

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): other



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

Alongside this document we have published responses from patients, patient representative groups, clinical commissioning groups, representative bodies, providers and local medical committees [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.

Other

Please use the links to jump to the submission you require.

- @ne Associates
- Bayer plc
- Deloitte Centre for Health Solutions
- ESP IT Consultancy Ltd
- Hackney Council (Health in Hackney Scrutiny Commission)
- Keele University Benchmarking Service
- Leeds City Council (Officer Response)
- Office of Fair Trading (Infrastructure and Public Markets)
- Patient Access
- Parliamentary and Health Service Ombudsman
- PPS Interim Support Ltd
- Dr Keith Struthers
- Anonymous

@ne Associates

My main concern is about the way too many GP's fail under their obligation to work 'in the best interests of patients'. Successive governments have introduced strategies to open up the provision of NHS services via any provider holding an NHS contract whether this be through provision of elective services or the wider AQP programme. This has been appropriately hunger under the constitutional banner of 'patient choice'.

Unavoidably, the GP is central to a patients decision making process and can 'expect to be supported in making informed choices about their care'. However, 2010 DoH and Kings Fund surveys have shown that over half the population are unaware of their right to choice. The best ongoing barometer of the existence of the choice, Choose and Book (C&B), continues to show that only around 55% of OP appointments are made through C&B. (We need to accept that use of C&B doesn't necessarily mean choice was offered and conversely that not using of C&B doesn't mean choice wasn't offered – the two probably balancing each other out).

Somewhere along the line the choice discussion is not taking place with the patient. The below is an extract from the DH publication 'Contract implementation Guidance - Choice of named consultant-led team' (11 Oct 2011)

So, do referrers (GP's) have to offer a patient a choice of named consultant-led team?

Yes, if patients want it. GMC guidance "Good medical practice—duties of a doctor" includes a duty to work in partnership with the patient, respecting the right to reach decisions with the doctor about their treatment and care. In line with this, there should be a discussion between the referrer and the patient on where and when the patient wants to be seen. This includes discussion of whether the patient wishes to be referred to a particular named consultant-led team.

Some GP's are advocates of choice, some indifferent; far too many are defiant, whether on the grounds of personal beliefs or because they believe they should be paid extra for it. They are though, whether they like it or not, the logical, ethical and expected champions of the choice discussion – they should now be contractually obliged to have this dialogue. Patients are entitled to be seen by the best available providers available to the NHS. Without the dialogue, this choice strategy to drive up standards will fail spectacularly as a result of GP's not acting in the best interests of patients.

I hope this contribution, perhaps sounding more like a letter to The Times than a response to your call for evidence, does though articulate a critical point about the GP role.



Dr David Bennett,
Chairman and Chief Executive
Monitor
4 Matthew Parker Street
London, SW1H 9NP

8 August 2013

Dear Dr Bennett

I am writing following the launch of Monitor's review on general practice services sector in England and to request a meeting to discuss the role these services can play in reducing unintended, unwanted pregnancy for women of all ages.

Bayer HealthCare (Bayer) is the leading pharmaceutical company with a focus on contraception. We believe that ensuring women of all ages have both information and support in accessing the contraceptive that is right for them is critical to reducing unintended pregnancy, and to improving women's health, wellbeing and life-chances.

The vast majority of contraceptive care takes place in general practice¹. It is important, therefore, that these services allow women to have access to the contraceptive method of their choice, including the full range of combined oral contraceptives and long-acting reversible (LARC) methods. However, a number of barriers to choice and access within general practice continue to persist.

For instance, as recognised by the Department of Health, many general practice staff have not had dedicated training in sexual health and are not able to fit LARC methods¹. Bayer is, therefore, concerned that the existing shortage of healthcare professionals trained to provide and fit all forms of contraceptives may impact on the uptake of LARC methods.

While women attending general practice for contraception may be referred to a community contraceptive clinic for a LARC method, this may be putting an additional barrier in the way of women accessing the LARC method of their choice. Ideally

Joe Brice
Head of Government & Industry
Affairs

Bayer plc
Bayer House
Strawberry Hill
Newbury
Berkshire
RG14 1JA

United Kingdom

Tel: +44 1635 563234
Mob: +44 7788 410209

joe.brice@bayer.com
www.bayer.co.uk

Bayer plc is registered
In England No.935048
Registered office:
Bayer House
Strawberry Hill
Newbury
Berkshire
RG14 1JA



women should be able to have the LARC method of their choice fitted at their local general practice by a qualified fitter.

As you will be aware, there are many services which the NHS deems essential for all general practices to provide. However, there are others which are deemed as enhanced services and this includes the fitting of some LARC methods, including IUS, IUD and SDI.

As of 1 April 2013, responsibility for enhanced services in contraception lies with local authority commissioners. Given this will be a new responsibility for councils, Bayer has concerns that some local authorities may not be fully aware of their commissioning responsibility in this regard and that this may have a detrimental effect on continuity of provision and access to LARC in general practice.

In order to explore this issue in more detail, Bayer has recently commenced an audit of the provision of enhanced service agreements for LARC methods across all local authorities in England. The audit is being carried out with a view to supporting councils to identify the mechanisms available to improve uptake of effective forms of contraception in general practice.

We would welcome the opportunity to discuss the initial findings from this audit with you in detail and our recommendations for how contraceptive provision in general practice can be improved.

[✂] In the meantime if I can provide you with any further information then do not hesitate to contact me.

Yours sincerely

Joe Brice
Head of Government & Industry Affairs

¹ Department of Health, *A Framework for Sexual Health Improvement in England*, March 2013

Deloitte.

Primary care: Today and tomorrow
Improving general practice
by working differently



Deloitte Centre
for Health Solutions

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The Deloitte Centre for Health Solutions

The Deloitte Centre for Health Solutions generates insights and thought leadership based on the key trends, challenges and opportunities within the healthcare and life sciences industry. Working closely with other centres in the Deloitte network, including the US centre in Washington, our team of researchers develop ideas, innovations and insights that encourage collaboration across the health value chain, connecting the public and private sectors, health providers and purchasers, and consumers and suppliers.

Foreword

Welcome to the Deloitte UK Centre for Health Solutions report on general practice in primary care. This report presents the Centre's views on:

- the current and future role of general practice
- the main challenges faced by the general practice workforce
- a range of evidence based solutions.

Some of the solutions are already being used by a number of innovative general practitioners, and others are ideas and insights into how the future workforce might adapt more effectively to the changing needs and expectations of their patients.

We believe that our report captures accurately the current situation and future challenges, shows that these issues are not insurmountable and that there are a range of practical options for tackling them. Our central proposition is the need for general practice to work differently, especially given the significant financial and National Health Service reform challenges facing primary care service.

This report is the first publication from the Centre for Health Solutions and represents our thoughts, experience and analysis of current data and research literature, combined with views of those on the frontline – policymakers, professional representative groups, practitioners and patient groups. We have sought to balance the facts with our insights and would like to thank all those who contributed their time to the research.

At this complex and challenging time, we hope that this report provides a useful perspective for you and your colleagues. We thank you for your interest and would welcome your feedback.

Karen Taylor

Director, Centre for Health Solutions

Executive summary

Primary care, and in particular care delivered by general practice, has been a cornerstone of the United Kingdom's healthcare system since the inception of the National Health Service (NHS) in 1948. Indeed, good quality primary care is considered an essential feature of all cost-effective healthcare systems. Patient satisfaction with primary care delivered through general practice has traditionally been high, albeit with local variations in both patient experience and quality of care.

The general practice delivery model has evolved slowly with most general practitioners (GPs) working in single or dual practices until the 1990s. The promotion of a 'primary care led NHS' during the 1990s and the implementation of new contract models from 2003 onwards, have resulted in the majority of GPs now working in larger group practices and health centres. Nevertheless, the delivery model still relies largely on face-to-face consultations between the patient and GP or, for a limited but growing number of interventions, between the patient and practice nurse.

The focus of this report is on the general practice as a provider of primary care services, and while it is based on the English NHS, many of the solutions could apply equally to general practice in the rest of the United Kingdom.

In the United Kingdom, as in many developed countries, life expectancy is rising accompanied by increasingly complex health challenges and unprecedented levels of demand for healthcare services. These challenges are exacerbated by policy initiatives for more care to be provided closer to home.

Of the many external influences on general practice, the ageing population is expected to have the greatest impact. People are living longer with average life expectancy now 78.2 years for males and 82.3 years for females. While there are likely to be more people in almost every age group, the greatest rise will be in older age groups.

This increase in life expectancy has been accompanied by an increase in the number of people living with chronic ill health and has led to a significant increase in the demand for primary care.

The biggest single challenge for general practices, therefore, is the need to shift from treating episodic illness to working in partnership with patients and other providers to improve health, and treat people in the community more cost-effectively. Increased demand also requires practices to improve information and communication around diagnosis and treatment options, and develop shared decision-making and self-management strategies to tackle chronic conditions.

As pressure on primary care is rising, the general practice workforce is ageing. Twenty-two per cent of GPs are aged over 55, compared to 17 per cent in 2000 and increasing numbers of GPs are salaried or work part time. There has also been a growing reliance on practice nurses, many of whom are approaching retirement, as well as increasing numbers of nurse practitioners and healthcare assistants. It is imperative that new ways of working are identified and adopted, particularly as previous solutions, such as increasing supply or paying staff more for existing ways of working, are unlikely to be sustainable given the unprecedented efficiency challenges facing the NHS over the next four years.

The Health and Social Care Act 2012 introduces comprehensive changes to the way the NHS will operate, with GPs expected to take a lead role in independent Clinical Commissioning Groups, and have a much greater influence over the design and delivery of local healthcare services. This includes responsibility for around 60 per cent of the £110 billion NHS budget. The central tenet of the reforms 'no decision about me without me' is aimed at increasing choice and service integration, providing care closer to home and placing a stronger emphasis on patient involvement. However this is likely to increase still further the expectations of, and demands on, the general practice workforce.

GP services will be commissioned by the NHS Commissioning Board, and GPs as providers will be expected to comply with new Commissioning Outcomes Framework standards. The tension between the need to comply with these standards, and adopt the new commissioning role, is likely to require clarity in terms of which services and interventions can continue to be provided by the NHS. Achieving financial savings while delivering the reforms is going to require a transformation in the skills and working practices of GPs and practice staff. It will also require the practice team to work in partnership with patients and a range of public, private and voluntary providers and provide robust, reliable evidence of the quality of care provided.

In this report we acknowledge general practice and its registered patient list system as a strong foundation upon which different models of care can be built. We propose a range of solutions involving new business models and incentives, and accelerated use of technologies, which shift the focus of primary care from providers to consumers. While some of the proposed solutions are already being trialled by a number of GPs, and the challenge is to increase the scale of adoption, others have yet to be adopted in any meaningful way. What they all have in common is the need for primary care staff to work differently.



We propose a range of solutions involving new business models and incentives, and accelerated use of technologies, which shift the focus of primary care from providers to consumers.

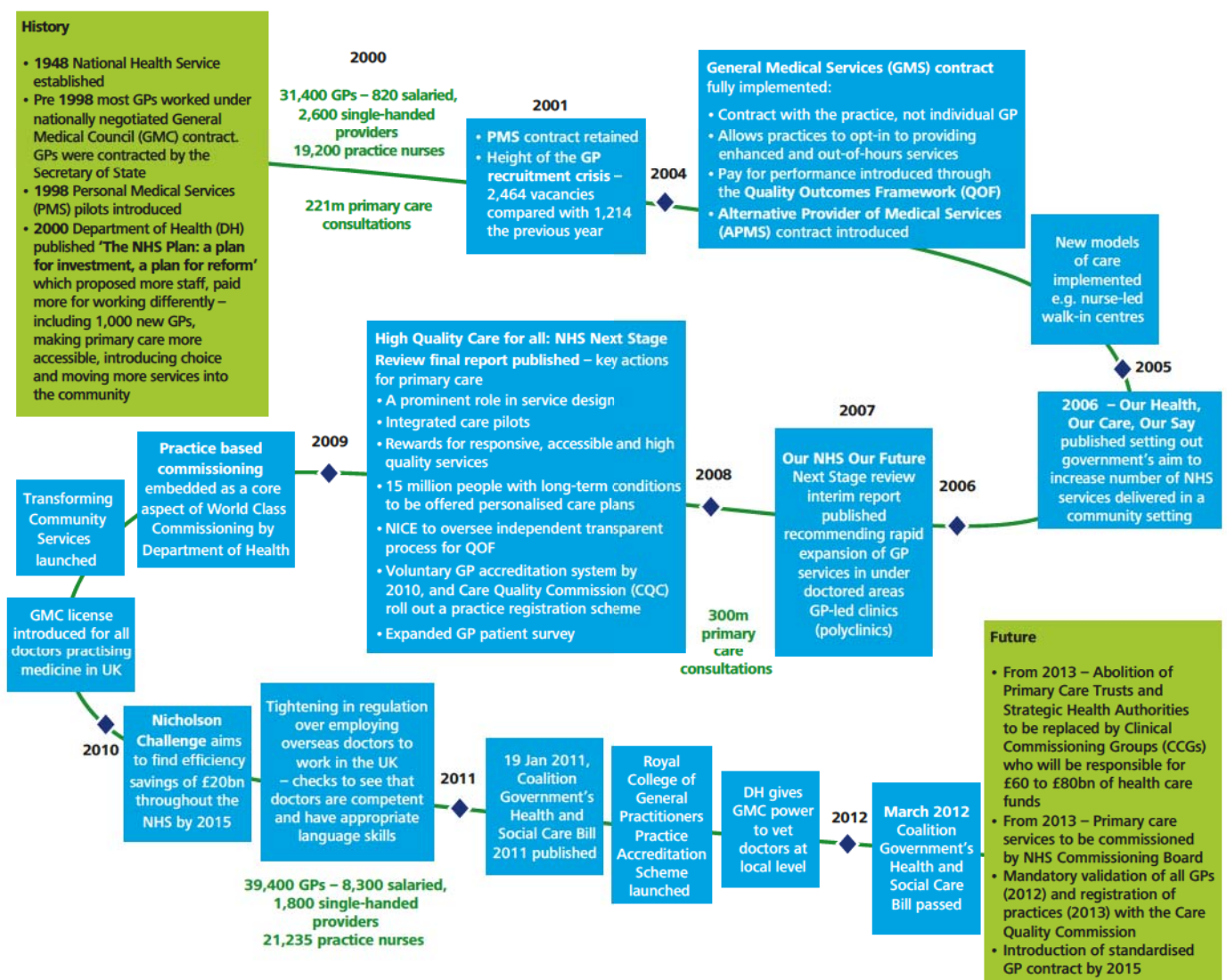
Part 1. Introduction

All UK residents are entitled by law to access primary care services, which are free at the point of need.¹ This principle has survived since the establishment of the NHS in 1948 and was restated in the 2012 NHS Constitution for England.² For most people, the GP or practice nurse is the first point of contact with the NHS, and over 90 per cent of all patient contacts with the health service occur in primary care. Following the formation of the NHS, GPs took responsibility for the healthcare needs of the local population, including controlling access to specialist care.³

Within one month, 90 per cent of the population had registered with a GP, a percentage that has remained fairly constant. GPs also chose to remain outside the NHS as independent contractors rather than salaried NHS employees.

