125) tests ordered by GPs per practice population by PCT.



Magnitude of variation

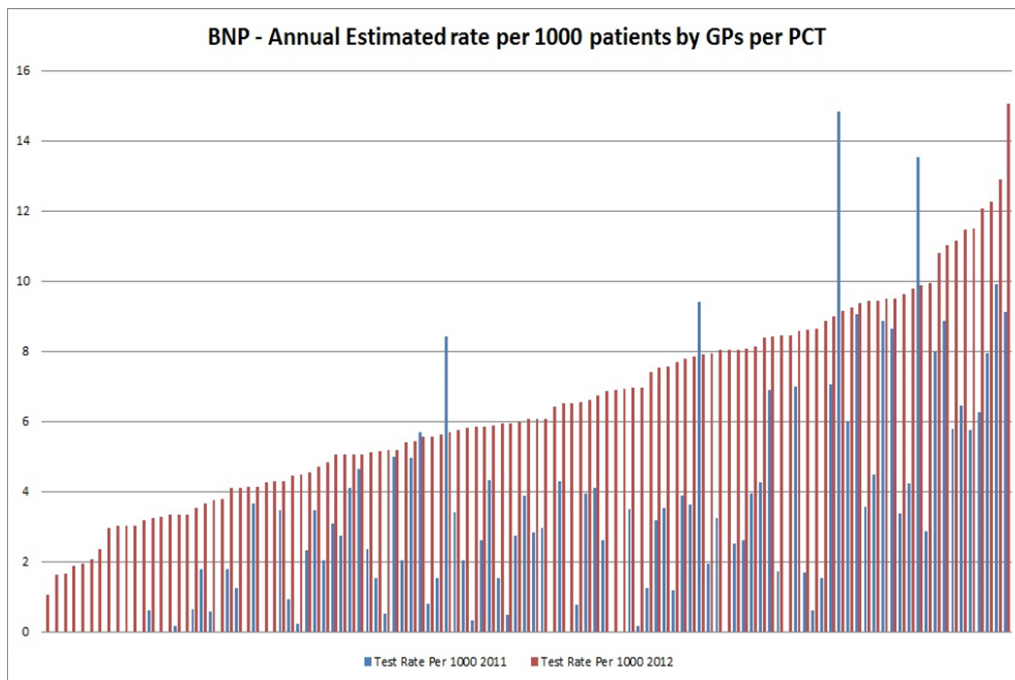
For PCTs in England, the estimated rate of use for CA125 tests ordered by GPs ranged from 0.11 to 9.0 per 1000 practice population (80-fold variation). When the five PCTs with the highest estimated rates and the five PCTs with the lowest estimated rates are excluded, the range is 0.92-8.4 per 1000 practice population and the variation is 9-fold. This is not due to differences in the prevalence of ovarian cancer. Some variation probably reflects differences in professional practice and commissioning prioritisation. It will also reflect the rate of diffusion of innovation since the updated guidance in 2011. Variation between individual practices is higher (data not available for publication).

B-type natriuretic peptide (BNP) is secreted into the blood in response to excessive stretching of the cardiac ventricular wall, an early precursor to the development of heart failure. Levels of BNP correlate with the severity of heart disease and are used to screen patients to determine which of them requires an echocardiogram to diagnose cardiac failure. The BNP test is a good rule-out test and neither an ECG nor chest X-ray adds to the diagnostic accuracy. NICE recommends the use of the BNP test in the pathway for chronic heart failure (<http://www.nice.org.uk/nicemedia/live/13099/50526/50526.pdf> (Accessed June 23rd 2013)),

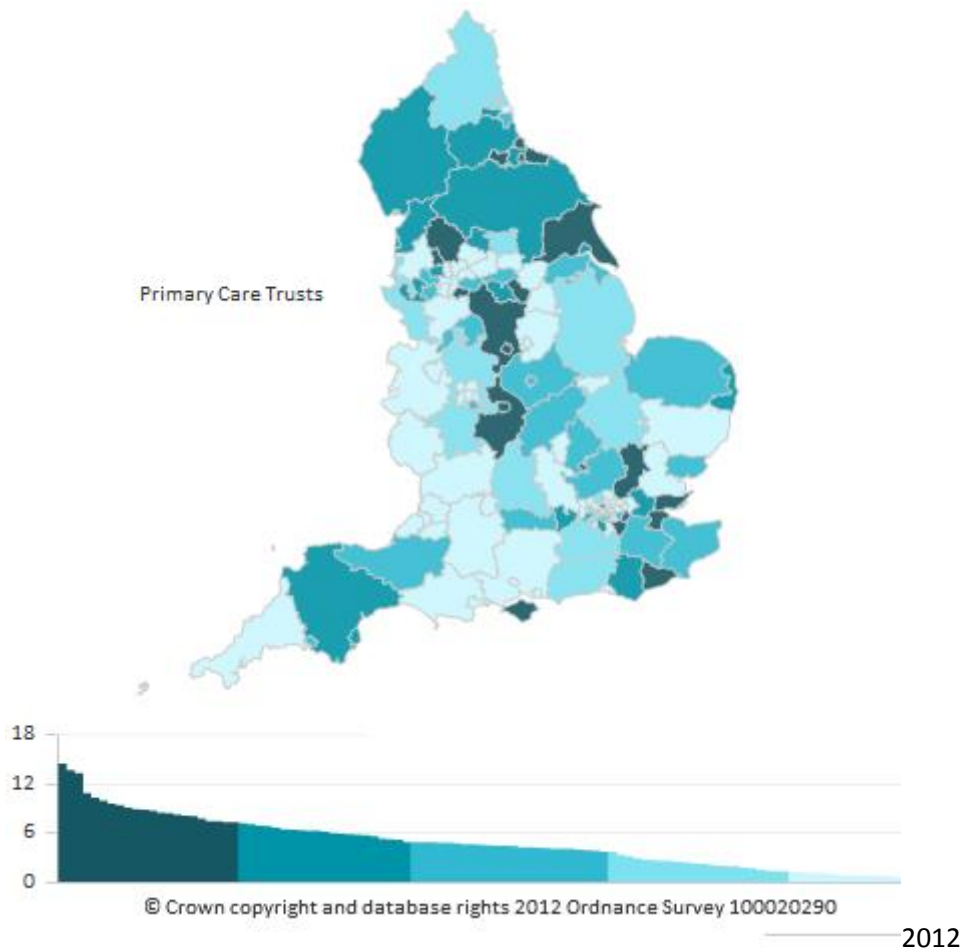
except when the patient has a history of myocardial infarction when the patient should be sent directly for echocardiography.

Elevated levels of serum BNP are also seen in chronic renal disease.

Data at practice level are available but not for release under the IG rules governing this data collection. The pattern across PCTS is typical of their constituent practices, although at practice level the variance is even greater.)



Estimated annual rate of use for brain natriuretic peptide (BNP or NTproBNP) tests ordered by GPs per practice population by PCT.



Magnitude of variation

For PCTs in England, the estimated annual rate of use of BNP tests ordered by GPs ranged from 0.05 to 14.4 per 1000 practice population (297-fold variation). When the four PCTs with the highest estimated annual rates and the four PCTs with the lowest estimated annual rates are excluded, the range is 0.11-10.2 per 1000 practice population, and the variation is 89-fold.

One reason for the degree of variation observed is differences in the uptake of this pathway by GPs and local cardiac services. In some PCTs, point-of-care testing of BNP is undertaken as part of a care pathway; as such, these tests will not be included in the dataset for this indicator (a survey of laboratory tests reported to primary care). Following the adoption of BNP testing as part of the pathway for the diagnosis of cardiac failure, there is likely to be a disproportionate use of BNP tests if the reason for investment in the test was delays in patients accessing echocardiography services.

