Monitor call for evidence on general practice services sector in England

I. The RCGP welcomes the opportunity to submit evidence to Monitor’s review of the general practice services sector in England.

II. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

III. We gratefully acknowledge the contributions of the RCGP Centre for Commissioning and RCGP Council members in formulating this response.

Our response

Overview

1. The RCGP welcomes Monitor’s stated aim to better understand the challenges faced by general practice at a time when it is operating under increased pressure. However, we
would strongly caution against the assumption that the challenges faced by
general practice are caused by a lack of competition, or that the best lever to
reduce perceived variability in access and/or quality would be an increase in
competition.

2. The primary challenge faced by general practice is workforce capacity. The Centre for
Workforce Intelligence has concluded that “the existing GP workforce has insufficient
capacity to meet current and expected patient needs”\(^1\). In order for choice and
competition to be meaningful it is necessary to have excess supply in the market; this is
clearly not the case for many areas of general practice.

3. We note that the consultation paper states that there are more than 40,000 fully trained
GPs working in England. However, this figure includes GP Specialty Training Registrars
(GPStRs), who are still in training. Latest figures in fact show that there are just over
35,500 fully qualified GPs working in England and just over 31,500 full time equivalent
fully qualified GPs\(^2\).

**Detailed response**

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

4. Firstly, we would note that GP Patient Surveys consistently show that **overall levels of
patient satisfaction with general practice are high**. In 2012/13, 86.7% of patients
rated their overall experience with their GP surgery as good, three quarters (76.3%) of
patients reported that their overall experience of making an appointment was good and
nine out of ten patients said that they had at least some level of confidence and trust in
the last GP they saw\(^3\). The doctor–patient relationship is highly-valued; it is therefore to
be expected that many patients choose not to switch practices as they are happy with
the services that they receive at their current GP surgery.

\(^1\) Centre for Workforce Intelligence (2013), GP in-depth review: Preliminary findings,

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

\(^3\) 2012-13 GP Patient Survey Aggregated Wave 1 and 2 results,
5. Secondly, it is important to understand that the **existing general practice workforce has insufficient capacity to meet current and expected patient needs**\(^4\). Unless more resources are invested in general practice and action is taken to increase the GP workforce there will not be sufficient capacity in some areas to allow patients to exercise choice now or in the future. As well as increasing the number of new GPs who enter the profession, it is crucial also to take action to retain the existing workforce by increasing levels of support and resource, particularly in areas where GPs are under most pressure, and providing better support for returners.

6. There is considerable regional and local variation in the availability of GPs per head of the population. Deprived areas of England broadly tend to have fewer GPs per head\(^5\), yet these areas often serve patients with higher levels of physical and mental illness (commencing at a younger age than in more affluent areas), more multimorbidities and greater problems with self-care. Consequent to this mismatch of need and resource, consultations in general practices serving very deprived areas are characterised by: multimorbidity and social complexity; shortage of time; less patient enablement, especially of patients with mental health problems; and, practitioner stress. **In order to improve both quality and access in these areas it is vital not only that action is taken to increase the GP workforce overall, but that a substantial share of this workforce increase should go towards improving support for under-doctored areas.**

7. It should be recognised that local geography can have an impact on patient choice. Patients are generally less likely to encounter a problem in switching practices in urban areas. Where there are closed lists in these areas this is likely to be because: funding is not sufficient to allow practices to expand their staffing; there are limits on premises space; or, the practice has a desire to maintain a quality service based on a defined population. Choice of GP practice may be more limited in small towns or rural areas, but in many cases it may be uneconomic and impractical to commission additional practices simply to allow choice. It is also important to understand the potential quality benefits of reducing clinician isolation in small towns or rural areas, by encouraging partnerships rather than pushing single clinician practices purely for the purposes of choice and competition.

---


\(^5\) Ibid.
8. **We feel strongly that geographically defined GP practice areas should be maintained.** The abolition of practice boundaries would destabilise GP practices (as it would be far more difficult to plan to meet demand), impact adversely on continuity of care and would make it harder for GPs to deliver integrated care alongside local authorities, as these are organised on a geographic basis. Furthermore, it is likely that a number of rural practices would become unsustainable, as they would face losing significant numbers of their patients - typically younger, healthier commuters - and would be left caring for a greater proportion of patients lacking mobility and/or with complex, long-term conditions. This imbalance would rarely be viable in the long term and would thus ultimately reduce choice in rural communities, to the detriment of the most ill and vulnerable.

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

9. We note that there has been an historic variation in funding between GMS and PMS contracts, but that this is being addressed by the Department of Health’s plan to bring PMS funding down to the same level as the GMS average over a seven-year period from 2014. We would note that it is vital that funding released from PMS reviews is retained within the GP contract as a whole and is not simply removed from general practice to plug deficits elsewhere in the NHS.

10. Monitor should be aware of the risk of loss leading with Alternative Medical Services Contracts (APMS) bids, which in the long term could be anti-competitive.

11. Some sessional GPs report that they do not see APMS practices offering long term placements or career opportunities, and so the turnover of staff is high. This suggests that time limited APMS contracts may not encourage long term investment in practices or the long term commitment of doctors to them.

The ability for new or existing providers to expand the scope of the NHS services they offer, particularly the factors that may influence CCGs or local authorities in deciding whether to commission services from general practice:

12. GP workload is restricting the ability of many GP practices to expand their services. As outlined above (paragraph 2) the existing general practice workforce is under considerable strain, with insufficient capacity to meet current and expected patient needs. There is a worrying lack of recent substantive evidence on GP activity and
workload⁶. However, the latest available studies of GP workload point to a significant increase in workload pressure in recent years, with the number of consultations for the average patient per year rising from 3.9 in 1995 to 5.5 in 2008 and with the biggest increases taking place amongst those aged over 70 years⁷. Investment in the general practice workforce is urgently needed in order to allow GPs the time and capacity both to reflect on how to organise care for the future and to expand the scope of services that they offer.

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

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

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

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

---

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

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

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

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

Any new forms of primary care or integrated care that local health communities are planning or considering and any potential enablers or barriers that need to be considered:

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

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

20. It is important to achieve a healthy balance between competition, collaboration and ownership in the local community. While commissioners should be free to use choice
and competition to improve value for patients, Monitor should ensure that rules relating to competition do not restrain collaborative work by GP providers that is aimed at improving quality of care and providing and developing a greater range of services.

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

**Additional Comments**

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

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

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

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council

------------------------

8 [http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing](http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing)