The Royal College of General Practitioners' Rural Forum response to the DH consultation: *Your choice of GP practice*

Dr Malcolm Ward Rural Forum Steering Group chair **May 2010**

The RCGP Rural Forum was launched at the RCGP Conference in Glasgow last November. Already around 350 RCGP members have joined the Forum and the following response to the DH consultation is based on a summary of email comments from those members. A representative collection of such email responses are included at the end of the document.

In summary the key points raised are listed here:

- The proposals appear to be rather hurried and ill thought out in response to the perceived needs of a minority of patients who are well and mobile (91% of the public are satisfied or highly satisfied with the existing arrangements according to the consultation paper).
- There are already options in place to cater for the needs of the working well who want to choose when and where they consult a GP: Walk in centres, extended GP surgery hours.

The proposals in the paper represent a "sledge hammer to crush a nut" approach which, we believe, will result in devastating fragmentation of patient care. The ensuing problems will affect all GP practices but the problems listed below are all the more extreme the more remote and rural the practice.

- Practice and work force instability: There is a risk that well and mobile patients will look to join urban practices near to the place of work. Urban practices may experience sudden increase in list size and have to take on more doctors. This may put a strain on rural practices whose numbers become less viable yet the remaining population will be the needy sick, frail and elderly. Yet when those mobile patients become ill and home bound they will need the services of the local practice. Popular practices that provide a good service to their communities could lose that popularity and local accessibility and efficiency if the list size suddenly increases due the effect of practice league tables.
- Mental health services, district nurse services, health visitor services, mid wife service are all geographically defined and for practical reasons. The same practical reasons that we have GP boundaries. Does the DH plan to abolish boundaries for all aspects of primary care?
- There will be huge cost increases to the NHS as, however hard the DH tries to push the costs on to GP practices, there will be a considerable increase in workload for PCTs to manage the complex new arrangements, and the ensuing increase in referrals to secondary care as patients chop and change doctors with loss of continuity of care. The patient who chooses to register with a distant practice but becomes suddenly ill is likely to rely on emergency services rather than attend the chosen distant practice. The local practice won't know anything about the patient.
- Patient safety will be put at risk if the proposals were to be implemented before the central spine for the holding of patient records becomes fully

functional. There is no sigh of this happening in the near future. Even if the technology was currently available to provide a reliable centrally held patient medical summary there is no solution as yet to cope with the large numbers of people who would not give their consent to this.

- We firmly believe that each of the following option proposals would have the effect of increasing the demand on ambulance services and secondary care as patients confused by new home visiting arrangements opt for what they will perceive to be the easy option.

Option A (choice to register with any GP but home address PCT has responsibility for contracting for home visits)

Most of the concerns expressed above would apply here. Either the PCT will have to contract with the local OOH provider to cover for such home visits which will be more expensive than the current system or the PCT will have to contract with a local practice.
Local practices would still have to define their boundary for home visits so boundaries would still be a controversial issue – where would you draw the line for who can get a visit by one practice as opposed to another? Practice boundaries in many remote and rural practices are likely to be geographically determined, particularly if you live on an island and there is less likely to be large scale patient movement however a small practice will be more sensitive to even small scale patient migration.

Option B (Practices retain responsibility for home visits regardless of where the patient lives)

This is simply unworkable; we have the scenario where the GP would have to take the day out if practice to visit the patient who lives a hundred miles or more away. If the practice had the responsibility of contracting the local GP practice for each distant registered patient there would be the prospect of each practice having vast numbers of such arrangements a recipe for chaos and disaster for exchange of patient information and keeping records up to date. This would also have huge workload implications for the PCTs involved which would also require to be made aware of the arrangements. It can take many weeks if not months to get temporary resident treatment details under the present system.

Option C

Dual registration might be suitable for a minority of patients such as those who prefer to consult at a surgery close to the place of work or those with specific circumstances as outlined in the submission by Professor Catti Moss (see below). However this would require a robust and prompt system of communication between the practices of all patient consultations. There would also need clarity of roles and responsibilities in the event of one or other of the practices diagnosing a complaint or treatment requirement. There would be additional costs to PCTs, two PCTs being

involved with each dual registered patient requiring clear rules for payments to practices and secondary care.

Option D

To remove all home visiting obligations for practices would mean the end of gold standard palliative care, something that has been highly valued by patients. It will also have a significant impact on secondary care as all home visiting will be done by emergency care practitioners or GPs who will not have the knowledge about the patient that would be the case for the family doctor who knows the patient well. This is likely to be very unpopular with the voting public.

The Rural Forum Steering Group believes the following to be more practical and cost effective solutions to the perceived problems:

- PCTs to be given the powers to encourage practices to have more flexible boundaries in areas where there are deemed to be particular problems.
- PCTs to encourage/incentivise those practices that currently do not provide extended hours services in areas where there is a perceived need.
- Consider option C with the provisos expressed above.

Email views received from members of the Rural Forum:

(removed from publicly available document to protect personal details of respondents).

Ends.