The graphs show modest 8-10 fold differences between the PCT areas but these differences increase to 80-fold when individual practices are compared (data not available for publication).

Despite the increase in use of this test between 2011 and 2012, BNP is still not being used or provided in large areas of England as a first line screen for heart failure. There will be therefore inefficient use of echocardiography services in these areas with a direct impact on patient care. Data presented at the NICE Implementation Collaborative, Pilot 4 (CG 108 on BNP Testing) Advisory Board in March showed that in areas where BNP had been used appropriately, the admission rates for

patients with heart failure were significantly reduced, probably because the BNP result allows the right patients to access echo more quickly and efficiently, avoiding the need for admission. It is possible that some areas have removed BNP tests because cardiac services cannot handle the caseload generated by such efficient screening.

The variation shown for these two tests is seen across almost every test investigated in this study for the Atlas of Variation. Variability of up to 100-fold cannot be explained by case mix differences, even taking into account the small number of practices with a specific patient base (e.g. university based practice). Regardless of whether the variation reveals over or under requesting, this variation reflects inefficient use of NHS resource and may indicate overall unacceptable levels of health care. These studies do not all yield data that tell us if patients have been harmed and more work needs to be done in that respect. Fryer's unpublished study does indicate poor control of diabetes which suggests that such variation in use is symptomatic of poor care overall. Individual GPs and their representative organisations may resent such critical analysis but there is good evidence that further direct education of GPs can improve the use of lab tests as shown in the next study.

Thomas et al (Lancet 2006; 367: 1990-1996) reported a cluster randomised controlled trial of 85 primary-care practices (370 family practitioners) using one regional centre. The interventions were quarterly feedback of practice requesting rates for nine laboratory tests, enhanced with educational messages and brief educational reminder messages added to the test result reports for nine laboratory tests. Practices that received either or both the enhanced feedback and the reminder messages were significantly less likely than the control group to request the targeted tests in total (enhanced feedback odds ratio 0.87, 95% CI 0.81–0.94; reminder messages 0.89, 0.83–0.93). Follow up demonstrated that this was as a result of improved clinical knowledge rather than simply trying to improve their score.

Audits of B12/folate assays at Salisbury District Hospital requested by GPs were done annually from 2010 to 2012 and suggest that educational effort can increase the level of appropriate testing from less than 10% to almost 40%. This improvement was achieved however with the additional power of electronic requesting and the laboratories unilateral decision not to perform tests on repeat samples at intervals of less than 3 months or where the clinical indications for the request did not comply with local and national guidelines ([British Committee for Standards in Haematology. Investigation and diagnosis of cobalamin and folate deficiencies. Clin Lab Haematol 1994;64:101-115](#); [Smellie WSA, Wilson D, McNulty CMA et al. Best practice in primary care pathology: review 1. J Clin Pathol 2005;58:1016-24](#); [NICE guideline 42 Dementia 2006, revised March 2011](#)).

Kent and Medway Pathology Network and 5 GP practices in Kent and Medway participated in a pilot scheme over 2 years from 2011 to 2013 to determine whether simple measures such as focussed teaching, guidance notes and simple contact information could improve their understanding of Immunology testing. Preliminary data from 3 practices shows an overall 28% reduction in and equivalent increase in appropriate use of requests for Immunology tests and high levels of satisfaction amongst the GPs involved.

Commissioning Services

GPs now control the budget for all local NHS provision including the provision of pathology tests. The level of variation shown above, the implied waste of resources and the probable impact of these on the quality of care for patients does not inspire confidence that commissioning, at least of pathology services, can be done effectively and safely by GPs, CCGs or CSS in isolation from any input from expert pathology bodies. There is no evidence of control of standards of commissioners' performance in the wholesale reconfiguration of pathology which is underway across the UK.

The Royal College of Pathologists recognises that competition in health care is intrinsic to any national health system. It should never be driven purely on financial grounds however and should always consider how the best quality of service can be provided within a limited budget. The devolved responsibility for commissioning in England and Wales consequent on the Health and Social Care Act risks loss of control or influence over the use of clinically relevant quality standards in commissioning decisions.

Increasing requests for assistance from bodies involved in reconfiguration last year led the College to create RCPATH Consulting (RCPC) as an offshoot advisory company. RCPC has recruited senior pathologists and biomedical scientists by competitive interview on the basis that they must be prepared to give entirely impartial advice. Reviews can be conducted only by invitation. The contracts which this company has completed or is in the course of completing have all confirmed that there is insufficient understanding of the complexities of the provision of pathology services amongst those responsible for making commissioning decisions. No two contracts have been alike. The details for these contracts are confidential and at least one may lead to litigation because the professional advice given does not match the finance management desired solution. Where RCPC's advice has been taken, difficult aspects of reconfiguration have been resolved.

The exercises in reconfiguration which have chosen not to involve formally the College or RCPATH Consulting are making variable and allegedly unsatisfactory progress. That in the East of England is perhaps the prime example. One proposal in that scheme suggested that GPs in one district could be served by a pathology lab 80 miles distant. Continuing uncertainty about the fate of labs in the East of England and in the East and West Midlands is adversely affecting the future viability of pathology services for large populations in England. It is no longer clear to what extent CCGs have any control over these exercises. There are good examples such as Pathlinks in Lincolnshire of reconfiguration driven professionally. There is no need to attempt such complex and difficult reorganisation of key diagnostic services without appropriate professional input. The current view that pathology testing can be safely removed from the centralised control of pathologists in hospital laboratories and provided in the community is not supported by the evidence presented above or by the following.

Point of care testing (POCT) has expanded greatly in recent years in primary care, much of it without any pathology lab involvement, any adherence to POCT national safety standards, any quality control (internal or external: IQC/EQA) of any kind and, in some cases, using devices without MHRA

clearance. The uptake of POCT accreditation within CPA inspections, still a voluntary exercise, is bypassed by the vast majority of providers. Before its demise NPSA reported serious patient harm and death due to inappropriate use of such devices in general practice. The replacement for NPSA, the National Reporting and Learning System (NRLS), embedded within NHS England, receives no reports of this nature and is unable to interrogate GP services for them. These gaps constitute a huge risk to patients and are not necessarily the fault of the GPs who are not always aware of the need for IQC/EQA.

A G Prentice
President
Royal College of Pathologists

Rutland Parent Carer Voice

In response to National Network of Parents and Carers Forum request

Please see our forums response below

We met up with all of Rutland's GP practice managers in May 2013 and had a very successful meeting.

Below is a summary of the minutes. Please note that I have removed personal names and the names of the surgeries.

The meeting was chaired by a parent who asked everyone to introduce themselves.

An email was read out from a parent praising how well every member of staff from one of the surgeries had treated her and her family. The Chair then stating that this was how majority of parents and carers felt about all surgeries but there were a few minor issues that parents and carers felt needing addressing before giving the email to the Practice Manager.

1) Gravelled car parks – not suitable for wheelchair users or those who are 'unsteady' on their feet

This is at present being addressed as they too are aware of the issues around the car park. This does not affect the other surgeries as they have designated tarmac car park for wheelchair users.

2) The name 'baby clinic' – not suitable when taking teenagers for blood tests

The surgery is looking to address this as they can now see how unsuitable the name is when talking to young adults.

3) The new telephone appointment system – not always practical to await a call from doctor.

The surgeries using this system are aware that there are issues and are already working to address them such as those who are unable to take call-backs from the surgeries at any time due to their jobs e.g. teachers, shop assistants etc. are now being offered designated times suitable to the patients for their call-back.

