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Department of Health's consultation "Your Choice of GP Practice"

1. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the 'voice' of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 38,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.
2. The College welcomes the opportunity to respond to this consultation: "Your Choice of GP Practice". We have received an unusually large number of detailed responses from our members.
3. Only a few of our members were positive about the proposals. An overwhelming percentage (approximately 75%) of our members who responded to this consultation were strongly against the proposals to allow people to register with any GP regardless of catchment area, because of their serious concerns about the potential impacts of this change for the health services provided for patients. Those members who recognised some merits in principal to the proposal also raised a number of serious

concerns about the potential implications of the proposals. Our members often did not reply to the specific questions posed for patients in the back of the survey document: the questions were seen as 'leading' - implying a positive response to the basic proposal from the start, and thus not allowing respondents to express a strong negative opinion. It also in effect stops members of the public from expressing satisfaction with the status quo.

4. We have also solicited the views of our Patient Partnership Group, whose comments are reflected in this response. Their views were rather more mixed than those of the practitioners; in particular it was notable that some of these group members welcomed greater flexibility in accessing their doctors.
5. We have attempted to reflect the key themes and concerns in this summary.
6. Our response should be put in the context of the working definition of general practice¹, which charges us with being '*the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned*', but also to '*make efficient use of health care resources through co-ordinating care, working with other professionals in the primary care setting*' and to '*manage simultaneously both acute and chronic health problems of individual patients*'. These are 3 of the 11 key characteristics that have made U.K. general practice both effective and efficient in terms of cost and health gain.

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<http://www.woncaeurope.org/Web%20documents/European%20Definition%20of%20family%20medicine/Definition%20EURACTshort%20version.pdf>

7. Our response should also be seen in the context of the RCGP Manifesto for Patient Care 2010² which calls for *'the GP-patient relationship to be maintained and improved. GPs deliver personalised and continuous care for patients and their families. We want to improve patients' access to high-quality care even more. We call on politicians to recognised the importance of the practice list – it strengthens the relationships that GPs have with their patients and allows them to target care to those who need it most.*

8. We accept the move towards increased patient autonomy and the right of individuals to make choices about their healthcare. Where our members put an alternative case, it was usually due to concerns about the following:
 - a) **capacity of services** – the ability of practices or primary care based services to meet a growing demand and risk of services deteriorating due to additional patient numbers: the argument that resources follow does not always apply

 - b) **complexity** – the additional costs of added human resourcing and the bureaucratic and financial consequences of new registration arrangements

 - c) **offset of population and personal advantage** – sometimes the most 'choice demanding' individuals can destabilise the services which work well for most of the people most of the time, and

 - d) **specific risks of losses in terms of clinical quality of care**, especially risks around health inequalities.

² The RCGP Manifesto for Patient Care 2010, published March 2010
https://www.rcgp.org.uk/pdf/RCGP_Political_Manifesto.pdf

Looking at these issues in more detail:

Fragmentation of co-ordinated services

9. The most significant and overarching concern is that the proposals would result in a breakdown in practice team care, and fragmentation of co-ordinated services. Mental health services, district nurse services, midwifery services and health visitor services are all geographically defined for practical reasons. General practices are geographically defined for the same reasons. We have grave concerns that the breakdown of practice boundaries will result in a breakdown of close relationships already established between local health providers, which in turn will result in a reduction in the quality and consistency of care. Public health initiatives, shared commissioning and enhanced services are all reliant on this model. Palliative care, child protection, and 'hospital at home' to avoid emergency admissions are all similarly reliant on the cross boundary working. A geographical separation between provider of general practice and other services is of particular concern where home visits may be needed or where family units have multiple services involved.
10. The most vulnerable members of our communities including the housebound, those with mental health issues, addiction problems, young children, the disabled and the very poor are inevitably the least mobile. They are more likely to have multiple and chronic health needs which demand a co-ordinated and consistent approach. Plainly they need to be able to access good local general practices and other local services, and any changes need to ensure that co-ordination of services is retained.
11. We also think that where practicable family members should be registered with the same GP. This allows GPs to provide holistic care within the context of the patients' home environment and family. These proposals risk fragmenting services and are a threat to the role of a "family doctor".

The dissolving of the role of the family doctor also has implications for child safety, please see below.