Figure 1 charts the history of primary care development particularly since 2000, when the last Government launched the NHS Plan and announced the need for more staff, paid more for working differently and that the development of primary care services was central to the modernisation of the NHS.⁴

Figure 1. Evolution of primary care provision



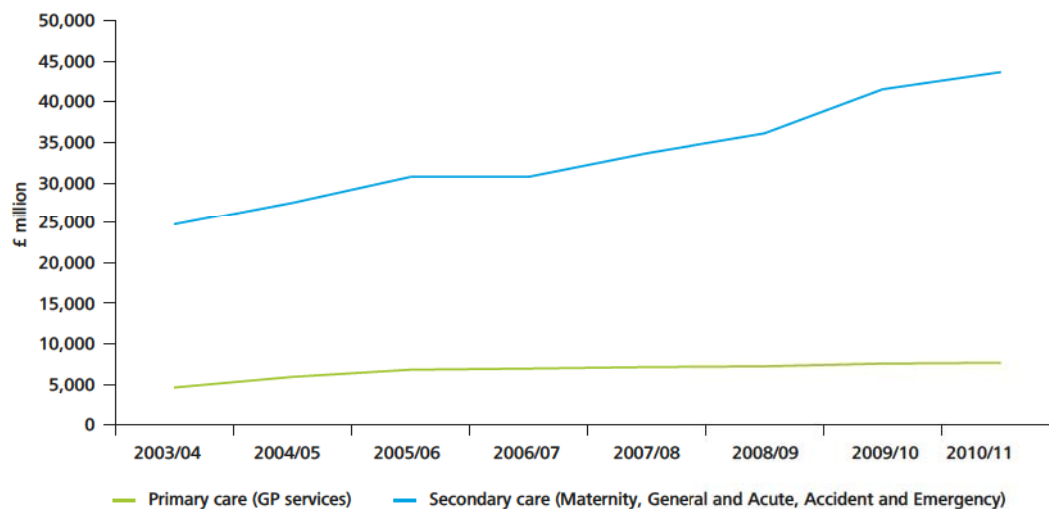
Traditionally, primary care services have been provided by GPs working as single handed practitioners and, more recently, as part of a general practice. GPs have generally provided the first point of contact or gateway to the NHS, treating and advising their registered list of patients and, where necessary, referring patients for further investigation and specialist care.⁵ Government expenditure on primary care in England increased from £5.8 billion in 2003-04 to £8.3 billion in 2010-11 (an average growth rate of 5.3 per cent per annum).⁶ More than 80 per cent of expenditure was on the primary care workforce.⁷

An analysis of the NHS summarised accounts (Figure 2) shows that since 2003-04 Primary Care Trust (PCT) spend on commissioning general practice services has increased at a slower pace than on acute hospital care (65.8 per cent and 76.4 per cent respectively). The majority of the increase on primary care occurred between 2003-04 and 2005-06 (47.4 per cent) while between 2006-07 and 2010-11 it was 10.2 per cent and over the last two years, only 1.3 per cent. Spending on acute services has been more varied, with a 24.3 per cent increase between 2003-04 and 2005-06, but an increase of 41.9 per cent between 2006-07 and 2010-11, with expenditure increasing 5.1 per cent over the last two years.⁸

Before 1998, the majority of GPs were employed under the 1990 General Medical Services (GMS) contract, a nationally negotiated agreement between the Secretary of State and individual GPs, which had been largely unchanged since 1966. GPs claimed funding for each item of service and a set fee per registered patient. Funding therefore followed the individual GP, not patient needs and provided little incentive to develop the role of other general practice staff.⁹

In 1998, the Department of Health (the Department) piloted a new locally negotiated Primary Medical Services (PMS) contract which enabled GP practices to negotiate greater flexibility through local contracts with their PCT based on meeting set quality standards and the particular needs of their local population. The aim was to improve GP services in under-doctored areas and increase the numbers and types of healthcare staff working in PMS practices.

Figure 2. Primary and Secondary healthcare costs commissioned by PCTs



Source: NHS Annual Summarised Accounts, 2001/02 – 2010/11

Note: 1. Primary care total is for GP services commissioned by PCTs only; this includes GMS, PMS, APMS, PCTMS costs and non-GMS services from GPs. It excludes prescribing costs, pharmaceutical, dental and ophthalmic services and 'other' costs.

2. Secondary care total is for maternity, general and acute and accident and emergency services costs commissioned by PCTs only. It excludes learning difficulties, mental illness, community health services and 'other' costs.

While the Department acknowledged that the PMS contract had delivered some benefits it did not consider that it should be applied nationally, as local negotiations meant they lacked consistency and would be inappropriate for tackling national issues.¹⁰ The Department did however agree that the PMS could be retained.

The Department and British Medical Association (BMA) agreed the terms of the new GMS contract in 2003, and the contract was implemented in full in April 2004. Practices were required to provide a core set of essential services but were able to opt-in to providing enhanced services and out-of-hours urgent care services. The Department passed responsibility for commissioning enhanced and out-of-hours services to PCTs.

The agreement also introduced a provision that payments for a proportion of services would be linked to achievement of quality standards under a Quality and Outcomes Framework, known as the QOF, and that the contract would be with the practice not the individual. A stronger governance framework was introduced, alongside scope for increased competition.¹¹ There was no nationally agreed pay scale; instead GP pay was taken as salary or, in the case of GP partners in the practice (around 70 per cent of GPs in 2004), as a share of practice profits after expenses.¹²

In 2004, a new Alternative Provider Medical Services (APMS) contract was also introduced to enable Primary Care Trusts to commission primary care from commercial or voluntary providers, or from foundation trusts. It was aimed at opening the market to alternative models of care so as to improve access and choice, particularly in more deprived areas, for example through GP-led health centres, walk-in clinics and polyclinics.¹³ By 2010, use of APMS contracts was still quite limited with most NHS run, and private organisations responsible for around three per cent of general practices.¹⁴

From 2012, GP capabilities will come under further scrutiny, with a requirement to comply with a mandatory revalidation process operated by the General Medical Council (GMC). Since autumn 2009, all doctors have been required by law to hold a licence from the GMC that describes a doctor's areas of licensed activity. Starting in late 2012, all licensed doctors will be subject to revalidation every five years and will need to demonstrate that they are practising in accordance with the generic standards of practice set by the GMC in *Good Medical Practice*. Assessments will be based on information drawn from doctors in their actual practice, feedback from patients and participation in continuing professional development.¹⁵ In addition, from April 2013 all practices will be required to register with the Care Quality Commission (CQC), the independent regulator of health and social care services in England, responsible for ensuring provision of care meets government quality and safety standards.¹⁶

The Health and Social Care Act 2012 introduces comprehensive changes to the way the NHS will operate, with an independent NHS Commissioning Board and independent statutory Clinical Commissioning Groups (CCGs). GPs will be expected to take a lead role in CCGs and have a much greater influence over the design and delivery of local healthcare services. This includes responsibility for around 60 per cent of the £110 billion NHS budget. GP services will be commissioned by the NHS Commissioning Board, with a plan to introduce a standardised GP contract by 2015.¹⁷

From the patient point of view, the central tenet of the healthcare reforms is "no decision about me without me". This is manifested in proposals to increase choice and service integration, provide care closer to home and place a stronger emphasis on patient involvement. These are likely to increase expectations and demands on the general practice workforce.¹⁸

From 2012, GP capabilities will come under further scrutiny, with a requirement to comply with a mandatory revalidation process operated by the General Medical Council.



This report examines the capacity and capability of general practice now and in the future, with a focus on GPs and general practice nurses as providers of primary care. Part 2 examines the provider challenges facing the general practice workforce, including:

- increased demand for primary care due to people living longer, and with more years spent in ill-health
- the changing nature and capacity of the general practice workforce
- the significant financial and reform challenges facing the NHS.

Part 3 presents a range of potential solutions, aimed at helping general practice to respond efficiently and effectively to the challenges. The solutions comprise:

- new models of care
- accelerated use of new technologies
- effective use of financial and other incentives.

Part 4 details the regulatory and financial barriers that also need to be addressed to implement and embed solutions more comprehensively across the NHS, and the actions that need to be taken by stakeholders with an interest in the continuing provision of high quality, safe and cost-effective healthcare services.

This report examines the capacity and capability of general practice now and in the future, with a focus on GPs and general practice nurses as providers of primary care.

Part 2. The provider challenges facing general practice

General practice provides a wide and increasing range of core face to face services, including health promotion and prevention, diagnosis and management of short-term illnesses, management and support of long-term conditions, prescription of medication and treatments, and provision of referral services. GP services are, however, becoming increasingly challenged as a result of rising demand and constraints on the availability of staff. The requirement to contain expenditure while implementing the NHS reform agenda imposes additional pressures on providers. This part of the report examines the main challenges faced by general practice.

Increasing demand for general practice services

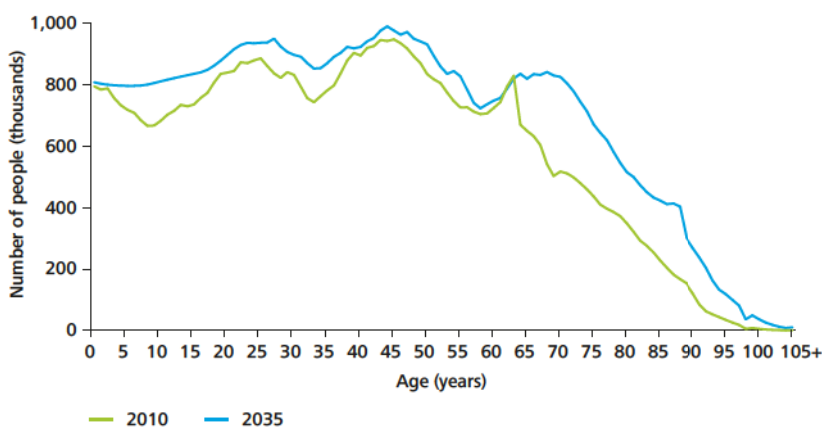
Over the last decade, there has been an expansion in the range of services provided and in the role of GPs in managing long-term conditions. As a result, between 1995 and 2008, the number of patient consultations rose by 75 per cent, from 171 million to more than 300 million. GP consultations increased by 11 per cent and nurse consultations rose by nearly 150 per cent.¹⁹

Of the many external influences on general practice, the ageing population is expected to have the greatest impact.²⁰ People are living longer, with the Office for National Statistics (ONS) predicting that by 2035 more than 23 per cent of the UK population will be over 65, compared with 16.5 per cent in 2010.²¹ If the pattern of consultations remains unchanged, by 2035 there could be a total of 433 million GP consultations, of which 180 million would be for people aged 65 and over, nearly double the current number.²² The ONS also predicts that by 2035 there will be 3.5 million people aged 85 and older.²³ Indeed, the ONS expects more people in almost every age group, but the greatest rise is in older age groups (Figure 3).

For many people, extra years of life may be undermined by long-term illnesses that are not curable and need active management. Such care is complex, particularly as the majority of such patients have more than one condition. In 2005, 65 per cent of the over-65 population had two or more long-term conditions, with some having as many as five or six.²⁴ The Department estimates that up to 75 per cent of people above the age of 75 are suffering from chronic disease, with the incidence of chronic disease in people aged 65 or over expected to double by 2030. Chronic disease is the leading cause of death and disability in the United Kingdom.²⁵

The fact that more people with chronic diseases are living longer has led to a significant increase in the average number of consultations per patient per year, from 3.9 in 1995 to 4.2 in 2000 and 5.5 in 2008, with a striking increase in average annual consultations among the over 75s, from 7.9 in 2000 to 12.3 in 2008 (see Figure 4).

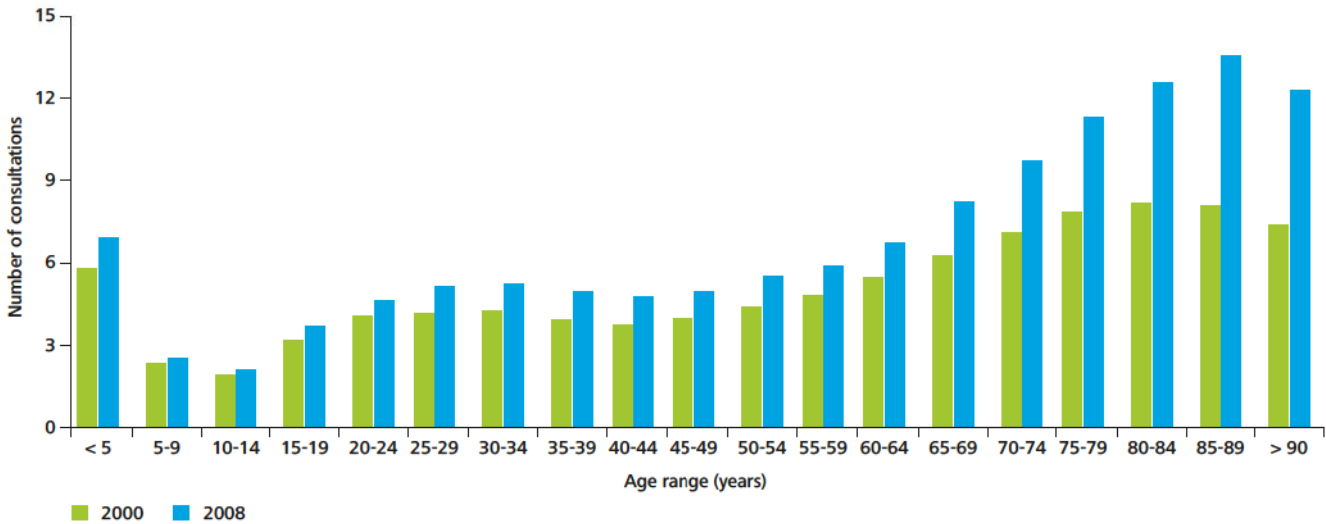
Figure 3. Projected age distribution of the UK population, 2010-35



Source: Office for National Statistics, National Population Projections, 2010

GP services are, however, becoming increasingly challenged as a result of rising demand and constraints on the availability of staff.

Figure 4. Change in average number of primary care consultations per person, 2000 and 2008



Source: NHS Information Centre, Q Research Consultation Rates, 2009

The changing nature and capacity of the workforce

Alongside a rise in demands and expectations, new challenges for general practice have emerged in relation to staff capacity and capability. The NHS Plan 2000 emphasised that the development of primary care services was key to the modernisation of the NHS. The plan set out its ambition to make primary care more accessible, offer patients more choice and move more services from secondary to primary provision. It acknowledged that this would require more staff, who would be better paid and who would work differently.²⁶

The plan was published against a background of GP unrest, with a broad consensus that the GP workload was unsustainable. During this period morale was endemically low, and this was borne out by a recruitment crisis, as new doctors opted to avoid the long hours and inflexibility associated with general practice.²⁷ Long hours and low pay relative to hospital consultants were seen as key reasons for poor recruitment and retention of GPs.²⁸

The introduction of new contracts for primary care increased the flexibility of provision

Since 2004, there have been substantial shifts in patterns of care. The new General Medical Services (GMS) contract encouraged GPs to work in larger practices or federated models, alongside an expanded role for nurses and other healthcare practitioners, including the development of the nurse practitioner role.²⁹

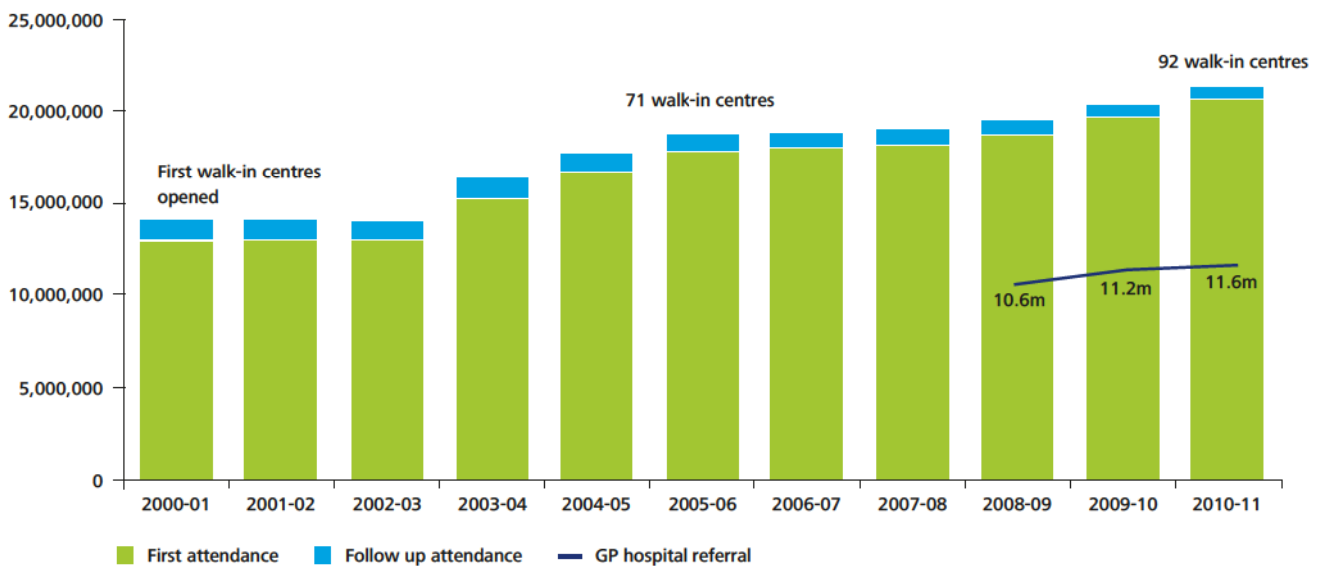
Contractual arrangements for general practice have also become more diverse. The proportion of practices operating under the new national GMS contract fell from 60 per cent in 2005 (the year after the new GMS contract was introduced) to 54.5 per cent (4,519 practices) in 2010, a small number of which were held by limited companies. The contract has led to an increase in the number of nurses working in general practice with healthcare assistants also playing a bigger role in delivering care.³⁰

The retained Personal Medical Services (PMS) contract included some of the new features of GMS, including access to QOF payments and the option not to provide for out-of-hours care. In 2005, 37 per cent of GPs were on PMS contracts. By 2010 there were 3,393 GPs (41 per cent) working under PMS contracts, a few of which were held privately. On average, GMS GPs were paid less than PMS GPs³¹ and GMS GPs worked longer hours.³²

The introduction of the Alternative Provider Medical Services (APMS) contracts as intended did increase the scope for flexibility by giving PCTs the opportunity to contract with commercial, voluntary or foundation trust providers, using locally determined and managed contracts to meet local needs.³³ Initially, limited use was made of this option. The 2008 NHS Next Stage Review, however, included a focus on improving access and increasing capacity in areas of greatest need.³⁴ Consequently, from 2009 to 2010 the number of practices working under the APMS contract (in which services are provided seven days a week, from 8am to 8pm) rose from 173 to 262. Of these, 120 (45.8 per cent) were administered by companies whose liability was limited by shares or guarantee.³⁵

While these new models have helped increase access to primary care they have generally failed to stem the rise in Accident and Emergency (A&E) attendances and GP referrals which was part of the rationale for improving access to general practice (Figure 5).³⁶

Figure 5. A&E attendances and GP hospital referrals

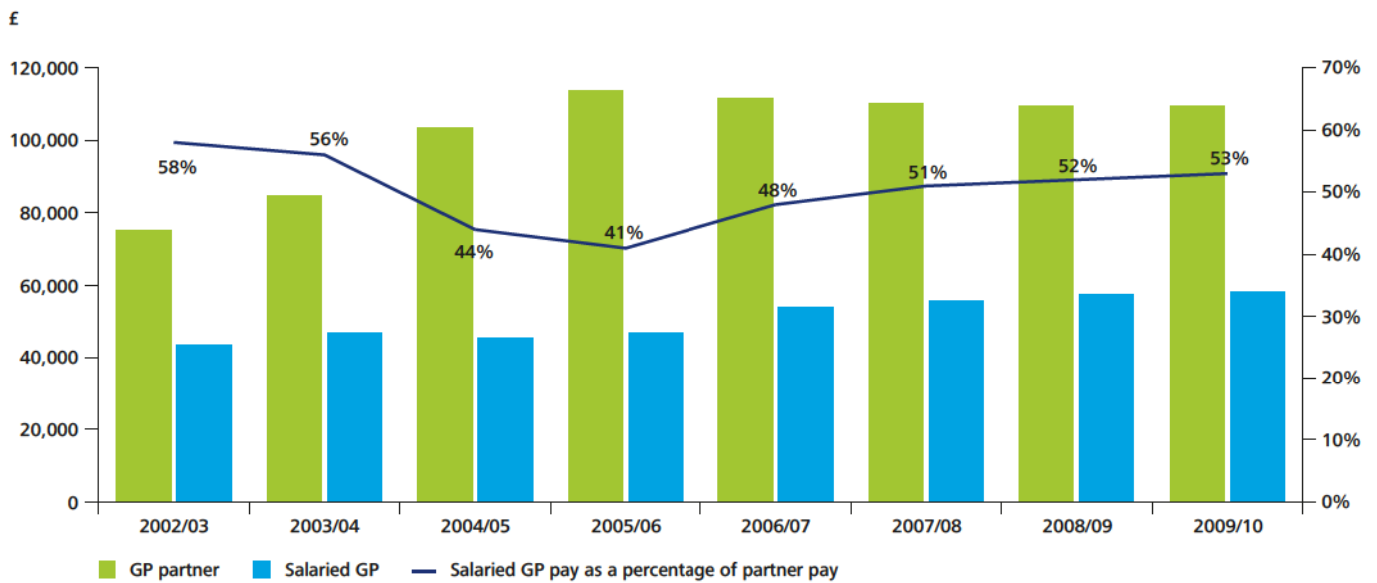


Source: Department of Health, Hospital Episode Statistics

The pay and headcount of general practice staff has increased

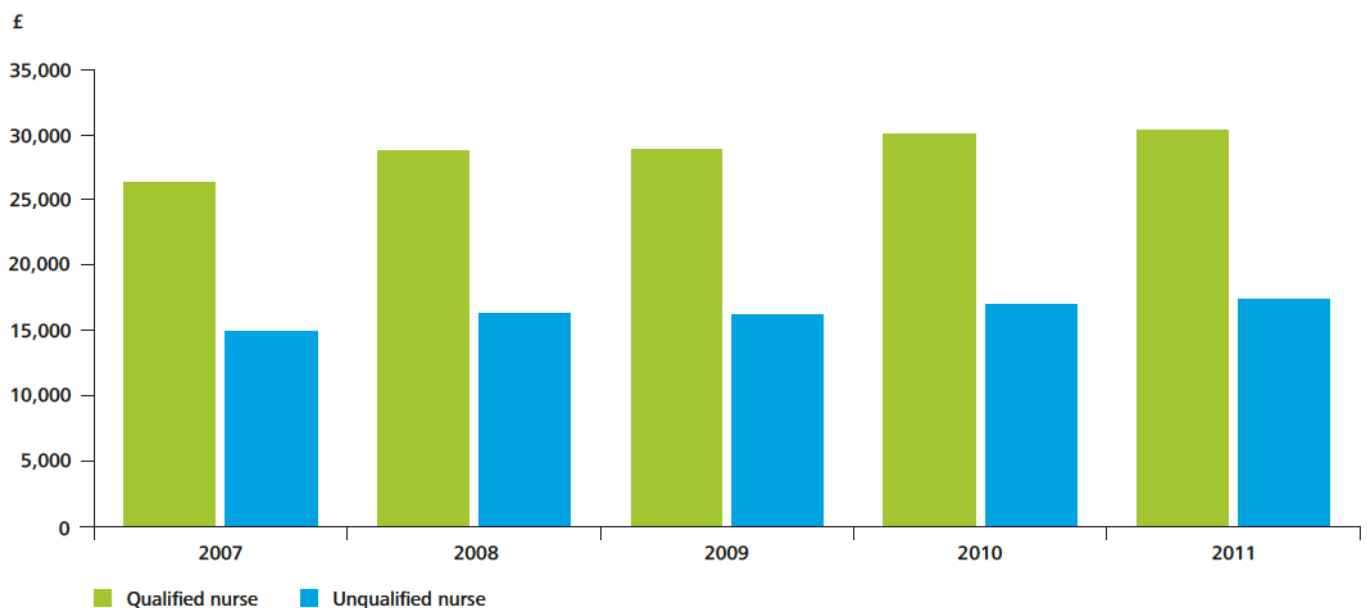
Following the introduction of the new GP contract in 2004 the pay of GP partners increased substantially. At the same time, hours of work decreased, linked in part to the fact that few GPs were providing out-of-hours care, and because practice nurses were taking more responsibility for routine consultations.³⁷ Since 2006, average GP pay has stabilised, with a slight decline in partner pay, and small annual increments for salaried GPs and practice nurses (Figure 6a and 6b).

Figure 6a. Average income before tax for GP partners and salaried GPs



Source: NHS Information Centre, GP earnings and expenses

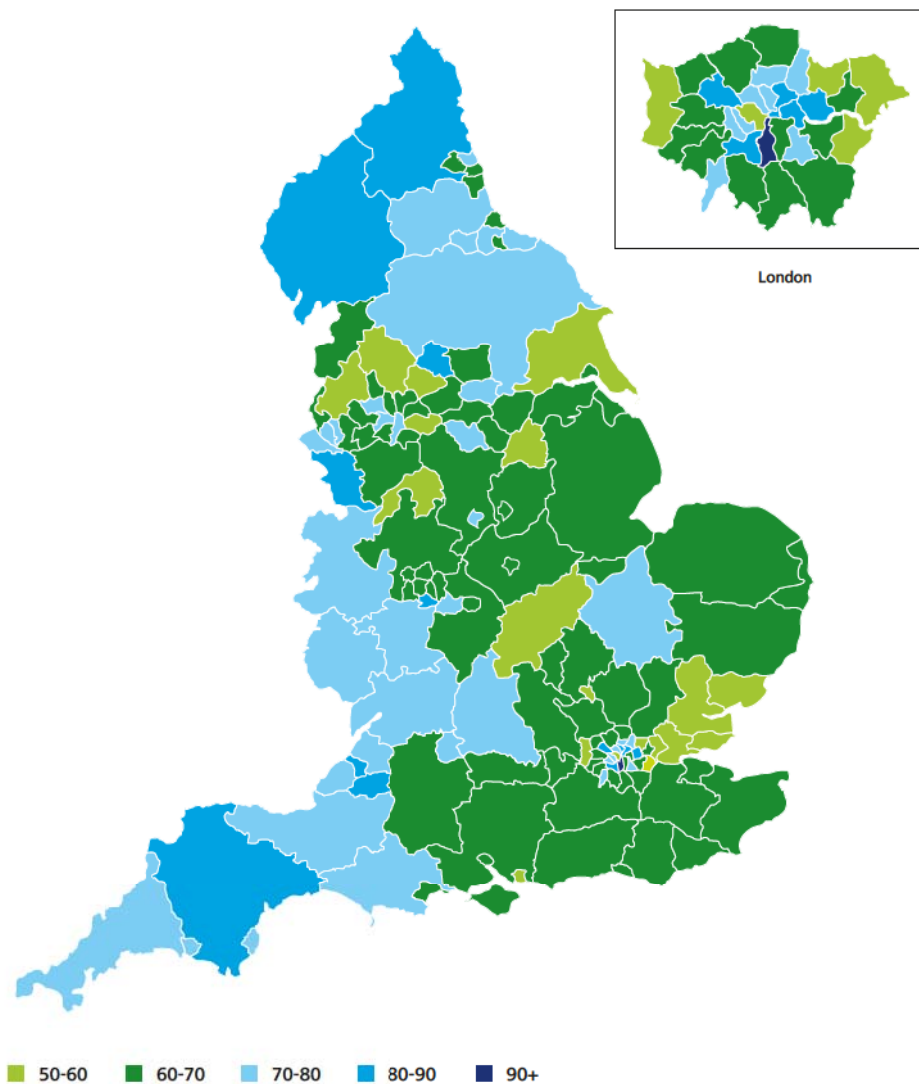
Figure 6b. Average income before tax for nurses in the United Kingdom



Source: NHS Information Centre, Average earnings July-September

The number of GPs in England increased from 31,400 in 2000 to 39,400 in 2010 and by 2010 there were 67.8 practitioners per 100,000 of population, compared with 58.1 in 2000. The national picture, however, hides wide regional variations, with access to GPs still inequitably distributed between areas of high and low deprivation. For example, in 2008 the average number of GPs weighted for age and need in the most deprived quintile was 56.4 per 100,000 population, and in the most affluent was 62.9 per 100,000.³⁸ The range was from fewer than 53 GPs to more than 90 GPs per 100,000 (see Figure 7).³⁹

Figure 7. GPs per 100,000 population, by Primary Care Trust

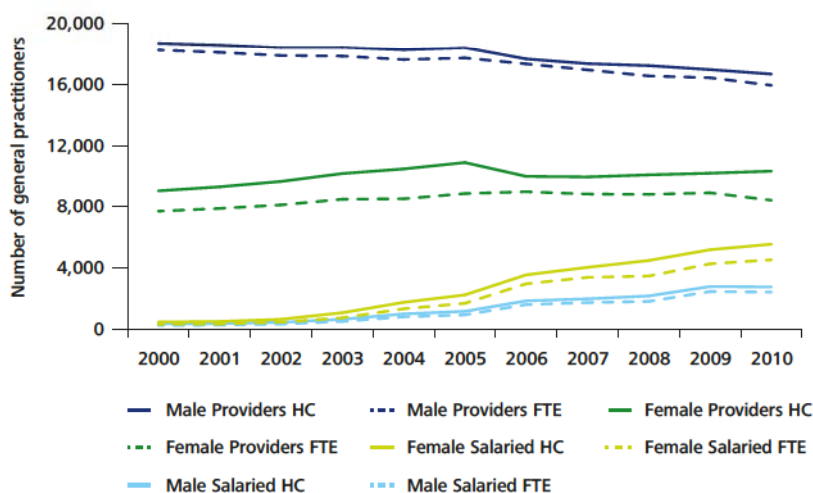


Source: London Health Observatories, Basket of indicators, 2010

GPs in most areas are now much more likely to work in larger practices, with the number of single handed GP providers in 2010 down to 1,809 (21.7 per cent), from 2,662 (29.7 per cent) in 2000.⁴⁰ Partnership opportunities are also becoming increasingly scarce. Indeed the number of salaried GPs employed in practices has increased ten-fold, from only 802 in 2000 to more than 8,700 in 2010. This can be seen across both male and female salaried GPs, who between 2000 and 2010 experienced an estimated average annual rise in headcount of 23.4 per cent and 28.2 per cent respectively (see Figure 8).⁴¹ A number of factors contribute to the increase in salaried GPs, including a desire among younger GPs for increased flexibility (three-quarters of salaried GPs work part time) and because the terms of the new GMS contract act as a disincentive to increasing partner numbers. Overall, around a third of care is now delivered by lower paid salaried and locum GPs or by practice nurses, who are paid even less, despite being responsible for increasing numbers of consultations.⁴²

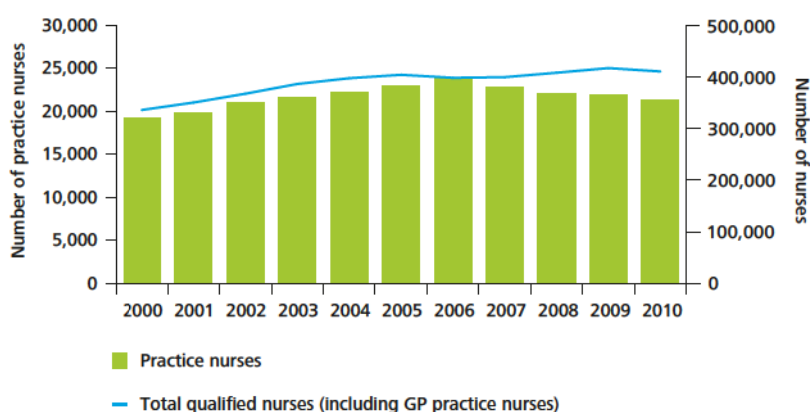
The headcount number of practice nurses peaked in 2006 at 23,797 and then started to decline, reaching 21,235 in 2010 (see Figure 9).⁴³ This trend largely was a result of the significant growth in nursing numbers from the late 1990s to 2005. During this period the government increased investment in nurse education places, implemented policies to improve retention and returners, and intensified international recruitment. In 2005, however, the Nursing and Midwifery Council (NMC) instigated much tougher registration requirements for overseas nurses, and from 2006 the main entry clinical grades in the NHS were removed from the Home Office shortage occupation list. The NMC also raised English language requirements and in 2008 moved to a point-based work permit system. The NHS financial deficit in 2005-06 also led to redundancies and recruitment freezes, and an overall reduction in nurse numbers.⁴⁴

Figure 8. Changes in numbers of general practitioners by HC/FTE 2000-2010



Note: HC is an abbreviation of headcount, FTE is an abbreviation of Full-Time Equivalent
Source: NHS Information Centre, General Practice Bulletin, 2000-2010

Figure 9. Number of practice nurses compared to total qualified nurses, 2000-10



Source: NHS Information Centre, General Practice Bulletin, 2000-2010

A number of factors contribute to the increase in salaried GPs, including a desire among younger GPs for increased flexibility (three-quarters of salaried GPs work part time) and because the terms of the new GMS contract act as a disincentive to increasing partner numbers.

The challenges involved in maintaining the supply of qualified staff are increasing

Arguably the greatest supply challenge facing primary care is that the average age profile of GPs is increasing. The proportion of GPs aged 55 and over rose from 17.5 per cent in 2000 to 22.2 per cent in 2010. Correspondingly, in 2010 GP leavers rose to a ten-year high of 7.8 per cent.⁴⁵ A BMA survey conducted in 2011 identified a rising number of male full-time GPs expressing their intention to retire over the next two years, and as many as 10,000 GPs expressing an intention to retire over the next five years.⁴⁶

At the same time, new entrants and returners to work as a percentage of the GP workforce have fallen, and an increasing proportion of joiners are female, leading to higher levels of demand for flexible and part time work.⁴⁷ Given it takes around ten years to train a doctor, any immediate recruitment shortfalls can only be met by qualified doctors from abroad. However, changes to employment regulations and agreements to limit recruitment from countries facing similar challenges means overseas hiring is unlikely to be a panacea.⁴⁸ All of this compounds the strains on the GP workforce.

