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

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

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

The market

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

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

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

1) A competitive market:

Providers should be able to establish practices at their own discretion. They should be allowed to identify areas of low or poor provision and assess whether to invest in those areas. NHSPN is very confident that the market itself can and would provide the most effective solutions for such areas. Investors would be interested in filling the
gaps where there are perhaps poor facilities or inadequate open hours, insufficient services or poor patient feedback/ CQC reports. The history of where independent sector providers opened walk in centres supports this view. It is policy and commissioning decisions combined with the reluctance of traditional GP practices to go into some areas that has left some areas without the necessary provision.

2) Patient choice:

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

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

3) Support for investment:

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

Access

The current system has failed to respond to the different ways in which patients want and indeed need to access GP services. There is a disturbing tendency to regard patients who do not wish to fit into traditional GP opening times and access arrangements as tiresome and unhelpful. The reality is that working hours across huge swathes of the economy are now quite different to what they were even 20 years ago. Moreover the emergence of a truly multi-cultural society means that there
are substantial groups of citizens who for a variety of entirely proper reason need and are accustomed to accessing primary care in different ways. That needs to be respected and responded to, not dismissed as a nuisance. The whole saga of Walk-In Centres perfectly illustrates this, Walk-In Centres were often set up in the face of resistance by conventional GP practices, succeeded despite this, and precisely because they responded to changing social and lifestyle patterns, but in too many cases are then the first services to be closed down by commissioners with too strong a bias towards conventional GP services as soon as financial pressures start to bite.

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

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

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

**Contracts and Commissioning**

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

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

An inevitable conclusion to be drawn from much of the above is that a significant "rethink" is needed about primary care commissioning. The move of primary care commissioning from the old PCTs to NHS England provides an opportunity for this, not least because the new Regional and Area teams will be in a position to develop a level of focus on the issues and the expertise that PCTs were too often lacking. We
are firmly of the view that commissioners need to become more sophisticated and more open both to commissioning services differently and to commissioning a wider range of services within primary care, either from GP practices or other providers.

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

8 am. Patricia has a very painful mouth ulcer

11am. Patricia goes to the Soho walk-in centre and waits for an appointment. Does she get a prescription?

- NO. The walk in centre doesn’t have GPs and the nurses can’t prescribe.
- YES. The walk in centre has GPs and the nurses can prescribe.

1pm. Patricia calls her own GP.

- NO. Patricia told she can only get an appointment on the day if she queues from 8.30am and waits until they can see her.
- YES. Patricia can get an appointment on the day if she queues from 8.30am and waits until they can see her.

Patricia can’t do this without incurring childcare costs. But the receptionist says everybody has issues accessing their GP and “you’ll just have to make time ....”

Patricia pushes back. The receptionist suggests Patricia puts a note through door requesting a prescription. By the end of the following day she will be told if the GP will prescribe.

2.30pm. Patricia calls a private GP. Can they help?

- YES. But NO, because £75 plus private prescription costs is too expensive.
- NO. The minor injuries unit is unable to prescribe. Patricia is advised to go to A&E.

2pm. Patricia walks to Barts minor injuries

Can Patricia get a prescription?

- NO. The minor injuries unit is unable to prescribe. Patricia is advised to go to A&E.
- YES. Patricia gets a prescription.

4pm. Patricia returns home. She manages to speak to the GP and 8 HOURS LATER she gets her prescription which is at reception.

Finally, high quality patient care is delivered.
ANNEX B

PRACTICES IN LEICESTER, BY SIZE
(image from https://www.google.com/maps/ms?vps=2&hl=en&ie=UTF8&oe=UTF8&msa=0&msid=202179206231773498408.0004d50d823cd7f922ee6)

<table>
<thead>
<tr>
<th>Color</th>
<th>Patient Count</th>
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<tbody>
<tr>
<td>Red</td>
<td>Less than 4,000 patients</td>
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<tr>
<td>Green</td>
<td>4,000 to 10,000 patients</td>
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<tr>
<td>Purple</td>
<td>10,000 to 15,000 patients</td>
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<tr>
<td>Yellow</td>
<td>Over 15,000 patients</td>
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