12. The RCGP Manifesto for Patient Care 2010³ calls for more care to be provided in the community and for GPs to continue to play a key role in the care of patients and their families from cradle to grave. Our concern therefore is that these proposals are potentially obstructive to these fundamental aims.

Changes in workloads/ instability

13. Many of our members have concerns about potential changes in their workloads should these proposals be implemented and patients be allowed to register anywhere. They are concerned that if people are allowed to choose any practice, it could lead to a similar situation as the school system where lots of patients from outside areas may select a popular practice: then those that live locally are either unable to register locally or find that the level of their care is compromised. It should also be said that those most vulnerable of patients; the elderly, the disabled and the mentally ill would be among those least likely to be able to exercise their right to choose which practice to attend.
14. The removal of practice boundaries could make the provision of general practice very unstable. It may mean that practices in city centre locations are unable to provide the level of care they are presently able to offer due to an increased number of patients on their lists. There is the reciprocal risk that commuters would join city centre practices and leave rural practices. This could have the effect that practices in rural locations may not be viable and would close, leaving the less mobile (and indeed more

³ The RCGP Manifesto for Patient Care 2010, published March 2010
https://www.rcgp.org.uk/pdf/RCGP_Political_Manifesto.pdf

needy) members of the rural community without access to a local GP. Our rural membership emphasised the particular importance in rural locations that practice boundaries are maintained, to ensure that rural communities are not left without access to primary care, which the 'commuters' will still need when they are based at home.

Home visits

15. If patients live far away from their practice, then a home visit would take up an increased amount of the GP's time, which would have implications for their workload. If any aspect of the proposals are implemented, it must be with a proviso that patients who live outside a practice's designated area will not be able to receive home visits. The problem with this approach is its short-sightedness: patients who are now fit, healthy and working may favour the convenience of being able to register with a practice close to their work, however this would be to the detriment of the services they might need close to home should they become very ill. There is also a risk that patients who have registered at a practice far from their home are likely to call on emergency services if they become suddenly ill rather than the practice that they are registered with. Not only is this more expensive for the health service, it means that in such circumstances the practice would not have access to full information about the emergency care received and this would have an impact on the continuity of care.

Child Protection

16. Child protection is another key issue. At present GPs are aware of dysfunctional and high risk families on their lists and have worked at developing robust relationships with key partners such as health visitors,

social services and midwives in order to protect vulnerable children. If people are able to register themselves and their children at practices outside of their communities, it would jeopardise healthcare professionals' and social services' ability to provide a seamless service and therefore there would be a real risk of vulnerable children falling through the net. There is also a real threat that such an approach would undermine the improvements made to child protection across the services since the dreadful cases of Victoria Climbié and Baby Peter.

Patient Safety

17. We also have concerns with regard to patient safety. We think that loosened registration rules may put patients temporarily at risk due to full patient records not being available. Although improved electronic records may help this, some of the risks will not be avoided. One obvious example of this would be a patient who obtains prescription drugs from more than one practice without the knowledge of a previous practice, where there is a 'time gap' in information transfer and current 'rules' about registration are no longer applied. Sadly we are aware that incidents of over-prescription already occur under the "temporary doctor system". Indeed the inquest into the tragic death of Marcia Lisa Bryant revealed that the breakdown in communication between practices contributed to her death. We therefore worry that these proposals will greatly increase the risk of this happening to the detriment of patient health. Should these proposals be implemented, it is essential to ensure that the central spine for holding patient records is comprehensive and fully functional first.

Costs

18. We also feel that the removal of practice boundaries will be a very costly undertaking, some of which costs may be hidden. For instance if a patient with multiple problems changed their GP, this could result in an increased number of referrals to secondary care. We also think it is likely that those registered at a practice at a distance from their home are more likely to access secondary care directly when they become ill. There is also a cost implication for the time necessary to co-ordinate and accommodate patients living a greater distance from their registered practice. The cost implications of these proposals should not be ignored as it would inevitably draw funding away from other vital services.

Options.

19. As is plain from the above, the College disagrees in principle to the thrust of the proposed changes. However in terms of the options proposed our thoughts are as follows:

Option C: full dual registration was considered to be completely in opposition to the principles of good general practice, risking complete loss of responsibility for individuals and their care regardless of the problems they have at a given time;

Option D: in an era where the loss of out of hours care has already given rise to concern, was also perceived very negatively – likely to be costly, fragmenting and counterproductive;

Option B presupposes the option to register at a huge distance from one's home, which we contest below; and

Option A was seen as the least of the four evils, but still contested by some.