The reduction in overseas recruitment places an even greater emphasis on the need for the UK to train its own workforce. However, fewer medical students are now electing to enter primary care. In 2011, some 3,160 doctors began GP speciality training; the majority direct from the Foundation Programme. That was a seven per cent reduction from 2010.⁴⁹ Some 6,028 doctors applied to start GP speciality training in 2011, a five per cent reduction from 2010. Indeed in 2010 the average competition ratio for applicants to general practice was 1.69 and only psychiatry had a lower ratio (1.41), with acute care and anaesthesia having ratios of 10 and 12 respectively.⁵⁰

Supply forecasts, modelled by the Centre for Workforce Intelligence, have shown that even if the government's recruitment target of 3,300 new entry level GP positions is met, the GP workforce will only continue to grow if GPs rejoin at historical levels (680 per annum). However, there is little evidence to suggest this will be the case.⁵¹

The practice nurse workforce is also ageing. Indeed, a review in 2009 found that a disproportionate number of primary care nurses expected to retire within 5-10 years.⁵² Almost one in five practice nurses are aged 55 or over, and the challenge of replacing those who retire is likely to become an increasingly prominent issue over the next few years.⁵³

Alongside a decline since 2006 in the numbers of practice nurses, since 2009 there has been a reduction in the number of pre-registration training places. Together with the cuts in international recruitment and an increase in nurse migration, the United Kingdom now faces a net outflow of nurses.⁵⁴ The general reduction in supply is likely to limit the number of nurses who might consider a career as a practice nurse. This in turn could limit the scope for GPs to delegate work to practice nurses.



The significant financial and reform challenges facing the NHS

Demand and supply side difficulties need to be considered against a backdrop of unprecedented financial and reform challenges facing the NHS. Between the years 1999-2000 and 2010-11, spending on the NHS increased on average by 6.6 per cent a year.⁵⁵ However, the coming five years herald a period of austerity, with NHS budgets expected to increase by no more than 0.4 per cent per year.⁵⁶ Given that demand for NHS services will likely increase, the Department expects the NHS to bridge the gap through efficiency savings and productivity improvements of some £20 billion a year by 2015 (the Nicholson Challenge).⁵⁷ General practice has a central role in helping the NHS achieve the savings, through referral management and, where clinically appropriate, helping keep patients out of hospital.⁵⁸

Achieving financial savings while delivering reforms is going to require a transformation in the skills and working practices of GPs and practice staff.

The proposals in the Health and Social Care Act have already been rehearsed in Part 1, however one of the stated aims, the intention to introduce a standardised GP contract by 2015 has significant implications for GPs as providers.⁵⁹ Given that PMS and APMS contracts are negotiated locally, this will no longer be feasible and the significant number of practices that operate under these contracts will need to adjust to working under a national contract. For the immediate future, however, the Department has said that despite its plans to move to a single GP contract, in the early stages there will still be GMS and PMS contracts.⁶⁰ This change is likely to lead to a new set of challenges, although the full extent of the impact is not yet clear.

From 2013, the government expects GPs as providers to comply with a new Commissioning Outcomes Framework, comprising a set of standards of care and associated indicators.⁶¹

Tension between the need to comply with provider standards and adopt the new commissioning role, is likely to highlight the need for clarity in terms of which services and interventions can continue to be provided by the NHS. Achieving financial savings while delivering reforms is going to require a transformation in the skills and working practices of GPs and practice staff. It will also require primary care to improve significantly the information it holds, as well as its communication with patients. Part 3 of the report details some suggested solutions to help general practice work differently. The focus is on general practice as a provider and we propose to review the wider implications of the commissioning changes in a separate report to be published in autumn 2012.



Part 3. The solutions – adopting new ways of working

In addition to the increased scale and scope of activity described in Part 2 there has been an increased emphasis on standards and training alongside more scrutiny of the quality of performance in general practice. However, the general practice delivery model remains largely focussed on face to face contact between the GP or practice nurse and the patient.

A key message of this report is that if general practice is to respond effectively to current and future challenges, it will need to adopt new ways of working. To succeed, any changes need to be evidence based, with robust, reliable information underpinning implementation. GPs will need to work more effectively, with patients and a range of public, private and voluntary providers. This part of the report identifies a number of potential solutions to these challenges. The list is not exhaustive but is focussed on examples where there is evidence as to their effectiveness.

The GP as a generalist working with others to deliver more care in the community

The new contract arrangements introduced since 2004 have, among other things, incentivised increasing amounts of specialist care within practices, blurring the boundaries between generalists (the traditional GP) and specialists. However there is limited evidence that increasing GP specialisation has reduced costs or hospital admissions. The conclusion of a King's Fund inquiry into general practice, and the view of the Royal College of General Practitioners (RCGP), is that the majority of GPs should remain generalists, providing continuity of care and helping people identify options. GPs should, however, extend their generalist role to act as care navigators, working alongside specialists, such as GPs with a special interest, and hospital specialists, to provide more care in the community.⁶³

The generalist GP should play a central role in coordinating the care of people with more complex needs, and advising on the pathway that patients might take. Developing a care coordination capability is particularly important for people living with chronic conditions or disabilities, and for those at the end of life. The coordinating role can help minimise disruption to care when crossing between primary, secondary and social care, and avoid expensive duplication of investigations.

It requires effective communication and clinical skills to interpret choices. This is likely to mean GPs becoming less of a gatekeeper and more of a care navigator.⁶⁴

There is also scope for GPs to work even more effectively with nurses in primary care, including nurse practitioners, practice nurses, district nurses and community nurses. Over recent years there have been great strides in developing the scope of nurses' capabilities and skills and the care they provide so as to extend nursing practice to increase patient access to services and enhance care.⁶⁵

Research by the Queen's Nursing Institute illustrates how GPs could make more effective use of wider nursing skills, including more integrated working with community nurses, particularly in providing home care.⁶⁶ Indeed, GPs have a long history of interaction with community based nurses, which has oscillated between them being based in the practice and part of the integrated primary healthcare team, to a 'neighbourhood' model in which nurses are aligned to a locality not the practice. One option is for practices to employ or develop formal partnerships with health visitors and district nurses. While the different funding streams for general practice and community nursing may present a barrier, the new commissioning regime, with its aim of developing a more co-ordinated and integrated approach to care within the local health economy could be a solution.

Adoption of GP-led triage systems to improve effectiveness of consultations

One long-standing aspect of general practice that needs to be challenged is dependence on face to face consultations. By building innovative tools and strategies into the way primary care practices operate, GPs and practice nurses would be able to see more of patients who need to be seen, cover more clinical territory and make a greater impact over a shorter time.⁶⁷ One initiative that has been positively received by patients is a GP telephone triage system.⁶⁸ Patients call the practice, the GP calls the patient back and together they agree an approach to the problem. In some cases this may be to attend for an immediate consultation or to attend at a mutually convenient time.⁶⁹

By 2009, some 12 per cent of practices used a GP telephone triage system. Reviews show that in 50-80 per cent of cases no appointment was needed and overall practices operating this approach had higher patient satisfaction levels on access and quality of care, and a notable decrease in "did not attend".⁷⁰ An independent review by the Health Service Journal of NHS Comparator datasets found that patients in practices with a GP triage system were 27 per cent less likely to attend A&E.⁷¹

The development of new primary care access models

Historically there have been numerous initiatives to improve access to general practice but few have changed how primary care is organised.⁷² The NHS Plan identified the need for investment in infrastructure,⁷³ and indeed since 2000 there have been a number of primary care infrastructure initiatives aimed at improving access for which there is quantitative and qualitative evidence of their impact:

- The £2 billion NHS LIFT (Local Improvement Finance Trust) scheme, established in 2000 as a public-private partnership initiative, had by 2011 provided some 244 purpose-built facilities aimed at delivering integrated primary, community and social care.⁷⁴ However a 2008 report by the King's Fund found that simply bringing staff together in one place did not necessarily change the way in which they worked and actually made joint working more difficult. It also found that the degree to which GP services integrated with other services varied widely. There were limited evaluations of the economics of the new facilities, and at the time none could demonstrate savings or improvements in cost-effectiveness. While there was evidence of some patient benefits, most PCTs felt that the schemes had driven up cost, while in rural areas access was more difficult.⁷⁵ The model was more likely to deliver benefits when facilities were developed in central locations with good transport links.⁷⁶

- In 2008, the government launched the Equitable Access Programme, and approved a £250 million access fund to develop at least 100 new GP practices in the 25 per cent of PCTs with the poorest provision, and set up a GP-led health centre (polyclinic) in every PCT.⁷⁷ These GP-led health centres were expected to open from 8am to 8pm, seven days a week and combine 'open access' with a registered patient element.⁷⁸ Research by the King's Fund concluded that the model offered opportunities (organisational factors and the management of long-term conditions) and risks (reduced access, lack of continuity, potentially higher costs than equivalent hospital services and limited impact on demand for hospital services). The research showed that when aggregating GPs into larger health centres the location of the centre was crucial.⁷⁹ Larger centres cost more per patient to run than ordinary GP practices, but were effective in addressing access issues in some deprived communities.⁸⁰

After a slow start, a growing number of people have started to use the new GP and nurse-led centres. In a 2011 Deloitte *Survey of Health Care Consumers in the UK*, which surveyed a largely highly educated population of consumers over a third of whom had private health insurance, some 22 per cent of respondents said they used a walk-in clinic or similar for non-emergency care; a 13 per cent increase on 2010. The trend was for greater use among younger age groups (38 per cent in the 18-24 range).⁸¹

Our review of the evidence suggests that if relocation and grouping of GPs into larger practices is to be successful in improving quality of care and tackling access issues, it needs to be accompanied by the redesign of care pathways, supported by changes in working practices and skill-mix, and use of new technologies. This needs to be underpinned by greater transparency in costs along the care pathway, including refinements in funding to more accurately reflect case-mix variability.

Developing integrated care models

The idea of better integrated services has been an ambition of successive governments, but to date there are only a small number of successful examples, mostly involving the Care Trust model.⁸² Integration can be between health and social care, to provide a common service (horizontal integration), or across primary, community and secondary care providers within a care pathway (vertical integration).

Although integrated care promises to deliver cost benefits, despite a large body of research, the evidence base for 'what works' remains mixed.⁸³

In 2008, the NHS Next Stage Review emphasised the importance of integration and set out a vision to provide seamless care, developed around patients and delivered by integrated teams across services. The review also promised to hand power to patients to integrate their own care through care plans and personal budgets. In response, in 2009 the Department launched an Integrated Care Pilot programme involving 16 different models of integrated care.

The NHS Future Forum summary report in 2011 stated: "we need to move beyond arguing for integration to making it happen".⁸⁴ The report called for the commissioning of integrated care for patients with long-term conditions, complex needs or at the end of life. It built on ideas submitted to the Forum by the King's Fund and the Nuffield Trust.⁸⁵ The Department subsequently asked the two organisations to contribute to the development of a national strategy on integrated care, and their report promoting increased integration was published in January 2012.⁸⁶

In March 2012, the report on the two-year research study into the 16 pilot sites concluded that well-managed integrated care reduced hospital admissions for elderly patients by at least 20 per cent. Overall, 54 per cent of staff thought patient care had improved and 72 per cent reported that they had better communication with other organisations. In pilots where case managers coordinated the care, outpatient visits and planned admissions both fell by around 21 per cent, with a reduction in hospital costs of 9 per cent. The study found, however, that patient satisfaction fell, with 28 per cent fewer patients feeling their GP had involved them in decisions about their care, and 9 per cent fewer saying they saw their preferred GP at the surgery.⁸⁷ This finding on patient satisfaction shows the difficulties in changing patient expectations about the personal relationship with the GP and the importance of effective and ongoing communication with patients about what to expect from new models of care.

Shared decision making and self management

Patient-centred care that allows patients and their GPs to exchange information and collaboratively decide on the treatment course to follow can improve health outcomes.⁸⁸

Decision support tools can often make shared decision-making more effective, with proponents citing improved patient satisfaction and increased medication adherence, leading to improved results. A literature review demonstrates that when people are given clear and accessible information about the likely risks and benefits of different choices of treatment, they are more likely than their doctors to defer or decline treatment. Conversely patients who aren't adequately informed may undergo treatment they may have preferred to avoid, and from which there may be no additional benefit.⁸⁹

A key role for general practice in providing care to an ageing population with multiple chronic conditions is supporting self-management. Reviews of self-management programmes suggest that they lead to better disease control, better patient outcomes and reduced utilization of healthcare services, particularly A&E and emergency admissions. All of these outcomes can potentially reduce costs while improving quality of care. Respondents report that it helps them live better lives and puts them in control of their condition. While not all approaches demonstrate quantifiable benefits, a common feature of successful self-management programmes is a self-management action plan.⁹⁰

Developing a more customer service type model

Today's service users expect a high level of service from their healthcare providers, and under the NHS reforms it will be much easier to switch providers if providers fail to offer the required services. There is only anecdotal evidence of patients' views on switching GP practices, although patient surveys highlight the desire for greater choice of GP.⁹¹ Patient power is growing, but is still a relatively untapped driver of change, likened by some to the power of the emancipation movement.⁹²

Like most other industries, primary care will need to change its focus toward the end user, and away from the traditional model of 'knowing what's best and not listening to the patient enough'.⁹³ The primary care model will unquestionably need to be refined to retain its viability in a consumer-driven healthcare market that offers more care options and new ways of communicating, for example real time access to test results and symptom monitoring.

Figure 10 summarises a number of other delivery models that could also help improve primary care delivery.

Figure 10. Models and approaches to assist general practices to work differently



Telemedicine has the potential to support GPs to care for more patients in their own homes and help patients self manage

Telemedicine includes both telecare (using equipment to support people in their own homes) and telehealth (using equipment to monitor vital signs and send data to clinicians). While the technology is important, it also needs to be integrated into a properly designed patient care plan. Use in primary care has largely been restricted to patients with heart failure and diabetes. However, it is starting to be used more widely, spurred by the Whole System Demonstrator project¹⁰⁴ and a Department commitment to accelerate the use of telehealth and telecare.¹⁰⁵ While there have been a number of pieces of research that call into question the cost and cost-effectiveness of telehealth, the project's initial findings indicate that the use of the technology has led to:

- a 20 per cent fall in emergency admission
- 15 per cent fewer visits to A&E
- 14 per cent fewer elective admissions
- 14 per cent fewer bed days
- an 8 per cent reduction in tariff costs
- a 45 per cent difference in mortality rate between those using telehealth and those in the control group.¹⁰⁶

The spread of telehealth technology is one of the key high impact innovations highlighted in the Government's Innovation, Health and Wealth Strategy.¹⁰⁷ From April 2013 compliance with high impact innovations will become a requirement for the Commissioning for Quality and Innovation payment framework, which estimates that adoption by the frontline could save the NHS up to £1.2 billion over five years.

Based on the lessons learned from the project, the Department launched the '3 million lives' campaign in January 2012 to drive the use of telehealth on a large scale. It identified that at least three million people with long-term conditions and/or social care needs could benefit from the use of telehealth and telecare services.

The Department has secured the collaboration of industry, government and other stakeholders over the next five years to help make widespread adoption of telehealth and telecare a reality.¹⁰⁸

Technology can improve equity in access to information on healthcare

People use the internet for everything from online shopping and banking to booking airline tickets, but fewer people use it to self-diagnose an illness, look up hospital quality ratings or book an appointment. Within general practice, touch-in arrival screens are widely employed to help avoid long queues, but there is little more technology-supported interaction between patient and provider.

Still, patients with mobile phone and internet-driven lifestyles increasingly expect to use information technology in their interactions with general practice. While there are inter-generational differences in the extent to which people use technology, some pilots have shown that older people can be fast adaptors. Examples of potential technology applications include 24-hour online systems that enable patients to book and cancel appointments, order repeat prescriptions or view their records.¹⁰⁹

A number of technology tools can also be used to improve communication and reduce GP visits:

- Mobile devices have great potential to promote self-management. There are some 88 mobile subscriptions per 100 individuals in the UK.¹¹⁰ Mobile phone capabilities could be particularly effective if they are integrated with bio-monitoring and personal health data to send targeted communications to pre-empt emergency situations and reduce the need for surgery visits. Sixty-three per cent of UK consumers said they would be very or somewhat likely to download treatment or medical condition information to a mobile device.

- A growing number of smartphone apps can track clinical information like heart rate and blood pressure. Integrating such information is key to creating a useful personal health record. Medically orientated apps have a variety of uses, including medication compliance, mobile and home monitoring, home care, managing conditions, and wellness and fitness. In 2012, in response to a challenge to find the best new ideas and existing smart phone apps that could help people and doctors manage care, the Department received nearly 500 entries, as well as 12,600 votes and comments in the competition to identify apps with huge potential to benefit patients and the NHS. Some of the most popular ideas included helping patients to manage long-term conditions, deal with post-traumatic stress and monitor blood pressure. One app could also help patients identify their local NHS services on a map. Patients Know Best, an app that has proved to be particularly successful in a number of hospitals as well as with GPs and community nurses, allows each patient to get all their records from all their clinicians and controls who gets access to them. The app means that patients can have online consultations with any member of their clinical team and develop a personalised care plan.¹¹¹

Traditionally, access to information on healthcare has been controlled by NHS providers. Increased access to information about primary care providers, hospitals and alternative services is giving consumers the ability to compare and contrast data relevant to their healthcare experience. With new interactive websites and health apps being created almost daily, many more people are using social media to rate their experience in a way that is accessible to families and friends. This interface is more meaningful to patients and easier to navigate than official data on websites, and people's views regarding what is important often differs from the clinician or management view.¹¹²

An expansion in the ways that patients and the public access information is changing expectations regarding the value of services.¹¹³ That has significant implications for primary care, as it abolishes the asymmetry in access to information which has been a feature of the medical model of care. Service users are less likely to consult their GP as passive recipients, and are more likely to have sought information themselves and be armed with a greater granularity of information than the GP might immediately have access to. This will have implications for the relationship between patient and provider and lead to the GP being more of an interpreter/navigator of information, options and scenarios.¹¹⁴

Innovative use of medical technology can support primary care to work differently

Reductions in the size, complexity and price of various types of medical equipment means that care can now be provided in people's homes which previously could only be accessed in a secondary care setting. Yet in a number of areas the healthcare system is still resistant to the adoption of new technology; for example practitioners may be reluctant to offer patients home monitoring equipment because of concern they won't be able to use it.¹¹⁵

The Department's Innovation Health and Wellbeing Strategy has emphasised that the adoption and diffusion of innovation must become a core business for the NHS. It refers to the Atlas of Variation, demonstrating unacceptably wide variation in the numbers of people receiving best practice care; with, for example, a 48 per cent variance in the number of people receiving best practice care for diabetes. It also highlights a number of examples where diffusion of innovation generated measurable benefits:

- Manchester Royal Infirmary redesigned dialysis provision to enable patients to choose home haemodialysis. Over 15 per cent of their patients now perform haemodialysis independently at home compared to the current UK average rate of 1-2 per cent. Projected annual savings at Manchester are approximately £1 million. Home dialysis has changed patients' lives, enabling them to spend more time with their families.



- An NHS team in Cambridge developed the 'Cytosponge', a simple pill that expands into a sponge designed to collect samples from the oesophagus to test for throat cancer. The procedure can be used by GPs at a cost of £25, replacing the need for a £600 endoscopy, and offers early identification and therefore better outcomes with a potential increase of 80 per cent in five-year survival rates for the 6,000 throat cancer cases each year.¹¹⁶

Overcoming GP reluctance in adopting innovation is central to the ambition of delivering more care closer to home. If the adoption of new technology is well planned and executed, it has the potential to transform the lives of staff and patients.

Financial incentives: New pay for performance arrangements

Currently most of the incentives used in primary care are financial, and are negotiated and agreed as part of GP contract negotiations. That includes QOF and enhanced services (Figure 11).

Figure 11. Enhanced Services that GPs can choose whether to provide¹¹⁷

Directed Enhanced Services: PCTs are obliged to achieve coverage of these services for their patients, though no individual practice is obliged to participate. Standards and prices are set nationally. They include Government priorities such as the development of patient access and extended hours access but also basic and universally needed services such as child immunisation. GP practices can choose whether or not to provide such services and the list of directed services is revised annually.

National Enhanced Services: PCTs can choose to commission these services, according to local needs, but in line with nationally set standards and prices. They include commonly needed services such as minor injury treatment.

Local Enhanced Services: PCTs have the freedom to design, negotiate and commission any other services they believe are needed in their area. Examples could include services for drug and alcohol abuse, the homeless or people with learning difficulties. In some cases the National Enhanced Service standards are used with adjustments to meet local needs, but otherwise standards and prices are negotiated locally. However, in the first few years of the contract local commissioners did not use Local Enhanced Services as widely as originally expected, initially because of the high cost of the core contracts but also because they consider that they give them relatively little leverage.

The introduction of contracts that allowed GPs to decide which services to provide and which to opt out of, other than those deemed as essential, eroded the monopoly that previously existed within primary care. If a local GP was not prepared to provide enhanced services then the PCT was free to commission the services from another provider. This has helped achieve one of the aims of the contract which was to incentivise those GPs that wanted to provide new services and for PCTs to be able to commission services based on local need.¹¹⁸

While there is likely to be less scope for offering financial incentives in the future, due to tighter funding and a desire to control public-sector pay deals, the decision to give CCGs responsibility for the commissioning budget may change the incentives available. The expectation is that making practices accountable for the financial consequences of their clinical decisions may also create a greater incentive to drive improvement and challenge poor practice.¹¹⁹

As noted in Part 1, the main pay-for-performance incentive has been the QOF. While the scheme is voluntary, some 99.8 per cent of practices take part.¹²⁰ The QOF was designed by a group of academic and health experts, and most initial indicators were based on clinical evidence that an input or intervention leads to improved health outcomes. The disease areas were chosen on the basis of high prevalence or significance in terms of their impact. The final form of the framework was subject to negotiation (and remains a subject of annual renegotiation) between the BMA and NHS Employers drawing on expert analysis.

Under the QOF, practices are awarded points for delivering services based on best available evidence of effectiveness. The more points a practice receives, the higher the payment.¹²¹ There are a maximum of 1,000 points available across four domains.



Practice payments are calculated on points achieved and prevalence of disease. The four domains, which between them have 134 indicators, are:

- Clinical – with a number of indicators across different clinical areas, such as coronary heart disease, heart failure, hypertension, dementia and stroke.
- Organisational – with indicators across the five areas of records and information, information for patients, education and training, practice management, medicines management and quality and productivity. It requires practices to hold policy information and have processes in place that actively demonstrate sound practice and understanding in the practice team.
- Patient experience – an indicator of the length of patient consultations.
- Additional services – a number of indicators across the four service areas of cervical screening, child health surveillance, maternity services and contraceptive services.

From the outset there was a significant overspend under the framework, with practices scoring much higher than the Department had predicted, for example in 2004-05 the average practice score was 91 per cent, compared with an estimate of 75 per cent.¹²² By 2010-11 the average score was 94.7 per cent, with a range of 89.2 to 98.2 per cent.¹²³

GPs have also been able to achieve full payment without covering the entire practice population. Furthermore, until 2009 payments were scaled in such a way that areas with high disease prevalence, often concentrated in areas of high deprivation, received less remuneration per patient than those with low prevalence, and payments did not reflect the full level of illness in the practice population.¹²⁴

Since 2004, there have been incremental changes to QOF with regard to the number of points allocated to each indicator and to the indicators themselves. In 2009, however, the QOF underwent a more fundamental change, with the National Institute for Health and Clinical Excellence (NICE) taking over responsibility for developing the menu of indicators. The final decision on content remains a matter for negotiation between the BMA and NHS Employers. In 2009, the distribution of points was also changed to ensure that QOF focused more on measuring outcomes, such as the health of patients, rather than processes, such as the management of the practice.¹²⁵ Reviews of pay-for-performance emphasise that there is no magic bullet for quality improvement, and that initiatives that produce long-term change are usually multiple and multi-layered.¹²⁶

The King's Fund inquiry into the quality of general practice noted that general practice has had an increasing focus on quality improvement in recent years, greater availability and sharing of data and information, and various forms of peer review of practice as a result of organisational changes, such as practice-based commissioning and new federated models of working. General practices are also making greater use of evidence-based clinical guidelines and decision-support aids (such as the Map of Medicine).

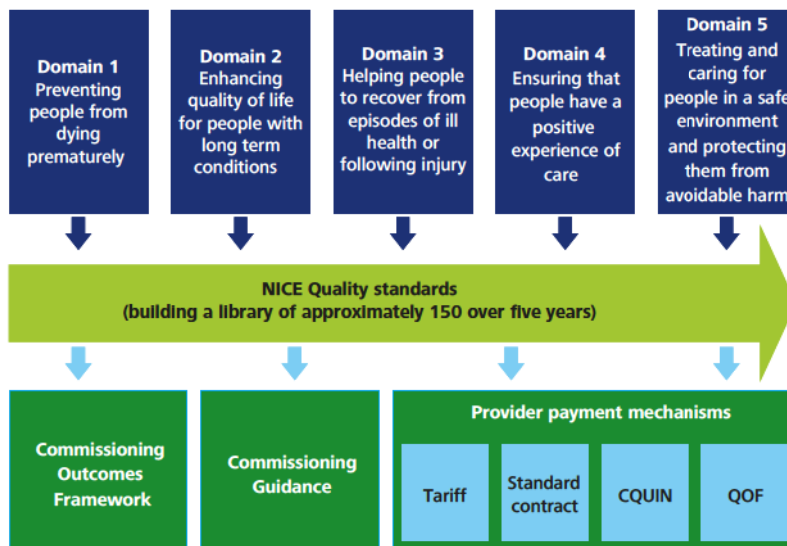
The implementation of the QOF has shown that general practice is prepared to change the nature of the care it provides in order to meet quality targets – for example, by making good use of practice nurses, investing in information technology, and employing 'QOF leads'. Furthermore, that there was evidence to suggest that the QOF had led to changes in the behaviours of GPs to improve the quality of care for a number of important medical conditions. It also highlighted research evidence that criticised QOF for skewing the focus of attention, with poorer performance on non-incentivised areas of care and the risk that performance management of particular measures risks creating tunnel vision and crowding out improvements in other areas of care.¹²⁷

In future, the NHS Commissioning Board will contract with GP practices. The content of these contracts (performance requirements and associated sanctions) are still being determined, as is the performance management regime. Recent government plans suggest there will be only one form of contract, but not until 2015. From April 2013 however, a proportion of practice income will be in the form of a 'quality premium' linked to the outcomes achieved by practices operating as part of a commissioning group. The measures used in the national contract will align to the five domains of the Outcomes Framework for 2012-13, which involves 150 NICE quality standards against which CCGs and practices will be held to account (Figure 12).¹²⁸ There is an opportunity in setting the new system to ensure that practices are given incentives to achieve a wider set of quality (process and outcome) measures, which also reward improvement.

Alternative models of incentivising and funding primary care are also being piloted, including individual patient and pooled budgets, which build on developments in social care. These have the potential to encourage general practice to work differently, rewarding integrated care and supporting some of the models discussed above.

Personal health budgets require major cultural and organisational changes for services, professionals and patients. Care plans which set out the person's health needs, the amount of money available to meet those needs and how this money will be spent are central to the implementation. A pilot programme was launched in 2009, and an evaluation in autumn 2011, based on interviews with 58 budget holders, was largely positive. The main findings were that information has a key role; and those eligible for NHS Continuing Healthcare tended to find the process easier, and reported benefits earlier. Detailed work is underway to explore a number of issues and to develop examples of good practice in order to roll out personal health budgets for the NHS from autumn 2012.¹²⁹

Figure 12. NHS Quality Improvement System



Source: Life Sciences Innovation Team: Review of the Department's Outcomes Framework 2012-13

Personal health budgets require major cultural and organisational changes for services, professionals and patients.

Part 4. Working differently

As discussed in part 3, new ways of working, including more effective use of technology and self-care models, offer solutions that can help bridge the gap between increased demand for primary care and growing constraints on capacity and capability. However, commissioners and providers have a number of regulatory and other requirements to address if primary care, and in particular general practice, is to be more effective, see Figure 13.

Figure 13. Requirements that will need to be addressed while 'working differently'



Patient surveys provide independent assessment of patient views

Since 2008, Ipsos MORI has run the national GP Patient Survey on behalf of the Department. This is an important and differentiating external evaluation which provides insights into quality of performance. It is a postal survey which each year gives over five million, randomly selected registered patients a direct say over the rewards given to practices in relation to their provision of quick and convenient access to GPs and other areas of importance to general practice. Results are published on a rolling four quarters basis alongside a full year's summary of patient experience. The survey also provides commissioners and other commentators with independent information on perceived performance.

The Department has indicated that the NHS Commissioning Board is likely to continue with some form of primary care patient survey given the increased emphasis given to patient experience in the new Health and Social Care Act.

Accelerating Solutions: Issues to be addressed to work differently

With the Health Act now law, the Department of Health and NHS Commissioning Board are in the process of clarifying systems and processes for contracting and holding practices to account. In the meantime, the NHS Outcomes Framework 2012-13, sets out the high-level national outcomes that the NHS should be aiming to improve (see Figure 12). It is structured around five domains with 35 indicators and builds on the definition of quality in the NHS Next Stage Review. The NHS Outcomes Framework is to be used to hold the Board to account as part of the broader Mandate that the Secretary of State for Health will set the NHS Commissioning Board. In turn, the Board is intending to draw on the national outcome measures set out in the NHS Outcomes Framework to develop a new Commissioning Outcomes Framework to help hold CCGs to account for effective commissioning and to promote improvements in quality and outcomes that they are achieving for their local populations.¹³²

General practice providers have a role to play in delivering on the five domains, and will need to consider how to best respond to those requirements. Figure 14 illustrates how the solutions in Part 3 of this report could help general practices deliver on these outcomes.

Figure 14. Applying solutions to the requirements in the NHS Outcomes Framework

Outcomes Framework: Five domains	Examples of solutions and tools from Part 3 that can help deliver improved outcomes
Preventing people from dying prematurely	New access models, shared decision-making, self-management, telemedicine, use of technology, primary prevention/public health work.
Enhancing quality of life for people with long-term conditions	Telephone triage, integrated care model, customer service model, telemedicine, use of access and monitoring technology, integrated pathway hubs, GP as generalist and care navigator, pharmacist-led care, group visits, mobile communication devices, smart phone apps.
Helping people to recover from episodes of ill health or following injury (while more likely hospital-based, initially still a role for GPs)	Integrated care, telemedicine, innovative technology, group visits.
Ensuring people have a positive experience of care	Telephone triage, customer service model, new access models, using more complex nursing skill mix, productive general practice, GP as care navigator.
Treating and caring for people in a safe environment, and protecting them from avoidable harm	New access models, using more complex nursing skill mix, productive general practice, pharmacist-led care, primary care home, telemedicine.

Actions for stakeholders

The NHS Commissioning Board should provide support and guidance to help GPs address challenges and implement solutions

In order to develop effective relationships with general practice, the Board needs to demonstrate in drafting the new contract that it understands the challenges in Part 2, it should also provide clarity as to the extent to which financial and other support is available to help general practices tackle the challenges in a cost effective way, including incentives that encourage the adoption of good practice.

General practices should make more effective use of registered list information

General practices are in a unique position to make more effective use of patient list information in planning and delivering effective patient-centred care. They should also consider the information provided in this report, including the challenges in Part 2 and the solutions in Part 3, to identify how they might best meet the needs of individual practice populations.

A key issue for practices is the need to develop models of patient and public engagement for their registered list of patients, and also those who for various reasons may not be on the list. Given the growing expectation that all providers will become more patient-focused in the delivery of care, general practices are in a prime position to lead on this by supporting consumer engagement and continuing to seek feedback from patients, and by acting on that feedback.

Health technology companies and the pharmaceutical industry have a role to play

The solutions in Part 3 illustrate the importance of technology in the future delivery of GP services. The use of technology for communication between providers and patients has the potential to deliver a measurable impact on patient outcomes. Technology can also be instrumental in supporting management and monitoring patient conditions. In order to encourage technology companies to develop tools, there needs to be clarity as to the willingness of general practice to make greater use of them. The Department of Health has signalled its support in its Innovation Health and Wealth strategy and associated documents. Technology companies need to work collaboratively with patients, general practices and CCGs to procure tools in a way that maximises their cost effectiveness.

Pharmaceutical companies need to re-evaluate the way they work with general practice

The information in Parts 2 and 3 should help companies develop a clearer view of the challenges and potential solutions facing general practice and should use this information to implement new approaches to the monitoring and use of pharmaceuticals. Pharmaceutical companies are well placed to help general practices work differently, including improving prescribing and supporting better adherence with drug regimes, as well as providing real world evidence on quality and safety. The introduction of Value Based Pricing will be relevant to this, and over the coming months we will examine this issue and report separately on our findings.

One approach that should be considered is for commissioners to work with industry to identify new ways of risk sharing in order to support the adoption of solutions.

Closing thoughts

Now that there is more clarity as to what the reforms mean for general practice in England, the capacity and capability of the general practice workforce will come under increasing pressure. The requirements of the reforms, even with careful implementation, are likely to add to this pressure.

The challenge to 'work differently' will be compounded by the need for general practices to develop a new mindset as they move from a system based on fee for service and QOF to one that requires a strategic approach to improving health, moving from the GPs' focus on individuals to a focus on population health, and changing the individual small business ethos of practices to one of a collaborative network of integrated service providers. The key to improving the delivery side of general practice is the development of the practice team, which will need to be underpinned by a robust Human Resources infrastructure.

Unless practices adopt more effective ways of working, the fallback position may well be to simply increase the number of GPs and nurses. However, this solution is fraught with its own challenges, not only with regard to training and recruiting sufficient numbers but also the impact on the cost of general practice. There are potential alternatives, many of which are provided in this report, and our hope is that GPs as providers and commissioners embrace the proposition on working differently and adopt some or all of the suggestions contained herein.

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Acronyms

A&E	accident and emergency
APMS	Alternative Provider Medical Services
BMA	British Medical Association
CCG	clinical commissioning group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
FTE	full-time equivalent
GMC	General Medical Council
GP	general practitioner
GPMS	General Personal Medical Services
HC	headcount
LIFT	Local Improvement Finance Trust
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NMC	National Midwifery Council
ONS	Office for National Statistics
PCT	primary care trust
PCTMS	Primary Care Trust Medical Services
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners

Contacts

Authors

Karen Taylor

Director

Deloitte Centre for Health Solutions

kartaylor@deloitte.co.uk

+44 (0) 20 7007 3680

Rebecca George

Public Sector Health Lead Partner

regeorge@deloitte.co.uk

+44 (0) 20 7303 6549

Simon Hammett

EMEA Healthcare and Life Sciences Lead Partner

shammett@deloitte.co.uk

+44 (0) 20 7303 6402

Contributors

Karen Young

Senior Manager

Deloitte Centre for Health Solutions

karyoung@deloitte.co.uk

+44 (0) 20 7007 9457

Heather Naylor

Analyst

Deloitte Centre for Health Solutions

henaylor@deloitte.co.uk

+44 (0) 20 7303 3533

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Contact information

To learn more about the Deloitte UK Centre for Health Solutions, its projects and events, please visit:

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Deloitte Centre for Health Solutions

Stonecutter Court 01/09

1 Stonecutter Street

London EC4A 4TR

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ESP IT Consultancy Ltd

We are a very small company based in Hampshire. Our work falls under digital communication, interoperability and evidenced based communication. In 2006 I completed a feasibility study about GP emergency referrals and identified a gap in the market for an IT System that would support patient who are in transition of care from primary care to secondary care. As part of the feasibility study I interviewed a GP. One of my questions was about change. The GP response was that GPs will not change until they are told to do so. This is an interesting time now that GPs are in the driving seat.

As a healthcare professional I found that communication across sectors is one of the most challenging areas. To keep patients, GPs, clinicians etc informed about patient care and movement is very difficult. Patient notes at hospital are all paper-base, this is a big problem as until they become digitalised it cannot be shared. The community and private organisations within the community, all have paper-based documentation, again this is limiting. GP Systems are restricted by the big IT suppliers. Our healthcare community need to think more laterally about the patient to create more suited services for patients.

GP services are businesses. My experience is that most GPs will work in the best interest of the patients, but they work with limitations and within their capacity.

We have developed a whole system demonstrator and have been testing the market with our proposed solutions to key people in local organisations to get a feel of the need and how our solutions will be perceived. Organisations includes patient groups, South Central Ambulance Service NHS 111, Housing in Southampton city, University Hospitals Southampton and Portsmouth Hospitals. These demonstrations has been positive, but we have been unable to engage with the Clinical Commissioning Group (CCG) and we are waiting for the Academic Health Sciences Network AHSN to come into play.

Our work is based on organisations working collaboratively. We still need to be able to interface with other existing IT systems suppliers and have been engaging with the GP System of Choice (GPSoC) and the Royal College of GP.

Please have a look at our website www.esp-it-consultancy.com.

I attach a brief presentation about us and our work. We would love to hear from you with your thoughts.

[Presentation appears below]

ETPIER™ Application Suite

Zabeda Ali-Fogarty
Managing Director
Revision 0v2
4th October 2013




Working with you to nurture growth

Objective

- Emergency referral
 - Scenario of emergency referral
 - Problems with emergency referrals
 - Understanding the root cause of these problems
- ETPIER[®] application suite

Emergency Referrals

Urgent care

Introduction

- An emergency referral is when a patient presents themselves to a General Practitioner (GP) showing signs and symptoms that require urgent medical intervention in another acute care setting
- The GP refers the patient on to the other acute care setting on their care pathway
- The patient receives treatment immediately in the other acute care setting

Scenario – Emergency Referral

- Patient goes to GP surgery with acute symptoms
- GP starts process to make emergency referral of the patient to an acute care setting
- The GP has a dialogue with a hospital Consultant if the patient is to be referred
- Patient travels to hospital with the referral information
- Patient presents themselves on to the ward
- Patient is given treatment
- Patient is discharged back in to community

Problems with this Scenario

- GP gives **referral information on paper** to the patient. This paper can be misplaced or lost by the patient.
- Staff receive the patient and there is **no record** of GP discussion with hospital Consultant
- Hospital staff have difficulty in reading the GP's letter properly due to **poor quality of information**
- Hospital staff have to **restart** information gathering with the patient
- **Duplication** of investigation
- **Delay** with medical treatment
- Medical treatment with **errors**
- Continuity of care **not followed through**

Long Terms Problems

- Hospital readmission
- Delayed hospital stay
- More visits to GP and community care
- No transparency in care
- Reduced accountability
- Extra cost
- Negative publicity

Root Causes

- No standard data set for emergency referrals
- No current IT system that supports the process of emergency referrals across sectors
 - At present there are only standalone systems serving either the community or the hospital
- Continuity of care is not carried through between the different sectors
- The correct information is not being shared at the right time with the right people

Feasibility Study on Emergency Referrals

- Understand the users and patients needs
- Understand the processes in different care settings
- Understand IT systems
- Understand data sets

Benefits of a Communication System for Emergency Referrals

- Quality
 - Save lives
 - Errors reduced
 - Transparency of care between sectors
 - Improved experience for patients
- Time
 - Enables faster treatment
 - Time saving – “a variable amount of time is spent finding information”
- Cost
 - Reduced stay in hospital
 - Reduced readmissions
 - Reduced doctor’s appointments

ETPIER™ Application Suite

Information sharing across sectors

ETPIER™ Application Suite

- Based on the research from a feasibility study and market research
- Applications
 - Emergency referrals
 - Community Nurse referrals
- Messaging platform
- Web based cloud managed services which can be accessed from any browser enabled device
- Secure end-to-end encryption with instant notification using pagers, text and e-mail

ETPIER™ Benefits

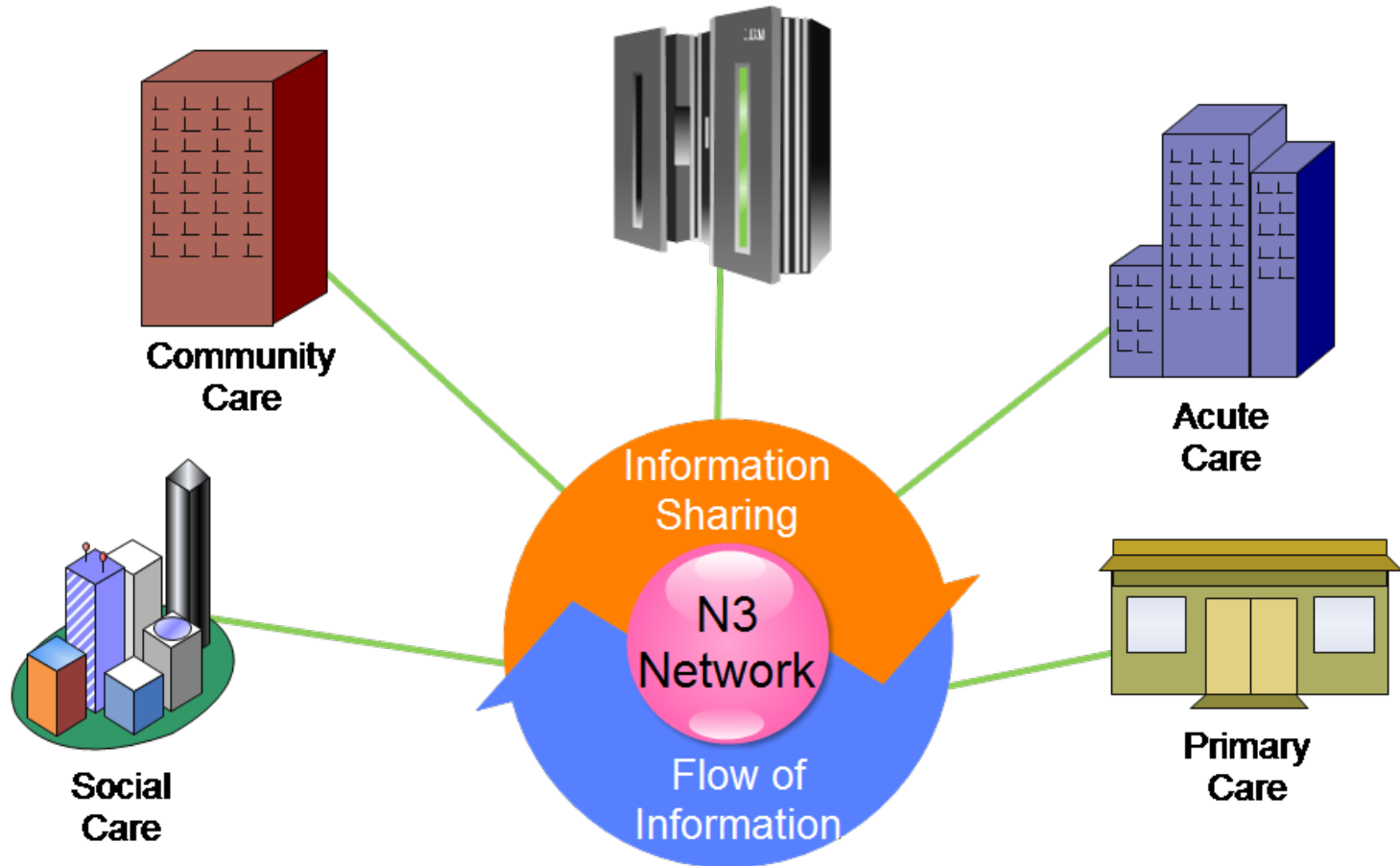
- Increase resource utilisation by ensuring correct real time information when its needed
- Reduce the time patients and staff use by providing access 24/7 to services
- Reduce the cost/time involved in searching/phoning/waiting for information by providing a single point of access
- Reduce investment costs by providing a monthly managed and monthly cost structure
- Enhance the patient experience by seamlessly linking services together
- Improve decision making by providing real-time information and trend analysis at any time
- Increase capacity to deliver more services by removing barriers to enhance performance

ETPIER™ Referral Services

- Emergency Referral
- Community Nurse Referral
 - Nursing assessment form
- Benefits
 - Simple and easy to use interface
 - No duplication of effort
 - Interoperability with the originating and receiving electronic patient record systems
 - Accessible from anywhere
 - Complete audit trail

ETPIER™ Topology

ETPIER™ Application Suite



Thank you

E-mail questions to:

zabeda@esp-it-consultancy.com

London Borough of Hackney
Area K, 2nd Floor
Hackney Service Centre
1 Hillman St
London, E8 1DY

31 July 2013

GP Services Call for Evidence
Monitor
133-155 Waterloo Rd
London SE1 8UG

Dear Sir/Madam

Health in Hackney Scrutiny Commission's review on 'Improving GP appointment systems'

Further to your call for evidence on *GP services sector in England* I am writing to let you know about the recent work of Health in Hackney Scrutiny Commission in this regard.

Health in Hackney Scrutiny Commission is one of five themed commissions in Hackney Council and comprises 8 councillors. We are cross party and carry out scrutiny reviews on issues of concern to local residents and also hold all the local health trusts to account.

The issue of access to GPs has come up frequently in our various reviews with the result that we've decided to carry out a short review on the specific issue of 'Improving GP appointment systems'. You can find the [Terms of Reference](#) here.

The key issue seems to be an increase in demand for appointments not being met with any increase in capacity with the result that many patients resort to A&E services or many from BME communities will go back to their home country for treatments.

Unfortunately our timetable does not align well with yours. We are devoting our 2 September 2013 Commission meeting in full to the issue and we aim to complete our review in Oct-Nov after having completed some site visits. We would be please to send our report after it has been agreed by the Commission on 13 November.

Some of the key issues we've encountered here are:

- a) Our review on [Increasing cancer survival](#) highlighted the fact that the crucial role of GPs in early diagnosis of cancer is being hampered in

Overview & Scrutiny

some practices by cultural and language barriers as well as general problems of poor communication between doctors and patients. Social Action for Health, a local third sector organisation, has carried out some major primary research in Hackney and we visited a focus group they were running with the Turkish/Kurdish community where these barriers were made apparent to us. This briefing note summarises the findings [Note on focus group with Turkish-Kurdish community on barriers to accessing GPs](#). Social Action for Health's initial report on this was entitled '*Cancer and early diagnosis: a dynamic situation in East London*' which was part of a larger national project "General practitioner – patient communications: cancer and early diagnosis".

- b) Our cancer scrutiny review also revealed how our then PCT had encountered problems when attempting to get a few local practices to take up an offer of support and training when a local study revealed wide discrepancies between practices in conversion rates for cancer diagnoses. While we acknowledge that this is a complex area and identifying cancer symptoms early on is a huge challenge for GPs, we continue to be concerned that there appears to be very few levers which the PCT and its successor the CCG can pull here. This is an issue we have raised with NHS England representatives when they have attended our meetings. While our local LPC Chair is a frequent attendee at our meetings and our relations are constructive, there is a broader issue around how the performance of GP practices locally can be held to account. There is no requirement on them to engage of course and while peer pressure within the local GP community can have some effect in driving up performance, surely this is not sufficient in itself.
- c) Our review on [Support services for chronic alcoholism](#) also uncovered problems in how the patient referral loop back to GPs from the specialist services could be improved in the treatment of chronic alcoholics. The result is that very vulnerable individuals can often fall out of the system.
- d) The barriers to engagement by certain groups such as older men or BME males remains an issue for public health services locally and we are of the view that GP services need to do more to make themselves more accessible. Appointment systems which for example require people to call back every morning at 8am for an appointment won't work for these cohorts. At the other end of the scale, younger residents find GP appointment systems totally unwieldy because of their inability to embrace online appointments, text messaging and use of web solutions such as Apps to improve access.
- e) At our recent meeting we discussed with the local LMC Chair and a representative of NHS England the use of 0844 numbers by certain GP practices. While we are pleased that these are now gradually being phased out, as these contracts come to an end, it remains an area of concern that they were allowed in the first place. 0844 numbers

Overview & Scrutiny

discriminate against low income households, which don't have BT landlines and are increasingly mobile only and indeed pay-as-you-go only households. These low income residents were being charged exorbitant rates just to access their GPs on busy lines where they would often have to remain on hold for long periods.

Finally, our local HealthWatch Hackney organisation and its predecessor Hackney LINK has been collecting local data for some time on concerns about GP Appointment Systems and we will be considering this at our September meeting. We and I am sure they would be happy to share this local data with you.

Should a member of your review team wish to attend our 2 September meeting they would be most welcome, however we will send you a copy of our report when it is completed.

If so please contact the support officer for the Commission: Jarlath O'Connell on 020 8356 3309 or jarlath.oconnell@hackney.gov.uk

Yours faithfully



Councillor Luke Akehurst
Chair of Health in Hackney Scrutiny Commission

David Holland

Operations Lead/Senior Analyst, Keele University Benchmarking Service

I've been made aware of your call for evidence for GP services in England, and believe I can contribute to this. I have undertaken an exercise which has taken patient level test results from four hospital LIMS systems (so far!) for HbA1c, and used the results to calculate the optimum re-test interval based on maximum benefit to the patient. It then analyses the data at a practice-by-practice level to show how many tests are under and over-requested, and can generate forecasts/scenarios based on these data to show predicted volumes of tests, cost savings and impact on patient outcomes if the inappropriately requested tests are done on time.

The four different sets of data showed very similar (near identical) patterns, and so I have up-scaled the data to show an indication of impact on volume, cost and outcome will look nationally simply by removing un-necessarily over-requested tests. This could lead to a reduction in workload of around 5%, saving approx. £1m (based on average test cost at time of investigation). The forecast also shows that the average HbA1c level of diabetes patients would then also drop from 7.12 to 6.97, which is particularly significant given that our current studies are using 7.00% as the cut-off point between well and poorly controlled HbA1c.

The data also analyses the impact of 'missed' tests and tests requested too late, which actually account for a greater volume than those requested too soon. In actual fact, if all un-necessarily over-requested tests were removed, but all the 'late' tests were done on time AND the missed tests added in, overall workload volume would in fact increase. It would also be anticipated that improving HbA1c outcomes would therefore lead to better patient care further down the care pathway, reducing hospital admissions and costs and leading to better management of diabetes. I would be happy to forward any documents as necessary from my research to support these views if you think they would be helpful.