4) Receptionist are not always aware of disabilities – Is there any way that the receptionists can tell that the person has a disability from their notes?

'Pop-up' box can be used to flag up any issues once the receptionist types the name of the individual into the system. This will reduce anxiety from the patient and their carers in the future.

5) Surgeries are not always aware that patients are carers

Although when joining the surgery there is a field on the form to be filled in if you are a carer new patients do not realise that this means them. They often think that it relates to those working in care homes etc.

Parents and carers **need** to tell the doctors that they are carers and who they are caring for especially if their child/young person was not diagnosed at birth with a disability.

6) Is there any training available such as Learning Disability/Autism Awareness available for surgery staff?

Learning Disability Primary Care Liaison Nurse informed us that training is available but the surgeries need to inform her of the training needs of their staff in order for her to meet their needs. However there is also the issue of how many staff can attend without affecting the surgeries.

7) Training courses for carers

Learning Disability Primary Care Liaison Nurse stated that there are courses for carers around Health Action Plan for all parents and carers. There are also the Traffic Light Booklet (useful if you need to attend a hospital) and Emergency Grab Sheet (useful to take with you everywhere).

8) Seeing your own doctor

All the surgeries are very keen for this to continue even though they are pressured to change to patients seeing whichever doctor is available.

All representatives from the surgeries are very keen that every parent and carer's views are heard and ask that they all join the Patient Participation Group at each surgery and/or use the suggestion boxes provided in the surgeries and/or on their websites.

Sense

This time round I have only been able to get a few responses to the call for evidence but in future I'm sure we could get some more for you. I am only new in post so came across this call late in the day!

Of the responses we have, I think it gives you a flavour of the difficulties that someone with a dual sensory impairment could come across in something so seemingly straightforward as a GP appointment. I have put them in bullet point form – I hope this is useful.

- My GP understands my specific needs very well. She does her best to support me with my specific needs.
- What are the issues for you when trying to access GP services:
Communication issues
- It is quite important that I see the same GP each time due to my complex medical conditions. She is most familiar with them.
- I am able to make an appointment to see a GP though if urgent I use walk-in surgery but am not guaranteed to see my own GP.
- I had no problems of changing to another GP practice. I had to fill in a long form to join my current GP practice though and was assigned to a new GP.
- When I first lost my hearing, I got dragged to the GP by some friends and the GP said “you can't have a hearing loss you're blind"! Needless to say, I changed GP.
- He suggested that rather than me going to the surgery and them having to book an interpreter, he'd do home visits and communicate with me by typing on my computer. We had an agreement where I could phone up and ask for a home visit, if it was urgent he'd come that day, but if I said it wasn't urgent he'd come when it next fit in with other home visits he was doing, which usually meant within two or three days. That worked brilliantly. The only problem with it was that when he was on holiday I was a bit stuck because it was only him who did it, not his partner or a temp. So in that situation, always seeing the same person was very important. But seeing the same GP is useful anyway when there's complicated medical stuff and a rare condition that GPs have never heard of. And his willingness to do things a bit differently to meet my needs was good. And it worked well for both sides, they saved on interpreter costs, and I was able to get appointments when I needed and keep things confidential.
- I registered with one GP surgery, who booked a BSL interpreter rather than manual, then refused to rebook the appointment because I'd refused to work

with the interpreter. In the end I changed GP. They booked a manual interpreter but the doctor I saw had no idea how to work with an interpreter and was so patronising to me, that since then I've just not been able to face trying again.

- I'd try changing GP again but it gets difficult when you're already on the second in the area. And I have real issues with the interpreting agency they use, so am not in a hurry to give them more work by making a GP appointment
-



Which?, 2 Marylebone Road, London, NW1 4DF

Date: - 1/08/2013 Response by: - Maria Booker, Business Development Lead - Health and Social Care

Response to Monitor's Call for Evidence on general practice services sector in England

INTRODUCTION

Which? welcomes Monitor's call for evidence to determine the extent to which commissioning and provision of general practice services is operating in the best interests of patients.

Public services are changing. Both Government and members of the public are increasingly expecting the choice of provider, 24/7 access, and application of technology that exist in other consumer markets. That is why Which? is increasing its focus on health and social care. In particular we want to see:

- Access to services - people should be given the right information and advice, in the right ways and at the right time to access the services and funding they need.
- Choice - where choice exists, people should be properly supported to engage with it. Choice should not put anyone at a disadvantage.
- Quality - everyone should receive a good minimum standard of service.
- Complaints and redress - effective mechanisms and powers must exist for people to make complaints and give feedback, and for consumer representatives to intervene where necessary.

In the context of the Government's challenge in the NHS Mandate that by 2015 everyone will be able to book their GP appointment, order a repeat prescription, talk to their GP and view their patient record online, Which? has carried out a programme of research to assess how the introduction of more technology - particularly online booking- might change the experience of primary care for the consumer.

Which? carried out a programme of research last summer, with a follow up survey in January, to understand the consumer experience of visiting a GP at present, through research with members of the public and GPs themselves. Which? was keen to understand what changes consumers wanted to see and how interested they were in what technology had to offer. The first stage of qualitative research identified some of the issues facing consumers, like access, complaints and the quality of GP relationships. Then two pieces of quantitative research explored how widely experienced these issues are and explored issues around reform in healthcare - particularly looking at the use of technology and the role of patient empowerment and choice. We then did a further quantitative survey to explore further why consumers chose to access GPs as they did, and what happened when they were not able to access the GP.

This briefing summarises the key findings of the research which we believe are relevant to Monitor's enquiry, in particular, the ability of patients to access GP services in the way they want to, how willing GPs are to offer online access, the quality of the general practice service provided, and what happens when things go wrong. The full research report is appended. We would be happy to discuss anything in this briefing with you in more detail if helpful.

Which? Is a consumer champion

We work to make things better for consumers. Our advice helps them make informed decisions. **Our campaigns make people's lives fairer, simpler and safer.** Our services and products put consumers' needs first to bring them better value.

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SUMMARY - WHAT WE FOUND

The current economic climate has put pressure on all areas of government spending and, at the same time, we have seen an increased use of technology within the public sector. For some time now, the Government has pledged to increase the use of technology across the public sector - including healthcare - because it can help deliver more efficient as well as more effective services. Publications such as *Innovation, Health and Wealth*¹ and *Digital First*² document this thinking in health.

*The Power of Information*³ (the Information Strategy), published in 2012, sets out a vision of patient empowerment supported by patient access via digital channels, which has more recently been formalised in the NHS Mandate.⁴ For example, the Mandate commits that by 2015 everyone will be able to book their GP appointments online, order a repeat prescription online and talk to their GP online.⁵ In light of this, Which? has examined current patients' and practitioners' attitudes towards communications in primary care and the use of technology both now and in the future.

This briefing identifies some of the current problems patients experience in primary care and identifies what role, if any, technology may have in helping address these problems. We address issues of access - including the frustrations of appointment booking and the poor uptake of online booking. In addition, we look at quality of service and the importance of a trusted relationship with a GP.

Can technology solve the problems of ease of access to GP services?

- The benefits of increased usage of technology appear clear- for example improved choice of booking methods, flexibility and potential money and time saving for the NHS. While the use of technology in primary care is inevitable, the assumption that the most frequent users of primary care would quickly jump on board is yet to be verified.
- Access is a key concern for patients - whilst patients and GPs agree that getting an appointment is generally easy, practitioner and patient views differ on the detail. GPs are consistently more likely than patients to think that it is 'easy' to make an appointment - for example 92% of GPs say it is easy to get a same day appointment at their surgery for a urgent issue, compared to just 62% of patients.
- Difficulty making an appointment was a key frustration for the patients we spoke to. In particular, time poor people - those in full time employment and younger age groups - are more likely to feel dissatisfied with the process. In these cases, the use of online booking, or telephone consultations, if rolled out more widely could help save time for patients and practices alike.
- According to our survey of GPs last year only 34% of practices offered online booking, so there is a *lack of availability*. But, in addition to this, only around a quarter of people (27% in our survey last August, 24% in our January survey) are aware of online booking being available - suggesting that *lack of awareness* is also a problem. For online booking to make a real difference, patients need to be aware of it and of the benefits it can bring.
- The Secretary of State has suggested that the increased use of communications technology could support people with long-term conditions more effectively whilst saving the NHS money. Our research suggests that people with long-term conditions, or elderly people, are likely to be happy with the current service that they receive and are less likely to find it difficult to get an appointment. However, this group are less likely to use technology to manage their health. Our research suggests that people with long-term illnesses and those aged over 65 are the least likely to be positive about using communications technology to manage their health.

¹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134597.pdf

² <http://digital.innovation.nhs.uk/pg/dashboard>

³ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134205.pdf

⁴ <https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf>

⁵ <http://www.dh.gov.uk/health/2012/11/nhs-mandate/>

- Whilst online booking is not widely used at the moment, there is evidence to suggest that it may be more widely taken up in the future, particularly by younger age groups. Younger groups and those in employment prioritise ease of access and flexibility and these groups are most likely to take up use of online booking. There is also a trend of increased use of technology in people's social and professional lives which is most prevalent among younger age groups.
- In addition, while few people currently use online booking, those that do believe it is easy and are generally satisfied with it.
- However, traditional approaches are consistently more likely to be favoured by older age groups and those with long-term illnesses. This group prioritises a long-term trusted relationship with a GP, over ease of access, and are less likely to consider using technology in healthcare.
- In addition, speed of access is important to patients and when patients are unable to get an urgent appointment they go elsewhere. When asked which, of a list of options, they had ever done as a result of not having got an appointment with a GP, 32% of people said they had gone to A&E.
- The Government needs to target patients who have greatest need and would get the greatest benefit in order to ensure that the rollout of online booking is as effective as possible. For younger age groups and those in full time employment online booking, and other uses of technology, could be well used.
- Some patients are currently frustrated with the access to their GP surgery, particularly for urgent appointments. Technology can help address this; but the importance of a trusted GP relationship cannot be overlooked.

Can technology improve the quality of service provided in primary care?

- The picture of patient satisfaction with GPs is broadly positive - but where things are going wrong, relationships with GPs suffer acutely. More frequent users, for example older people or those with long term illnesses, are more likely to be positive about the service they receive.
- Relatively few patients have switched GP practices because of poor service - most have either remained with their original GP practice, or have switched when they moved to a new area. Patients are confused about their rights to 'switch' (40% of people do not think they have a choice of GP). If giving patients choice of GP is meant to raise standards of practice, it's crucial that when they use 'exit' to express their dissatisfaction with a service this message is picked up by providers. Many patients in our survey exercised 'soft switching' - actively seeking out (64%) or avoiding a particular GP (24%) at their practice. We are concerned that this type of 'exit' will not send a message to providers that patients are unhappy with the service, and as such problems will remain hidden.
- While complaints are not widespread, there is evidence that they are not being dealt with effectively and patients are not receiving the redress that they would receive in other markets. Of those we surveyed who had made a complaint, only 1 in 5 were satisfied with the outcome (albeit with a small sample size). People need to both feel able to switch providers when they are not happy with the service they receive, but also have confidence that complaints and issues are handled effectively in a way that improves service.
- In recent years there appears to have been a shift in focus for primary care - while personal relationships and care was the previous emphasis, ease of access and communications has taken a greater priority - for example, in the provision of walk-in centres and extended surgery hours. This has not necessarily impacted on quality of care, but perhaps it has meant that expectations among younger generations are more focused on ease and speed of access. Certainly, the younger cohort of patients in our survey were less concerned with seeing the same GP each time. Technology speaks to this second issue - of flexibility and ease of access - yet there is some concern among patients that quality and personal relationships could be negatively impacted by technology.

What needs to happen to move forward with technology to benefit consumers

- While both patients and GPs agree that increased use of technology in primary care is inevitable, there are some significant barriers that need to be overcome before both the consumer and the practitioner are won over to the benefits.
- Low levels of perceived availability and poor take up by patients is currently holding the process back. Further progress is needed, but patients and professionals alike need to have their concerns addressed.
- For GPs, they are likely to be concerned about the privacy and security concerns surrounding online healthcare. In addition, they are not convinced that the increase of technology in the NHS would save them time or indeed save the NHS money. Some have concerns that the infrastructure is not yet ready for this change. The government needs to address these concerns by communicating how technology would save time and money and how local GP surgeries would be supported. In particular, our survey suggests there is a risk that smaller practices could be left behind. Currently smaller practices are less likely to be using online booking, and other forms of technology. They are also more likely to have concerns about the practicalities and the infrastructure needed.
- For patients, there is not a one size fits all approach. In order for technology to benefit all consumers the needs of different patients need to be considered. The rollout of online booking may leave older age groups behind and risk damaging trusted relationships. However, many people could receive an improved experience particularly of access by improving the availability of appointments for time-poor people. Many patients believe that technology could save the NHS time and money. However, patients also share some concerns with GPs that need to be addressed - particularly half of patients are worried about privacy and clear communications are needed about how people's private information will be securely handled.

Meeting the needs of all patients

- As identified above, patients tend to fall into two general groups when it comes to their experiences of primary care and views about technology within the sector. Our research shows that older age groups and those with long-term illnesses or disabilities (often the highest users of primary care) tend to be positive about their experience and the medical care they receive. However, on the other side they are less likely to be interested in using online booking facilities or other uses of technology.
- The younger age groups, who are often in employment and likely to be time-poor are more likely to get on board with technology. They are concerned about access and flexibility and less likely to be happy with the current service received.
- Our research paints a picture of a service that does not meet the needs and expectations of all those who use it. Younger age groups, together with those in full time employment and who face more time pressure, will be more interested in greater use of communications technology. A more flexible approach to booking appointments - such as telephone triage or online booking - could be used to positive effect here. Rather than empowered 'customers', these patients felt that whilst the GP's time was rightly seen as precious, their own appeared to be unimportant. Technology - firstly online booking - needs to be introduced in a way which meets the needs of those who feel frustrated by the current system, while not leaving those more frequent users left behind.



The Consumer Experience of GPs - Which? Research

METHODOLOGY

This methodology below explains the research we have done with consumers on their experience of GP services, and also directly with GPs. However other Which? research is referenced in the following report.

1) Patient research

Populus, on behalf of Which?, conducted 1034 telephone interviews with a representative sample of UK adults between 23rd and 28th August 2012. Sample was weighted to be demographically representative of all UK adults. In the sample, 1012 people are registered with a GP, and referred to as 'patients' in the report.

In addition, Which? conducted two focus groups among patients in London and St Albans during July 2012. The focus groups helped to shape the quantitative research and better understand patient experience.

Profile of GP patients: Our survey shows that, on average, people have visited their GP surgery about five times in the last year, with 17% of people visiting more than ten times and 11% of registered patients not visiting.

This briefing examines trends among different groups of patients, including those who visit more frequently compared to those who visit less frequently.

2) GP research

Medeconnect, on behalf of Which?, interviewed a representative sample of 1001 GPs across the UK online between 22nd and 31st August 2012. The sample was weighted to be representative of all GPs in the UK. Data is analysed by practice type, region and role of GPs.