20. Our preferred option is to maintain the current system of limited walk-in services for acute care far from home, longer opening hours, and the emerging opportunities of electronic records, should be adequate for the needs of the fit commuting population.

Conclusion

21. Healthcare professionals have a duty to balance the needs of all our patients. The extra time, money and resources needed to appropriately manage the care of those patients who live a long way from their surgery is not in the best interests of the majority of the patients registered with a local surgery.
22. According to the Department's own statistics, 91% of patients state that they are satisfied or very satisfied with the care they receive under the present system. It seems to us that the proposals are an inappropriate and disproportionate response to the perceived problems within the present system.
23. Many of our members have also commented that although they understand the difficulties some patients who work have in accessing their GPs, they have taken on extended practising hours to accommodate their needs and therefore feel that the substantial changes proposed in this document are not necessary.

Alternative Approaches

24. We do of course recognise that the primary care system was designed with a more static population in mind. Some groups of society are increasingly mobile and may (perhaps rightly) feel that the present system does not best suit their needs. We accept that the "one size fits all" approach may not feel the best fit for them. We also accept that some managerial action may be needed to avoid inappropriate list closures, but perceive the current powers of PCTs to be able to address this already. The removal of practice boundaries is neither the correct nor proportionate way to solve this problem. The risks posed by the removal of practice boundaries, in particular the fragmentation of care, risks to patient safety,

practice and workforce instability and not least the potential closures of rural practices significantly outweigh the potential benefits for a small percentage of the population.

25. We have also considered the British Medical Association GPC review: *Reforming General Practice Boundaries*⁴ and we recommend the alternative solutions set out in section 3 of this document onwards. We would refer you to that document rather than rehearsing their content here. Further we believe that the federated model of general practice can provide a framework in which many improvements in access and care can be delivered:

Primary Care Federations

26. We strongly recommend the development of GP practices working together in primary care federations as a way to offer improved service delivery and patient access in the community. This has the potential to offer patients improved access and flexibility over extended areas, including access to out-of-hours care. The federated approach also removes the complications and potential risks of dual registration that have been outlined. GP practices within a federation structure can offer their patients different approaches to access: innovative access to “booked appointments” and a capacity to also provide “walk-in” clinics. The model is adaptive and the design can be tailored to meet the needs of different geographical areas and patient populations. Importantly GP federations create economies of scale that can increase efficiency in primary care delivery and allow resources to be reinvested; whilst

⁴ “Reforming General Practice Boundaries” General Practitioners Committee (January 2010)
http://www.bma.org.uk/images/reformgpboundaries_tcm41-193919.pdf

maintaining the core traditional values of primary care that patients trust within existing and familiar buildings.

27. Characteristics of the federated model include i) a formal legal structure, ii) a written public constitution and public engagement strategy iii) an executive management team and board.

28. Further detail on the federated model is set out in "*Primary Care Federations – putting patients first*"⁵. The RCGP has commissioned, with support from the Department of Health, a practical toolkit which will be delivered by the Kings Fund and the Nuffield Trust. This will be launched later this year at the RCGP Annual Conference and will support GP practices in federating by providing legal advice and models of governance and service design; a literature review and GP survey is also planned. A stakeholder workshop on Primary Care Federations will be hosted by the RCGP on 5 July.

Remote Consultations

29. In particular we recommend the increased use of the opportunities that IT can offer, such as the use of webcams, skype and telephone consultations. This would allow patients to continue to receive care from their General Practitioner, who they are registered with, and yet overcomes the obstacle of distance. It should also be stated that the use of these approaches would be far more economical than the proposed abolition of practice boundaries.

Drop- in Centres

30. We consider that it would be a far better use of resources to improve and promote drop-in facilities in major cities where commuters can receive

⁵ Primary Care Federations – putting patients first, Royal College of General Practitioners (June 200*)
<http://www.rcgp.org.uk/PDF/Primary%20Care%20Federations%20document.pdf>

treatment for minor health issues, whilst remaining registered with their local GP practice. There is emerging evidence of such centres providing a valuable service for more mobile patients, and reducing unnecessary calls on A&E and other stretched services.

Yours sincerely

A handwritten signature in black ink that reads "Amanda Howe". The signature is written in a cursive style with a large initial 'A'.

Professor Amanda Howe