I have also been working in collaboration with Professor Tony Fryer (amongst others) in publication of work around demand management, again particularly around appropriate use of HbA1c testing for treatment of diabetes. I'm sure he's probably already aware of the call for evidence, but will forward it on to him just to be sure, as he may also want to contribute.

Leeds City Council’s response to the current Monitor call for evidence on “aspects of the provision and commissioning of GP services which may not be working in the best interests of patients”

Introduction

This is Leeds City Council’s officer response to the recent Monitor Call for Evidence on “aspects of the provision and commissioning of GP services which may not be working in the best interests of patients”. The response is framed around issues from the local authority perspective, and although is not written in such a way that there is a separate response to individual questions, our evidence will particularly relate to:

- the ability of patients to access GP services, including their ability to switch practices
- any new forms of primary care or integrated care that local health communities are planning or considering and any potential enablers or barriers that need to be considered.

We are aware that the Leeds CCGs have submitted individual responses. These have been collated by CCG colleagues into one set of evidence for inclusion in this local authority response, where appropriate. We also note that commissioning of GP services is now the responsibility of NHS England Area Teams.

Health and Wellbeing in Leeds

The Leeds Health and Wellbeing Board has recently signed off its Joint Health and Wellbeing Strategy, which has 5 outcomes, 15 priorities and 22 indicators – supporting our vision that Leeds will be a healthy and caring city for all ages. Our three CCGs are fully signed up to the Strategy, and its cross-cutting principle that “people who are the poorest, will improve their health the fastest”. The Leeds response is structured round the outcomes, priorities and principles of our strategy.

Section 1: “Ensure that people have equitable access to services”

The Leeds CCG combined evidence on patient experience tells us that access to primary care in Leeds is generally good, which is reflected in patient surveys. None of the city’s GP practices currently have closed lists making it easy for patients to register with a GP.

The Leeds JSNA provides evidence of how groups with protected characteristics do not always have equitable access to GP services and what steps can be taken to realise more equitable access.

People with Learning Difficulties

The health care of people with learning disabilities continues to be a significant issue. National reports such as ‘Healthcare for All’ (2009) have highlighted the barriers that people with learning

disabilities face in accessing health services and receiving equitable treatment. Within Leeds, this situation is being addressed through a range of initiatives within the city. For example, the implementation of the Directed Enhanced Service Guidance (DES) has resulted in an annual increase in people receiving NHS Health Checks through general practices.

Recommendations from JSNA: “The improvements in health services need to be developed further. We need to improve engagement with all stakeholder groups, particularly in service planning and provision. The good work in improving access needs to continue. There remains a concern, however, that NHS Health Checks for those with the most complex needs may not be as comprehensive as they should be.”

Refugees and Asylum seekers

All migrants can face barriers to accessing appropriate primary care, stemming from communication problems, social isolation and economic hardship. Restricted access to primary care has shown an increase of non-urgent presentations in local A&E departments from both EU and non-EU migrants since 2008.

Recommendations from JSNA: The 2008 Migrant Health Report makes the following recommendations for action, which are still largely valid:

- Make better use of available data and improve current data collection systems e.g. commonly produce NHS activity statistics broken down by ethnic group.
- devising and implementing a plan to increase GP registration by migrant workers
- more training within NHS organisations on issues surrounding asylum seekers, refugees and other migrants.
- NHS commissioning organisations should review commissioned services for adequacy in relation to issues affecting migrants. “

Gypsies and travellers

In 2004 the University of Sheffield undertook a comprehensive study for the DoH, which is the most robust research currently available. A key finding was that poor access to, and uptake of, health services is a major factor in Gypsy and Traveller health. Many Travellers do not access health services because of complex – to them - procedures for registering and accessing services. The National Association of Traveller Health workers (NAHWT) suggest that: 'The most common problem for Travellers is difficulty in accessing primary care through GPs because of their (the GP's) insistence in having a permanent address'.

In June 2013, Leeds published a Health Needs Assessment for the Gypsy and Traveller Community. Data was collected from a total of 71 Gypsy Travellers in Leeds. 92% of respondents to the Leeds HNA were registered with a GP and 80% said all the people living with them were also registered. The 8% who were not registered were men. 40% of those registered said they had been invited for an NHS Health Check and 68% of those who had been invited had attended. 25% of those who were currently registered with a GP had to travel more than 3 miles to the practice. Although it is encouraging to see relatively good levels of registration, this was still identified in discussion as often problematic with specific practices. Additionally, Gypsies and Travellers who are 'roadside' reported finding it much harder to get an appointment with any GP as per the 2004 Sheffield findings - previously if you were travelling you could register as a temporary patient, but this is

either not possible now, or the reception staff actively discourage it. Generally respondents were positive about their last experience of using a GP and in terms of services people said were bad, they were not necessarily bad in terms of provision, but in terms of overall accessibility and whether people felt they were treated with respect.

Cross-cutting issues re. access:

Transport: Reported as an issue for people with learning difficulties, older people, refugees and asylum seekers, Gypsies and Travellers (here in Leeds, sites are not in proximity to GP practices – some people may need to take several buses or travel over 3 miles to their nearest practice) within the Leeds evidence base. Nationally, the evidence suggests that lack of access to transport is experienced disproportionately by women, children and disabled people, people from minority ethnic groups, older people and people with low socio-economic status.

Health Impact Assessment guidance nationally tells us that in planning and commissioning any services, it is essential that access is improved and that health inequalities reduce, not widen, by:

- ensuring access implications of siting of community services and facilities for all communities is understood
- improving public transport provision to community health facilities and hospitals for disadvantaged communities that have poor public transport access
- improving transport provision for people with special transport needs
- improving opportunities for active travel by allowing access through walking or cycling

Given physical access is an issue for many groups, planning and commissioning innovative services and support, e.g. making more use of TeleHealth could be explored. Social media and web-based facilities could also be an innovative option. However, there is a need to be mindful of potential negative impacts on socially excluded groups through the 'digital divide'.

Section 2: “Increase the number of people that have more choice and control over their health and social care services”

As part of Leeds' commitment to integration of health and social care, over the past 18 months, feedback has been gathered from people accessing services and from carers about their experiences of health and social care services, in particular about how services support them to manage long-term conditions and work together with other health and social care services. Furthermore, in 2012 the Leeds LINK carried out a report on GPs which covered access.

Messages from both these significant work programmes provides the following evidence of instances of commissioning and provision not being in the best interest of patients:

- Need to have longer appointment slots – waiting times / not always presenting with one issue – need more time for discussion
- Consistency in appointment systems and limitations of booking – this can impact negatively on many vulnerable groups, e.g. carers
- The use of 0844 or 0845 numbers is looked into and the cost implications of this for patients and a local number are always made available to patients especially for mobile phone users.

- More flexibility and later surgery times need to be looked at as an option to address the needs of working people. More flexibility of access may also support work around the urgent care agenda.
- Choices and access: issues with patients balancing the wish to see the same doctor with whom they get on / understanding their condition against the need for an urgent appointment when preferred choice of GP is not available for several weeks.

The combined CCG evidence tells us that across Leeds, practices offer a combination of same day, open access and pre-bookable appointments. They also offer telephone appointments for those patients where it is appropriate and convenient. The majority of practices in Leeds also offer extended hours in primary care.

Currently, patients can change practices if they wish. We see little demand for this from patients. Anecdotally one or two cases have been raised in the past regarding practice boundaries and patients wishing to remain with a practice despite moving outside of the boundary.

Section 3: “Ensure people have a positive experience of their care”

Leeds has an excellent track record of integration for health and social care and we are taking a whole-systems approach to moving forward at scale and pace to ensure the highest quality of care possible for patients and carers in Leeds. The model for service delivery for adults is comprises integrated health and social care neighbourhood teams across the city who coordinate care and support around the needs of older people and those with long term conditions. Focused on clusters of GP practices and their registered populations, teams work together with primary care, using outputs from risk stratification to provide an opportunity for proactive input to prevent ill health and deterioration of health. Additionally, Leeds has dynamic primary care providers who recognise the fundamental changes that need to occur in the provision of their services in order to meet the needs of their patients, and there is an active debate about how this might happen.

In terms of our work on integration of health and social care services, local evidence suggests that estates and asset management as well as restrictions on how money is allocated, moved around and spent have arisen as barriers to ensuring services effectively meet patient need.

- Estates – co-location of staff from different organisations is critical to the development of integrated services. We have taken a pragmatic approach so far in Leeds, and used existing NHS, school and community estate to bring our neighbourhood teams together. However we know that, in some cases, this is not a sustainable solution and we need to take a new look at how we use our estates, supported by new technologies, to support integration.
- NHS and local authority procurement rules can be different – this does not always make it easy to develop, build and kit out co-located services which are essential to providing integration hubs.
- Planning of services based on understanding of population need and the evidence base – and commissioning of GP services at a regional level.
- Currently there are mechanisms through enhanced services for CCGs to commission work from primary care providers but this only allows for small scale changes. More fundamental change is needed if we are to meet the financial challenges of the future while maintaining safe, high quality services for patients.
- There is a lack of flexibility to move money around the system, particularly between health organisations and between health and the local authority

Section 4: “People will live in healthy and sustainable communities”

As a local authority, Leeds has responsibility for long-term strategic planning and housing growth. We recognise it is essential that access to quality healthcare services is considered at the very beginning of any development, and that the right conversations need to be had with the right people.

However, given the recent structural upheaval of the NHS, there is some confusion from a Local Authority perspective which NHS organisation has the responsibility for commissioning GP services. For example, CCGs have a statutory duty, and therefore an active role, to work with and support the area team to plan GP services, which is welcomed, but does not always offer clarity around who to approach. This lack of transparency can impact on our ability and effectiveness around ensuring access to health services is considered as an integral part of new housing developments.

As a major city with a growing population and a desire to be the Best City in the UK, we would welcome a move to a local Leeds commissioning responsibility rather than a regional / West Yorkshire geographic scope of responsibility.

References

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- Leeds Gypsy and Traveller HNA (2013)
- Making Leeds Better (2007)
- Leeds GP survey report (2012)
- Design principles for integrated health and social care in Leeds DRAFT (2013)
- Leeds' Expression of Interest to become an integrated Health and Social Care Pioneer (2013)

Dear Sir / Madam,

The Office of Fair Trading (OFT) welcomes Monitor's call for evidence on general practice services in England and the opportunity provided to comment on the workings of competition and choice in this crucial health sector.

Monitor's overall objective of making markets work for the benefit of patients is closely aligned with that of the OFT. Therefore, and as in Monitor's 'Fair Playing Field' review, we would welcome a close partnership between both organisations during the process of gathering and analysing information.¹ With that in mind, and given the range of concerns identified in the call for evidence, the OFT would like to use this (initial) submission to highlight the main relevant insights arising from OFT work on related issues, including in relation to specific health markets. In addition, the OFT would welcome the opportunity for further engagement, both during the preparation of the final issues statement (including, if appropriate, by contributing to more detailed research on specific issues), and on any related follow-up work or interventions.

In its drive to gain a better understanding of whether any characteristics of the commissioning and provision of GP services in England hinders patients accessing the best possible care, Monitor identifies a number of potential concerns. These closely relate to those highlighted in the OFT's work on commissioning in the public sector, in the OFT's work on specific health markets, and on issues of relevance to the working of competition and choice in public markets.²

More specifically, Monitor highlights in its call for evidence its particular interest in patients' ability to access GP services, including their ability to

¹ See OFT's response to Monitor's call for initial submissions on Fair and Level Playing Field, available at http://www.of.gov.uk/shared_of/public-markets/playing-field-response.pdf. This initial response was complemented by OFT engagement, including at senior level, in the run up to publication of the final report.

² See, for instance, OFT(1314), 'Commissioning and procurement in the public sector', available at www.of.gov.uk/shared_of/reports/comp_policy/OFT1314.pdf, and references below for other relevant OFT work on competition and choice in public markets, and on specific health markets.

switch practices. The relevance of switching as a driver of competition cannot be overestimated, as highlighted in a number of OFT sectoral and cross-sectoral studies.³ More specifically, the OFT's work on private healthcare highlighted that the ability of patients to drive efficiencies and stimulate enhanced competition can be severely hindered by information asymmetries and switching costs (which, in turn, might be related to potential delays in appointments and/or longer travelling distances).⁴ Furthermore, the OFT's market study on dentistry found evidence that, in the presence of information asymmetries, dissatisfied patients are deterred from looking for a new provider because they are concerned that switching could result in a change for the worse.⁵ These findings confirm the crucial role of information provision, as highlighted in the OFT's cross sectoral work on the role of consumer choice in public markets.⁶ In particular, the analysis of the current use and potential for further development of choice tools (facilitating the access to, assessment of, and action on information on providers) is especially relevant when assessing competition and choice in this sector.⁷

The call for evidence further identifies barriers to entry and/or expansion as an area of special interest, and refers to the potential impact of different types of contracts. In this context, it is worth noting that the relevance of adequate commissioning frameworks, ensuring an alignment of incentives between commissioners and providers, is highlighted in a range of OFT studies, including in relation to the impact of (some of the characteristics of) NHS

³ See, for instance, OFT(655) 'Switching Costs' , available at http://www.of.gov.uk/shared_of/reports/comp_policy/oft655.pdf, or 'The OFT's market studies' presentation at the 2008 Beesley lectures, available at http://www.of.gov.uk/shared_of/speeches/spe0908a.pdf. The relevance of switching is further highlighted by the fact that the EU Commission includes switching data as one of the variables in its Consumer Markets Scoreboard – see http://ec.europa.eu/consumers/consumer_research/cms_en.htm for further detail.

⁴ See OFT(1412), 'Private Healthcare market study' , available at http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf

⁵ See OFT(1414), 'Dentistry: an OFT market study', available at http://www.of.gov.uk/shared_of/market-studies/Dentistry/OFT1414.pdf

⁶ See, for instance, OFT(1214), 'Choice and Competition in Public Sector Markets', available at <http://www.of.gov.uk/713560/publications/reports/advocacy/oft1214>,

⁷ See OFT(1321), 'Empowering consumers of public services through choice tools' available at <http://www.of.gov.uk/713560/publications/reports/advocacy/oft1321>

contracts insulating dentistry practices from competition, hence hindering entry and expansion of NHS and private services.⁸ Therefore, while endorsing the focus on barriers to entry and expansion, including in relation to the development of new models of primary care by local health communities, we would encourage Monitor to expand this analysis to consider also the interaction between the provision of NHS and non-NHS services and the extent to which barriers to entry and/or expansion in one sector might be impacting the other. In doing so, Monitor will be able to build on and complement the work undertaken in 'A Fair Playing Field for the Benefit of NHS patients – Monitor's independent review for the Secretary of State for Health'⁹ while recognising the crucial role played by GPs as providers and point of access of a variety of healthcare services.

At a more general level, the OFT's experience in analysing markets can also provide useful insights in other issues identified by Monitor as meriting further consideration, including on economic agents' incentives and on consumer behaviour.¹⁰

While, as highlighted above, we generally endorse Monitor's focus on issues relating to barriers to entry, promoting genuine choice and ensuring the right incentives, we consider that it might be useful to consider the impact on competition and choice resulting not only from each specific factor, but also from the interaction between them.

We also note that the call for evidence does not refer to coordinated conduct. From our exploratory analysis of market dynamics in this sector, we consider that this issue merits further consideration, including through the gathering of

⁸ For a general discussion of the role of commissioning frameworks, see OFT(1214), *ibid*. The role of contracts in the dentistry sector is analysed in OFT(1414), *ibid*.

⁹ See 'A Fair Playing Field for the Benefit of NHS patients – Monitor's independent review for the Secretary of State for Health', available at <http://www.monitor-nhsft.gov.uk/sites/default/files/publications/The%20Fair%20Playing%20Field%20Review%20FINAL.pdf>

¹⁰ See, for instance, and PriceWaterhouseCoopers' report for the OFT on 'Understanding Commissioning behaviours', available at http://www.of.gov.uk/shared_of/reports/comp_policy/commissioning%2Bcompetition.pdf, and OFT(1224), 'What does Behavioural Economics Mean for Competition Policy', available at http://oft.gov.uk/shared_of/economic_research/oft1224.pdf

evidence on the extent and impact on competition of any agreements for information-sharing between GP practices (including in relation to tendering processes), on catchment areas and on 'no-poaching'.

In light of the above comments, and given the wide range of issues and scope for synergies between the work of Monitor and the OFT, we reiterate our offer for further engagement and look forward to the opportunity to contribute in detail to this important work.

If you have any questions or would like to discuss this further please do not hesitate to contact me.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'Carmen Suarez', written over a horizontal line.