To supplement the GP research, Which? spoke to a number of health experts and some GPs in greater depth to discuss the findings and current practice with practitioners. These interviews were conducted during September 2012.

3) Further patient research

A telephone omnibus survey run by Populus which interviewed 1009 GB adults online between 4th -6th January 2013. Again the sample was weighted to be demographically representative of all GB adults.

92% of those surveyed were registered with an NHS GP practice.

80% of those who were registered had made one or more appointments with a GP for themselves or someone else in the last 12 months.

CAN TECHNOLOGY SOLVE THE PROBLEMS CONSUMERS FACE?

Our research identifies a number of problems or concerns which consumers currently face in primary care. This chapter seeks to discuss whether technology will help or hinder these issues and how technology will impact the experience of patients in primary care.

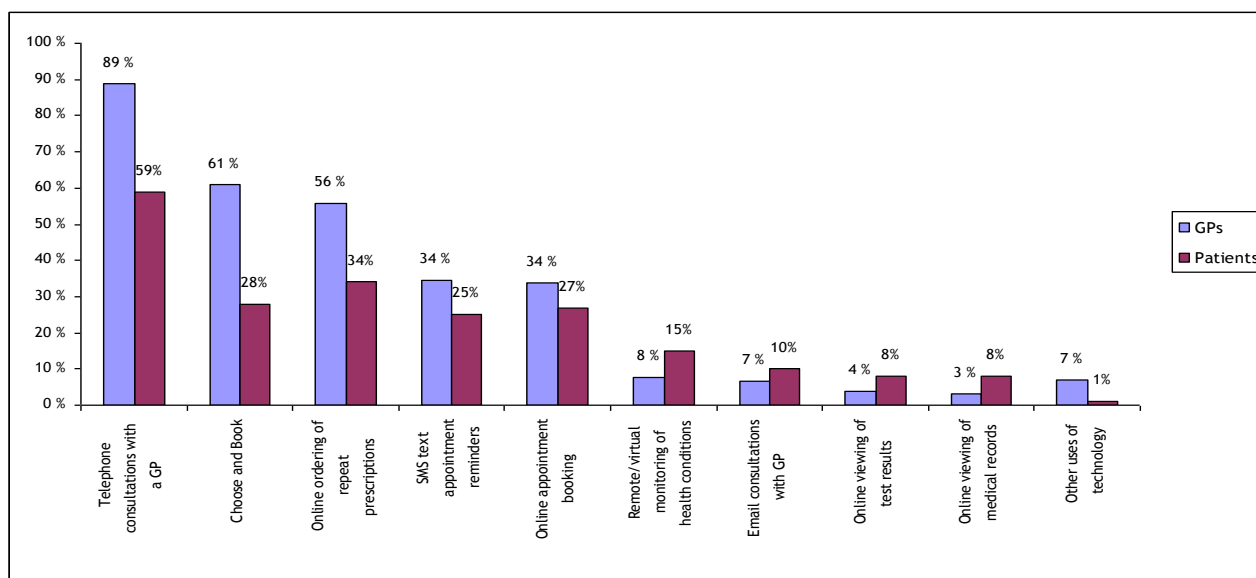
In particular, we explore issues of access - including frustrations with bookings, poor uptake of online booking, the availability of urgent appointments and the time pressures on the NHS. We also explore issues of quality - looking at what is important for a trusted GP relationship and what role technology has in enabling higher quality service and support. Finally, we look at what action patients take when it comes to complaining and playing an active role being empower to make the best choices.

1. ISSUES OF ACCESS

Lack of awareness of availability of technology

At the moment, patients don't necessarily know about the new technologies on offer at their practices - to use them, they need to be aware of them. There is a disparity between what GPs say is available and what patients are aware of. In particular, the research suggests that some people may not use online booking as they are not aware it exists.

The chart below shows the percentage of GPs and patients who say that each of these technologies is available in their GP practice. The data suggests that patients may be less familiar with what services are available and therefore some who may want to use them do not.



89% of GPs say that telephone consultations are available in their practices, but just 59% of patients say that this is the case. Also, 61% of GPs say that Choose and Book is available at their practice, but just 28% of patients are aware this is the case (although we might expect this, given that Choose and Book is a service that will by its nature only be offered to some patients). In the case of telephone consultations and Choose and Book, the qualitative interviews with GPs suggested that these were both very useful tools for GPs. In particular, telephone consultations are considered to be useful for both helping GPs to speak to more patients, but also because GPs can triage patients so that fewer need to visit the practice.



As technology is used more widely in primary care, communications and information provision for patients will be very important.

Frustrations with the ease and speed of booking appointments

Traditional approaches to appointment booking can be problematic. The qualitative research showed that patients do often experience frustrations with appointment booking. Often, while the service experienced at the GP is high quality, the experience of booking an appointment is described as ‘frustrating’ and ‘time consuming’. Some people described feeling like their GP was ‘unobtainable’ and one in ten patients were dissatisfied with the time it took to book an appointment.

Younger age groups and those in full time employment are more likely to be frustrated with the access to their GPs - generally finding it more difficult to book appointments and being less satisfied with waiting times. However, older age groups are generally more likely to be satisfied with the approach of booking appointments and are more likely to book in person and value the personal relationship with a GP. With this in mind, there is a need for a differentiated approach - patients from older age groups and those who are more frequent visitors prefer the more personal traditional approach, however younger time-poor people are more likely to support a wider move to online booking. Technology could address the frustrations with booking that is felt by younger groups and employed people.

Telephone is the most commonly used method of booking, however many people experience difficulties when trying to book. More than half of all people did not get through immediately when they last tried to call to get an appointment. 31% found the line was engaged and 5% had no answer. 28% were put on hold briefly and 6% were on hold for a long time. When people are trying to get an urgent appointment this can be frustrating.

Consumers tell us that convenience and ease are the main reasons that they choose the method to book with. Those who book online say it is easy, but those who book in person or by phone chose this method as they think it is more convenient and easier than others. People want to have a hassle free approach to booking. Yet that does not stop people feeling frustrated by their chosen method.

Our research shows that one in four people have not seen a doctor at all when they needed to because it would take too long to get an appointment and a third of people have to take time off work or make special arrangements in order to book a GP appointment.

In the focus groups, online booking was seen as a ‘no-brainer’ and while few currently used online booking, most saw the benefits. However, people do not believe it should entirely replace more traditional methods of booking. Indeed, the issue of urgent appointments, which are currently considered to be more difficult by patients, may not necessarily be resolved by online booking.

There is evidence that online booking may be more widely taken up in the future. A quarter of patients say that they are aware of online booking available at their practice. Of these patients, 22% currently use online booking. Of those who don’t currently use online booking where it is available, 31% are interested in using online booking but 46% are not. Similarly, looking at those who do not currently have online booking available, 61% of these people say that they are likely to use online booking if it were available and 38% say that they are not. Using this data, we can estimate that, if online booking were rolled out across all practices we could see around 30% of all appointments being booked online⁶.

⁶ This takes into account the total number of appointments currently booked and those ‘very likely’ to be booked online if it were rolled out at all surgeries.



Poor uptake of online booking

As greater use of technology is implemented in primary care, consumer demand for new and innovative methods of managing health is seen as key in making this happen. The research suggests that currently a small proportion of patients are actually using online booking. In addition, smaller GP practices are less likely to have taken it up.

By 2015, the Government has pledged that all patients will be able to book online. Our research identifies the extent to which consumers are ready for this innovation and the groups who may thrive or struggle under these new plans.