Carmen Suarez

Assistant Director
Services, Infrastructure and Public Markets
Office of Fair Trading

Patient Access

You have asked for evidence concerning access to general practice for your review

<http://www.monitor.gov.uk/node/3902>

We work with a number of practices who have exceptionally good access (minutes to speak to a GP, always offered an appointment same day) but we are aware that in general access is highly variable. We also have the means of measuring access very precisely in terms of volumes and waiting times, even minutes, and the pattern of demand which can show evidence of a highly restricted service. Even if most appointments appear to be booked same day, if they are all booked within a few minutes of 8am this is because when they are all taken, there is nothing left for patients calling any later.

We have very large volumes of evidence on these matters, examples in the public domain here:

<http://www.patient-access.org.uk/case-studies/practices/>

What I'm not quite sure is how you intend to use this evidence and where it is going. One strange part of your question is the emphasis on ease of changing practice. We know that people can, and it's not difficult, but few bother to do so. We don't here patients saying "I wish it were easier to change my GP". We do hear patients saying all the time, "I trust my GP, just can't get an appointment." That, surely, should be your main question.

Written evidence from the Parliamentary and Health Service Ombudsman to the Monitor call for evidence on general practice services sector in England

Executive Summary

1. The Parliamentary and Health Service Ombudsman welcomes the opportunity to contribute to this call for evidence into the general practice services sector. One of our strategic aims is to enable public services, including those involved with the delivery of emergency services, to learn from complaints and use them to improve the service they provide to everyone.
2. In *Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2011-12* we expressed concern that some GPs were failing to handle even the most basic complaints correctly.¹
3. In this consultation response we detail evidence regarding the increasing number of complaint we receive concerning complaint handling and practices removing patients from lists, providing an illustrative example of a case involving threatened removal from a list.

Introduction

4. For the overwhelming majority of people, their experience of care in the NHS is very positive and greatly valued. But sometimes things go wrong. When this happens, how people and organisations deal with it determines whether the individual receives justice, whether the organisation learns a positive lesson from what went wrong and ultimately whether public trust and confidence in the service can be restored or maintained.
5. An effective complaints system is a core part of a well-designed and managed public service. When handled well, complaints make a difference. A good response to a complaint can ensure justice for the individual. Importantly, it can also ensure that learning takes place so that mistakes are not repeated and the quality of service improves for all. However, as detailed by the Francis Report², the reality is that too often complaints do not make the difference that they should.
6. To support the use of complaints in the improvement of public services, we investigate complaints that individuals have been treated unfairly or have

¹ <http://www.ombudsman.org.uk/listening-and-learning-2012>

² Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (<http://www.midstaffspublicinquiry.com/report> Accessed 22/05/13)

Written evidence from the Parliamentary and Health Service Ombudsman to the Monitor call for evidence on general practice services sector in England

received poor service from the NHS in England, Government departments and other public organisations, and from which the complainant has yet to receive a satisfactory response. If our investigations find significant or repeated mistakes, we share this information with service providers, professional regulators, Government departments and others involved in the delivery of public services to help them do their job. Most members of the public who bring their complaint to us, tell us that they are looking for three simple things:

- an explanation of what went wrong
- an apology
- an adequate remedy, with action to be taken so that other people do not have to experience the same poor service

7. But sadly, the public perception of complaining is so poor that research we commissioned in 2012 showed:

- the overwhelming majority (64%) of people who complain do not believe that their complaint will lead to any change
- 39% of those who want to complain about a public service do not make a complaint. Almost 60% of this group told us that their reason for not complaining was that they believed the complaints process would be complex, involve them having to chase a response and that they feared nothing would change as a result of their complaint

As a member of the public said to us, the complaints system '*has not been designed with the public in mind*'. This is a damning indictment of much of today's public service complaint handling. We owe it to those who have a complaint to change this and to ensure that complaints make a difference in the future.

8. A good complaints handling system is essential to ensure that patient choice and competition operates effectively. In regards to general practice, we have seen a significant increase in complaints regarding the handling of

Written evidence from the Parliamentary and Health Service Ombudsman to the Monitor call for evidence on general practice services sector in England

complaints, which have increased by 27% between 2011/12 and 2012/13.³ The most complained about issues regarding the handling of complaints are ‘no acknowledgement of mistakes’, ‘poor explanation’ and ‘inadequate apology’, which between 2011/12 and 2012/13 have increased respectively by 23%, 19% and 35%, demonstrating that some general practices are failing to get even the basic aspects of complaint handling right.

9. In regards to complaints concerning the service provided by general practice itself, one of the most important concerns we have received is unfair removal of patients from lists. In many of the complaints we receive best practice guidelines are not being followed, suggesting that more could be done to ensure best practice is shared and effective benchmarking is in place to support patients to receive the highest quality of care.

An illustrative example

10. The following case, recently published by the Ombudsman⁴, provides an illustrative example of the complaints we have received concerning removal of patients from lists.
11. Ms B’s son, Mr H (who was 23 at the time of the events complained about), has severe learning disabilities and behavioural problems. He also has epilepsy. Mr H has historically been prescribed a series of medicines that he takes in liquid or dissolvable form because he becomes very distressed if he has to take tablets. One of those medicines is midazolam, which is used in emergencies if his epileptic seizures last beyond three minutes.
12. Ms B attended the Practice in April 2011 for a repeat prescription of midazolam. However, she said that she was advised that she would need to see Dr L, a GP at the Practice, to discuss her son’s medication. Ms B attended an appointment with Dr L on 3 May and she said that he told her that the Practice would not prescribe midazolam for Mr H because it was too expensive.

³ Preliminary analysis of complaints as put to the Ombudsman concerning general practice

⁴ <http://www.ombudsman.org.uk/improving-public-service/reports-and-consultations/reports/health/report-by-the-health-service-ombudsman-for-england-of-an-investigation-into-a-complaint-made-by-ms-b>

Written evidence from the Parliamentary and Health Service Ombudsman to the Monitor call for evidence on general practice services sector in England

13. Ms B said that Dr L also told her that he would no longer prescribe any of Mr H's other medicines in liquid form for cost reasons and that he would only prescribe tablets in future. Ms B said that when she questioned Dr L about this, he told her to find a GP '*who has bigger budgets*' and who would '*be happy to prescribe the medications*'. Ms B said that this decision not to prescribe her son suitable medication put him at risk, including death.
14. Ms B subsequently complained to the Practice about Dr L's decision. As a result of this, Dr L wrote to inform her that there had been a '*total breakdown*' in the doctor-patient relationship and advised her to find a new GP within 21 days or he would remove her and Mr H from his list of patients (the Practice's list). Ms B said that this caused her significant distress and inconvenience, and following this failure of the Practice to resolve the complaint locally, Ms B referred the complaint to the Ombudsman.
15. After completing our investigation we upheld Ms B's complaint, making recommendations to ensure that Ms B and Mr H received appropriate remedy and ensure that this service failure and maladministration does not recur.

Conclusion

16. This example demonstrates the importance of sharing best practice and effective benchmarking is in place regarding complaint handling and the removal of patients from lists.
17. Our experience and research tells us that for public services to turn around a situation in which complaint handling is failing, there need to be significant changes in the way an organisation operates in six key areas.
18. **Leadership & Governance:** Complaints are taken seriously at the very top of an organisation, inform leadership decision making and contribute to how the leadership is held to account. Our research on the governance of hospital trusts regarding complaints⁵ showed that there is a defensive culture that prevents complaints from being used effectively. Our research also demonstrated the strong link between use of individual complaints and patient stories during board meetings, and the effectiveness in using

⁵ <http://www.ombudsman.org.uk/about-us/news-centre/press-releases/2013/new-research-shows-nhs-boards-believe-use-of-complaints-information-needs-to-get-better>

**Written evidence from the Parliamentary and Health Service Ombudsman to the Monitor
call for evidence on general practice services sector in England**

complaints in the early identification of risks. These findings may also be applicable to the governance of general practice, in particular that the review of individual complaints and patient stories by general practice partners may support the early identification of risks, and in creating a culture that listens to patients and learns from mistakes.

19. **Engagement & alignment:** Staff are engaged in discussion of the benefits of changing and participate in the development of new practices which contribute to a more open culture which seeks feedback (including from complaints). News ways are used to engage patients, and patient confidence to express concerns and complaints is also grown.
20. **Formal mechanisms and practices:** It is made clear to all where and how to complain, and they are made to feel that complaints will be welcomed and acted on quickly. Patients are dealt with as individuals - helpfully, promptly and sensitively. Good practice adopted by public services should reflect the *Ombudsman's Principles of Good Complaint Handling*.
21. **Skills:** All staff have the knowledge, skills and training to deal with complaints at the earliest point possible. They also have the necessary authority or access to people who can get things done and support them in getting a problem sorted. Staff are supported in developing the confidence and humility to say sorry in a meaningful way, to take action to fix problems flagged by complaints, and a culture of openness is nurtured at all levels.
22. **Measurement:** Complaints are treated as critical management information and intelligence about what is happening.
23. **Accountability:** Accountability for complaints runs from staff on the frontline to board level. There is clarity around who is responsible for listening and putting things right. Complaint handling is an integral part of how services are judged by those charged with scrutinising the service, including governors, commissioners, public and regulators and Parliament.

August 2013

PPS Interim Support Ltd

My concerns over the role of general practices in the provision of NHS services is their unique position as key decision makers on the commissioning of services, gatekeeping access and also using the premises and services funded through the NHS for Primary care service provision to tender for and provide services under the AQP banner. There is no clear separation between the GP Practice primary care provision and the GP practice as an AQP leading to the patient public / patients being misled to believe that receiving your AQP service at a GP practice is all part of the NHS GP service (a good thing) and that receiving your AQP service at a high street outlet is a "Private" (bad thing) and a threat to the NHS. For a level playing field there must be clear distinction between the GP practice as a primary care provider and a GP practice as an AQP.

This also applies to access and connection to the NHS N3 network and systems such as Choose and Book where GP practices piggy back on the primary care connection whereas other AQP's must complete an onerous and costly N3 connection and IGSoC process to offer choice.

GP practices have also demonstrated the willingness to blackmail the NHS in to paying additional fees to use systems mandated by the NHS eg incentive payments to use Choose and Book. Or to refuse point blank to use Choose and Book which, given that under the NHS Constitution Patients have a right to choice, there is no way a GP can memorise all the possible services available and the current waiting times and therefore offer choice to patients.

Further more in failing to get GP's to use Choose and Book the CCG is failing AQP's as any new AQP entrant has no way of getting the patients attention at the point of referral if the GP does not use Choose and Book, yet an AQP is required by the contract to invest huge sums of money to gain access to, set up and manage Choose and Book and associated systems.

GP's have clearly shown themselves to be self interested with very few practices showing any willingness to provide the preventative primary care services that all the evidence shows is the most cost effective form of health care. Simple checks such as blood pressure and weight on arrival at a practice will only be undertaken if they get paid an additional fee. GP inefficiency leads to significant costs in secondary care such as referring patients for elective surgery without checking blood pressure or recognising that the patients weight will inevitably lead to the patient being referred back until one or both conditions have been managed in primary care. A new model of primary care provision based on prevention and self care has to be promoted with the practices funding based on long term outcomes.

Just as we have been critical of those in the finance industry for taking their annual bonus based on projected profit when five years later it has bankrupted the country

then so we should for primary care. GP practice earnings should be skewed to much longer term health and well being outcomes and not ticking a box.

The old model of a family GP has long gone. The public have no excuse for not being aware in these days that they control almost all factors impacting upon their general health and well being other than their genetic risk. The relationship between patient and GP must change and NHS funded primary care should not and must not be controlled by GP's and their local branch of the LMC. This is the last bastion of closed shop unionism purely looking after the self interests of the GP.

Dr Keith Struthers

Consultant Microbiologist

Re: Medical Microbiology Testing in Primary Care

Please see attached the cover of our book which was published in 2012.

The ISBN number is 978-1-84076-159-7

This book was specifically done to address critical quality issues we saw in Primary Care with microbiology.

Mansons Publishing has been taken over by CRC Press, Taylor and Francis, and I have forwarded this email to Caroline Makepeace, Senior Editor.

I am happy to discuss, and provide further information as needed.

[Attachment appears below]



MEDICAL MICROBIOLOGY TESTING IN PRIMARY CARE

The book's purpose is to help community-based primary care physicians and nurses, and laboratory-based microbiologists, better understand each other's requirements in collecting specimens and interpreting results, and thus improve the quality of patient care.

The book's structure focuses on three basic principles: deciding whether a specimen is clinically necessary, how to collect the specimen effectively, and how to interpret the laboratory report.

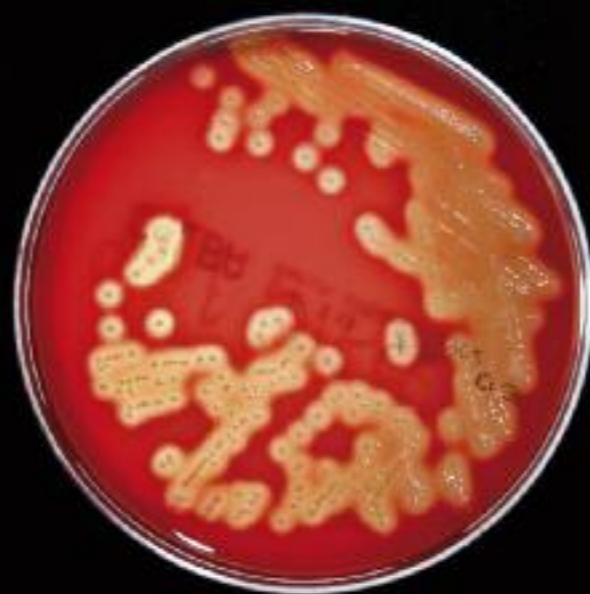
At the beginning of each chapter a case scenario is used to identify critical steps in processing a particular specimen type, followed by quick action guides to assess current practice and implement necessary changes in procedure.

The award winning author of Clinical Bacteriology (BMA student book of the year on publication) has brought together a microbiologist, a primary care physician and a specialist in infectious disease, to produce this concise, highly illustrated guide, of value alike to primary care physicians, nurses, microbiologists and students.



MEDICAL MICROBIOLOGY TESTING IN PRIMARY CARE

MEDICAL MICROBIOLOGY
TESTING IN PRIMARY CARE



Struthers, Weinbren
Taggart, Wiberg



J Keith Struthers, Michael J Weinbren
Christopher Taggart, Kjell J Wiberg



[X]

Response to Monitor's call for Evidence on General Practice Services Sector in England

Further to your request for evidence re: the above, please find below responses to your areas of interest as detailed in the above document.

If you require further information, please do not hesitate to contact me on the email address below:

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

Patients have the opportunity to make appointments with their GP Practice during the day Monday – Friday and in some instances on a Saturday morning. Opening hours of GP Practices vary and though the core hours of the contract are from 8am to 6:30pm, this simply means that a Practice must be open during those times and not necessarily providing appointments. Appointment provision will vary from practice to practice. The extended hours DES expects practices to provide some extended hours outside of the core hours, but again this varies and there are some practices that open beyond what is required of the core and extended hours together and indeed some practices that do not even sign up to provide extended hours.

Commissioners having been moving towards centralising GP services i.e. discouraging single handed practices, pushing practices within a certain distance of each other to merge and operate from one location to reduce rent reimbursement – all of this has had a negative impact on GP access and patient choice and has reduced access points for GP services, resulting in increased attendances in A&E.

Patients have the ability to change their GP Practice so long as they live within the catchment area of the practice.

For those practices that are willing to register patients outside of their catchment area or in another borough there are particular challenges that will result in the practice ultimately refusing to register the patient. For example, cross boundary issues with community services or local authority services. If a patient is registered with a GP in Lambeth but lives in Chelsea – if the patient requires a visit from a community nurse a request will be made to Lambeth community nursing services who will refuse to see the patient because it is out of their boundary area. The community nurses in the Chelsea area will refuse to see the patient because they are not registered with a doctor in their area and with whom they have a relationship. Responsible commissioning implies that the area in which the patient is registered is responsible for their care, but the interdependent services will not cross geographical boundaries to provide care. This area needs to be thought through and a process for reciprocal arrangements needs to be identified that is fed down to front line staff on the ground.

The recent PMS reviews and weighting of list sizes carried out in general practice (I have direct experience of Lambeth area) have resulted in significant funding losses to general practice which have impacted on resources and the ability to offer appointments. The majority of practices have had to lose staff, reduce services and this has had a direct impact on access.

General Practice is under significant pressure to complete administrative functions requiring clinical input. This takes clinicians away from their time allocated to seeing patients and more and more time is required to be involved in commissioning, attend meetings, respond to documents, demonstrate targets etc. all of this takes time away from seeing patients and providing more capacity in primary care.

The impact of the rules for setting up and or expanding a general practice

Commissioners are reluctant to allow branch surgeries or to reimburse rent and rates for additional premises locations. Currently there is no process for applying for rent and rates reimbursement for additional premises in England. There is very limited support for premises issues in general practice and this has a major impact on practice expansion.



Making the health sector
work for patients

Contact us

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

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

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