Despite frustrations with the traditional approaches to booking, there has been a poor uptake of online booking. At the moment, a quarter of patients are aware of online booking facilities available in the practice but just 2% of patients *usually* book appointments online. 4% of patients, who have visited the GP, have booked an appointment online in the last 12 months. Perhaps unsurprisingly, telephone booking is most likely to be used (85% of people usually book appointments by telephone speaking to a receptionist and 91% have used telephone to book in the last year) and 9% of people book in person.

Although the sample size is small, it is interesting to see that of those who have used the online booking system in the last year (27 people), more than half of them said that it was easier than other online booking websites and just 1 person said it was more difficult. Therefore the reality of using it may be better than people expect. Given this, it is interesting that of those who have online booking available but do not use it, 39% don't because they think it is easier to book by phone or in person. 12% say they haven't got round to it yet and 12% say they don't know how to use it.

The data also suggests that the larger practices are more likely to be using new technologies. There is a risk that larger practices may get ahead of smaller practices in the use of technology, perhaps creating tiered levels of accessibility to primary care.

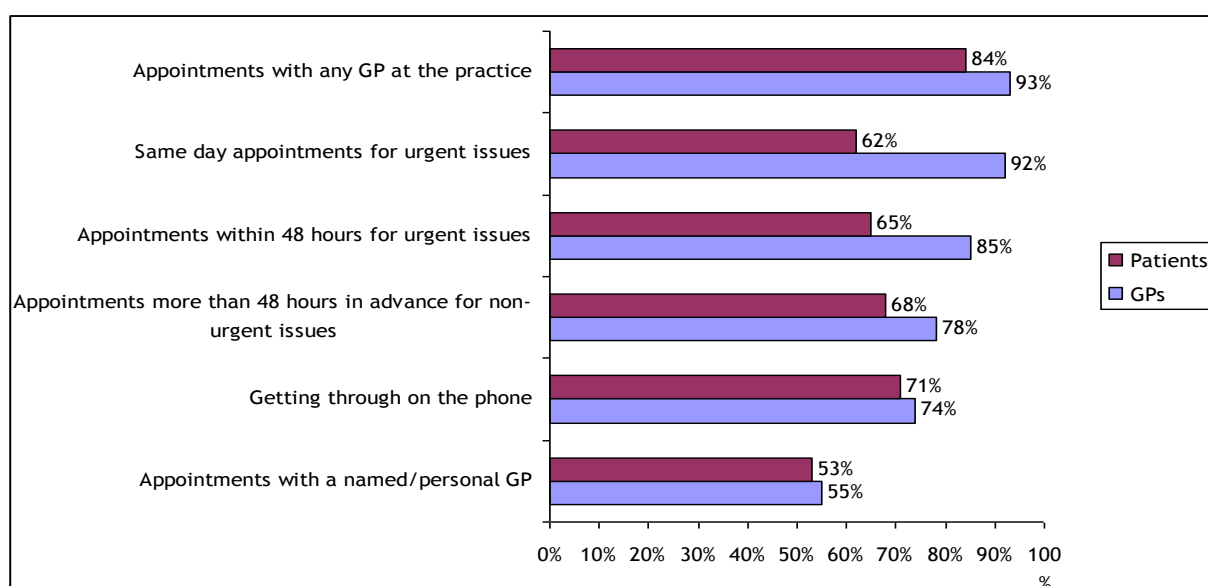
Looking ahead, younger people are more likely to consider using online booking than older age groups (86% of 18-24 year olds agree compared to 25% of people aged 65+). People in social group AB (70%) are more likely to consider using online booking than those in social group DE (48%). 45% of people with a long term illness/disability would be *unlikely* to use online booking if it were available, compared to 34% of those without. Therefore, while online booking may be a time saver for some, it is likely to have limited impact if higher users do not take it up.

As the Government rolls out online booking facilities further it needs to bear in mind the groups who are most likely to take it up, and also those who are less likely. Technology, and only booking specifically, can particularly help those who are time poor and in employment who currently find access to GPs more difficult. If more people were encouraged to book online and it was easy to do then more patients would be likely to take it up - the research suggests there is a perception that it is difficult or a hassle and this is stopping use.

Availability of urgent appointments

Access is important to patients. Overall, patients and GPs agree that access to their practices for booking appointments is generally fairly easy. However, when it comes to making urgent appointments many patients do not think it is easy. 30% of patients say it is difficult to make a same day appointment for an urgent issue - this includes 40% of 18-24 year olds, compared to 22% of people aged 65 or over. 70% of retired people say it is easy to book a same day appointment for urgent issues, compared to 59% of people working full time. 18% of people who wanted to book a same day appointment at their last appointment were not able to.

Ease of access to a GP in one form or another was a commonly-identified priority to improve GP services, with patients expressing frustration at: *'being told to call after 8am but not getting an answer till 9:30 only to be told all the appointments have gone'*. The perception of patients about booking urgent appointments is quite different from that of GPs. While 92% of GPs think that it is easy to book a same day appointment for urgent issues at their surgery, just 62% of patients agree. Similarly 85% of GPs agree that booking appointments within 48 hours for urgent appointments is easy, compared to 65% of patients. The chart below shows the percentage of GPs and patients who think that each of these approaches is very or fairly easy.



People are going elsewhere when they cannot get a GP appointment. One in three people who have not seen a doctor because it would take too long to get an appointment went to A & E and 20% called an ambulance.

While technology can make access easier and remove some of the frustrations of telephone booking, online booking is currently not seen to address the issue of booking urgent appointments. Since the issue of urgent appointments is important to patients, the question remains unanswered about how technology could help people to get urgent appointments when needed.

The time demands on primary care

Many patients report problems with both the time taken to book appointments and also waiting times in surgeries. In particular, younger age groups and those in full time employment identify these concerns.

Younger people are more likely to be concerned about waiting times and accessibility when booking appointments. 90% of people over 65 say that the time that they have to wait is good, however just 58% of people aged 18-24 agree. In addition, as seen above people aged 55 or over are more likely to say it is easy to make a same day appointment for urgent issues at their GP, than those in younger age groups.

While both GPs and patients agree that use of technology in primary care is inevitable, just 48% of GPs, compared to 73% of patients, think that it would save time and make things more efficient. However, people who are more likely to be time-poor are more likely to think that more use of technology would save time, than those who are more frequent users (for example older age groups). Time poor



patients do think technology would save time and so we would expect that online booking, telephone consultations and other innovations would be most valuable for these patients.

GPs are less likely to think that technology will save them time. 57% of GPs say that more use of technology in primary healthcare will increase doctors workloads (compared to 32% of patients agreeing). This suggests that there are still questions to be answered about the time pressures, or time savings, which would be a result of more technology. We are in a time of major change in the National Health Service, when GPs are being asked to take on a number of new roles. Given this, and considering the workload barriers that many of the GPs we surveyed envisaged, it's crucial that GPs are supported to deliver the 'information revolution.'

Financial pressures on primary care

The current financial climate means that budgets are being cut across the public sector. Technology has the potential to reduce costs, but the sector is not convinced yet.

Just over half (55%) of all patients think that more use of technology would save the NHS money. However, on a practice level just 34% of GPs think that greater use of technology would save their practice money and 36% disagree.

In addition, 36% of people think that the NHS doesn't have the right IT systems in place to implement new technologies. This compares to 48% of GPs who think that their practices don't have the right IT systems to implement new technologies. These issues need to be addressed in order to maximise the benefits to both patients and practitioners when technology use increases.

	Patients		GPs	
	Agree	Disagree	Agree	Disagree
More use of technology would save time, making things more efficient for both patients and GPs	73%	15%	48%	37%
More use of technology would save the NHS[my practice (GPs)] money	55%	20%	34%	36%
I am concerned about the privacy risks of using technology in primary healthcare	49%	37%	76%	19%
More use of technology in primary healthcare will increase doctors workloads	32%	36%	57%	31%
The NHS [my practice (GPs)] doesn't have the right IT systems to implement new technologies	36%	19%	48%	37%

The government needs to identify how GP surgeries would be supported in the inevitable use of more technology and needs to demonstrate how it would be cost effective. The use of technology is being used more widely in the current financial climate, but the NHS and particularly smaller GP surgeries need to have the evidence of the benefits.

2. ISSUES OF QUALITY

Relationships with GPs

The overall picture of patient experience of using GPs is a very positive one. Patients we surveyed were generally happy with the service at their GP surgery. They commended both the medical and



non-medical treatment and service they receive. However there are two challenges in light of this - firstly that when things go wrong, the relationships suffer acutely. Secondly, patient expectations are not always met when they cannot see the same GP or receive varied service from different practitioners.

Doctors are generally trusted as professionals⁷. Which? research shows that 70% of people trust GPs to act in their best interest, compared to just 8% who do not⁸ - something that can also be seen in the fact that compared to other public services, and to consumer markets, people feel very well-protected when making decisions about GPs.

The qualitative research we carried out certainly uncovered a wide range of variability in the quality of relationships with GPs than our headline figures suggested, from 'I'd never go to a GP again unless I absolutely had to' to 'they couldn't do enough for me'. The quantitative research identifies that older age groups are generally more likely to be positive about their GP experience overall and they are also more likely to be frequent users.

However, compared to other public services people do not feel particularly confident or knowledgeable when making decisions about GPs. The proportion of people feeling confident that they are able to make the best choice (54%) is at a level comparable with poorly performing consumer sectors such as the energy market. On the whole, consumers do not feel knowledgeable about decisions relating to their GP with only half saying they do and one in five saying they do not.⁹

Part of the story here is that some patients may be (or feel) under-qualified to judge the performance of an expert due to their relative lack of knowledge, or may express 'gratitude bias.'¹⁰ Where we feel indebted to a professional for helping us with a major health problem, we may be less inclined to recall the more negative aspects of our interaction with them.

The increased availability of online information and the changing focus on patients as consumers in the public sector has given people greater empowerment. Technology can provide greater empowerment for patients to be able to make more informed decisions. This reflects the societal context of a generation of people who are used to searching out information for themselves rather than accepting the words of a professional as sacrosanct, as well as specific efforts in the healthcare sector to move towards shared decision-making around treatment options rather than the more paternalistic model that existed previously.

However, one of the GPs we spoke to saw some disadvantages to the empowerment of patients that technology and online information could bring. This doctor now had to spend time in appointments correcting misinformation garnered from the internet - or deal with patients keen to see the 'best' member of staff rather than the most appropriate for their needs.

Different people value different things from a relationship with their GP. Generally, people who have been at their practice longer, older age groups and frequent visitors are more likely to have a particular GP that they prefer to see. Half of all people agree that it is important to see the same GP every time that they visit the GP surgery. This highlights the importance of a personal and ongoing relationship with a GP that people want to see. For older age groups particularly, an ongoing relationship with one trusted GP is important. 70% of people with a long term illness or disability have a particular GP they prefer to see, compared to 60% of those who do not. People who visit their GP more frequently are more likely to have a particular GP that they prefer - 76% of people who have been to their GP more than 10 times in the last year agree, compared to 56% of people who have been

⁷ <http://www.ipsos-mori.com/researchpublications/researcharchive/2818/Doctors-are-most-trusted-profession-politicians-least-trusted.aspx>

⁸ October QCR

⁹ Online survey of 5,257 UK consumers, conducted on behalf of Which? by YouGov plc from 9th to 13th July, 2012. The data was weighted to be representative of the adult population of the UK.

¹⁰ <http://data.parliament.uk/DepositedPapers/Files/DEP2012-1652/NHSOutcomesFramework2013-14TechnicalAppendix.pdf>

just once. 60% of people with a long-term illness/disability agree that it is important for them to see the same GP each time they go, compared to 42% who do not. Overall, more frequent users of primary care are more likely to say it is important to see the same GP - 32% of people who have visited once in the last year agree, compared to 63% of those who have visited 10 times or more.

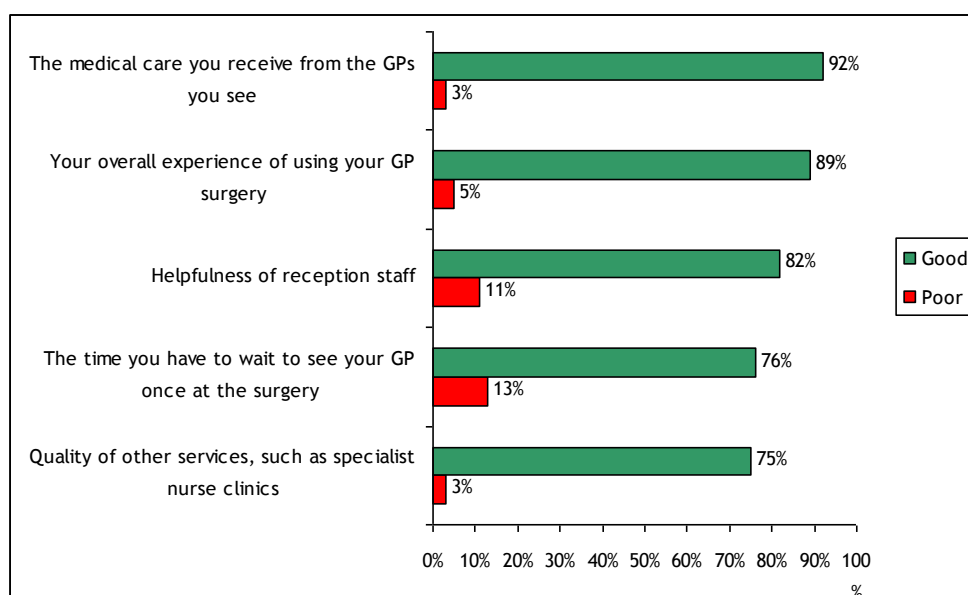
However, it is interesting to observe that GPs and patients agree that booking 'appointments with a named or personal GP' is the most difficult way to make an appointment - 55% and 53% respectively believe it is easy. On the other hand, GPs and patients agree that 'appointments with any GP at the practice' is easier to book.

Quality of advice and support

Generally, people are satisfied with the service that they receive at their GP surgery. However, as highlighted above, when something goes wrong it can have significant impact on patient experience. Indeed, while few people actually complain, the main reasons for complaints are based on the medical advice or support.

The majority of patients (86%) agree that they are confident in the medical advice and support that they are given by their GP. Indeed, patients rate their GPs very highly on all measures of service:

- 92% of people say that the medical care they receive from their GP is very or fairly good;
- 82% say that the helpfulness of reception staff is good and 76% of people say that the time they have to see their GP is 'good'.
- However, 13% of people describe the time they have to wait to see their GP as poor.
- Overall, 89% of people describe their overall experience at their GP as 'good' and only 5% describe it as 'poor'.



Again, the qualitative phase of our research revealed that under these apparently positive statistics lurk a number of more negative experiences such as misdiagnosis (which may not happen often but can be very severe when it does).



One patient in our focus groups movingly summed up the difference that good ‘customer service’ skills can make in managing a long-term condition, demonstrating that the divide between clinical care and ‘soft skills’ is by no means absolute. Their health had previously suffered due to a poor relationship with a GP - repeatedly ending up in acute care - but now: *‘getting a doctor who you can trust and speak to makes a big difference. It helps you manage your condition and get the right medication’*

Around one in ten people say that the service the helpfulness of reception staff and the time that they have to wait is poor. This is where, as discussed, technology could play a key role in improving things. If technology could be used to triage or reduce the number of appointments or bookings made through the reception, it may allow staff more time with patients.

Patients exercise ‘soft’ choice or switching

Most people have been with their GP for a considerable amount of time (45% have been registered for more than 20 years at the same GP and 29% of people have only been registered with one GP through their life). While 79% say they would switch practice if they were not happy with the service, just 3% of people have actually switched GP because they were unhappy. Given the more mixed findings from our qualitative research, we question whether they reflect an immature consumer market where alternatives are either unknown or unavailable.

Patients are confused about their rights to ‘switch’. In the face of variable service, we are concerned that patients do not know enough about their entitlements to make a truly informed choice about whether to stay or go: *‘you can leave a bank but you can’t really leave a GP’.*

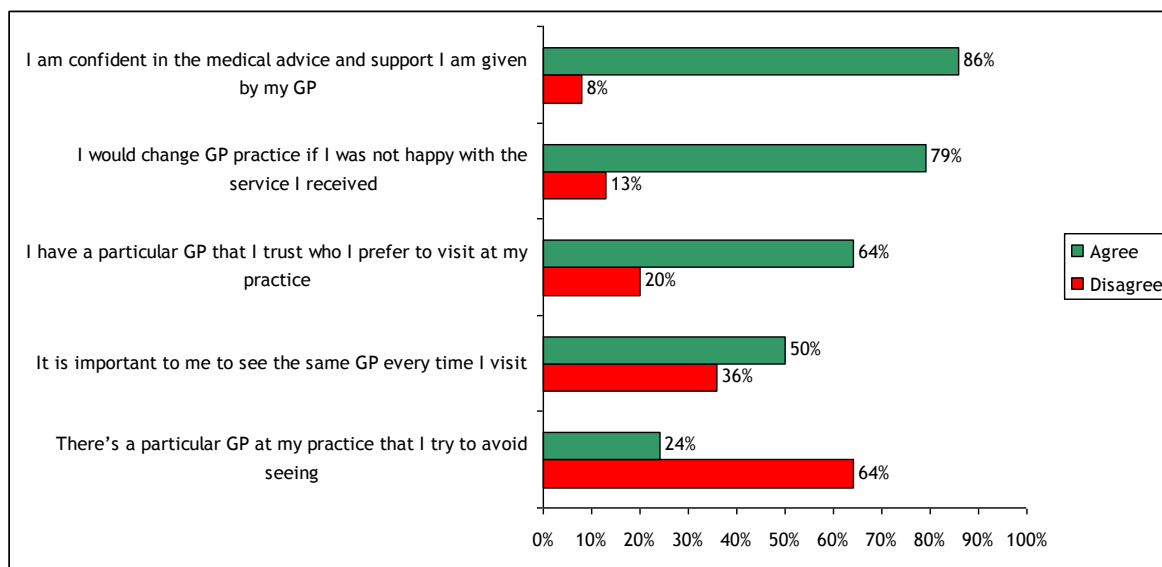
This is reflected in other research too, which shows that only 28% of people think they have a choice of GPs, compared to 40% who do not think they do. Furthermore we know that when making choices about GPs, people put considerably less effort in to their decision than similar decisions in other areas; only 29% of people say they put effort into choosing a GP, compared to 41% who say they do when choosing a dentist¹¹

Before considering moving practice, patients may be more selective in their use of services at their practices. For example, 64% have a GP at their practice who they prefer to visit and one in four people try to avoid seeing a particular GP. This evidence suggests that perhaps people are making a ‘soft choice’ of GP, rather than switching practice.

If giving patients choice of GP is meant to raise standards of practice, it’s crucial that when they use ‘exit’ to express their dissatisfaction with a service this message is picked up by providers. Many patients in our survey exercised ‘soft switching’ - actively seeking out or avoiding a particular GP at their practice. We are concerned that this type of ‘exit’ will not send a message to providers that patients are unhappy with the service, and as such problems will remain hidden.

¹¹ Online survey of 5,257 UK consumers, conducted on behalf of Which? by YouGov plc from 9th to 13th July, 2012. The data was weighted to be representative of the adult population of the UK.

Which?



The perception remains that there is little option other than to stick with an unsatisfactory practice if you live in an area where lists are full, or by moving you risk even worse performance. Choice can appear as a theory rather than a reality: *'all this theory of choice doesn't really exist'*. Leaving aside the practical implications of switching GP were it a feasible option for all patients, we know from our research that continuity of relationships in primary care is important to many people. Therefore, this is not a market where the switching model will function in their interests. What choice patients do exercise - i.e. the ability to select what GP they see - may also be under threat as the trend towards access over personalised care continues. If 'churn' rates are likely to remain low, other incentives for poorer-performing GPs to improve their practice are needed.

With public service reform at this time concentrating on the power of choice and competition to drive up standards within markets, we are concerned that in primary care this is not currently feasible. Even where patients do 'vote with their feet' through a soft switch to another GP at the same practice, or by moving altogether, these signals are unlikely to be picked up by commissioners. As one of the GPs we spoke to put it: *'they may be leaving us and doing the same [i.e. voting with their feet because they're not happy and then telling their new practice about it...] but we don't know that'*

One implication for future primary care policy is that feedback and complaints systems must be fit for purpose. Rather than relying on competition and choice to raise standards, practices and commissioners must be proactive in reaching out to patients for their feedback - both positive and negative - as a matter of course. Technology can have a role in feedback, but also could be one way to empower patients to make better choices and identify the best service they could receive.

Complaints and redress

Other Which? research has shown that 58% of people who experienced a problem related to a GP in the last 12 months, did not complain. Of these over half said they did not complain because they thought nothing would be done, while 40% thought complaining would not be worth the effort. More worryingly, 27% did not complain because they thought complaining could lead to worse service or treatment.¹²

This research shows:

¹² Online survey of 5,257 UK consumers, conducted on behalf of Which? by YouGov plc from 9th to 13th July, 2012. The data was weighted to be representative of the adult population of the UK. 395 GP users had experienced a problem in the last 12 months.



A third who considered complaining did not: Within the survey, 102 patients said that they considered making a complaint about treatment or service at their GP - 10% of people. Of these people, two thirds of them actually did make a complaint and one third did not. The sample sizes we are considering are small and so we need to take some caution, but we can give an indication of the types of complaints and how patients felt they were treated.

What are the complaints? Generally speaking, people were more likely to make a complaint about the medical side of their patient experience than the non-medical side. 28% of people who considered complaining had a complaint about the attitude/behaviour of medical staff at the practice and 18% had a complaint about the medical care or treatment they received. 12% of people say that they were given the wrong diagnosis.

On the other hand, 11% of people had a complaint to make about the attitude or behaviour of a member of the non-medical staff and 9% of people had a complaint about difficulties making an appointment. 8% of people who considered complaining were concerned about waiting times. This suggests that, while patients report some frustration with the practicalities of GPs surgeries and appointment booking, complaints are more likely to be about medical treatment problems that arise.

Why did people complain? Most people wanted to complain in order to improve things for others and in order for the problem to be put right. Half of all people wanted an acknowledgment of the problems that they had experienced and 30% wanted an apology. A quarter of people who complained wanted the professional concerned to be held accountable.

While only a small proportion of people complained, it is important to note that just over half of them were satisfied with the outcome and 47% were not. This raises concern that, still half of complaints are not being dealt with in a way that is satisfactory to the patients. Complaints in our focus groups had a mixed outcome, with some patients being satisfied and others never hearing back about what happened as a result of their complaint. Few people are moving surgery because of poor service, however this research identifies that many complaints are being left unresolved.



Making the health sector
work for patients

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