The People's Inquiry: One Year On

Evidence presented by Dr Ron Singer (RS)

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Queen Elizabeth II Conference Centre, Broad Sanctuary, London SW1P 3EE, Shelley Room

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Naledi Kline (NK); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:
Thank you very much for giving us your time again, which we appreciate. We're in session a year on from our report which I can't believe. We're looking really at whether or not our recommendations remain valid, what's happened, what's changed, and to gather some information to write an update.

RS:
I'm here really with an East London hat on, although of course I have other connections. I wanted to just make a couple of general points and then go through the specifics. London has always been a problem as we know, we have the (1992) Tomlinson review and RAWP (1970s-1980s Resource Allocation Working Party)before that. But one of the things that has come up as a result of the GP activity in East London is a potential partial explanation for one of the London factors that were not accounted for.

We know about the teaching hospital effect and about the over-specialisation and the poor points of some teaching hospitals as DGHs: but the other thing is that London population which absorbs a lot of the NHS budget is statistically a ***younger*** population than the rest of the country. And some of the research coming out of East London is showing that people from the deprived fourth and fifth quintiles get ill at a younger age. An age-related formula therefore misses this, and so the workload that comes to general practice or in hospitals is greater without appropriate funding.

The easiest way to understand this, which I think is going to become a theme for re-working some of the formula in the future both for CCGs and for GP general-practice streams, is that we already understand that the sickness rate for men and women differs at the same age: so when you do weightings for age and sex you split the men from the women as it were. But no one has taken account of the fact that age is a poor guide if you take age from birth. It's better if you can take age to death because that gives you a better indication of how much morbidity people carry and therefore when they are going to need health services.

So that's what I want to say about that. Certainly for Newham and Tower Hamlets it has a very big effect because they have a hugely younger population than the average.

RS:
On to some specifics. I wanted to start with conflicts of interest, because that has become of increasing interest as the contracts have rolled out, and exactly why they are rolling out in the way they are. The Public Accounts Committee had this run-in over Enfield and Barnet and Haringey CCGs, where I used to work in fact, over out of hours, where the quote is

> "Public Accounts highlighted the case of Barnet, Enfield and Haringey CCGs. It found that eight members of the Barnet group are shareholders in Barndoc out of hours provider and

one member chairs it. Five members of the CCGs in Enfield and Haringey groups are also shareholders in the company."

RL:
Do we know if the shareholding pre-dates the reforms or did this happen afterwards?

RS:
It pre-dates it by a long time. Conflict of interest is an increasing problem, and there are other issues that I can't reveal in those three CCGs, in one of them particularly, where conflicts of interest over contracting arrangements with general practices is a big issue.

SR:
That would be a live issue, because they are just re-tendering. On a five-borough basis.

RS:
Yes it is a live issue. I don't know which particular contract you are talking about?

SR:
Out of hours for NHS funding.

RS:
I've moved on. I've left out of hours, I'm moving on to other things which I am going to explain now in a bit more detail. So what's happened since we last met is that GPs are being corralled into networks. This started with clinical networks. Tower Hamlets is the outstanding example of clinical networks because they have received an award for what they have done by driving up standards in a deprived area. The CCG also won a *Health Service Journal* award for its work.

So GPs have moved into clinical networks, but the extension of that is that GPs have moved into business entities, networks called various things in various places including networks. So it's very confusing but nevertheless this is a different thing. They've formed themselves in some cases into limited companies. The reason that they are doing this is in order that they can contract as a body, as a GP body, with the CCG for services, diabetes being the obvious example, but I am sure there are many others.

The worry there is that while this getting together and cooperating with general practice is a very good thing, it would be very easy for private companies to take them over in the future, as we have seen with out of hours. There is a great worry there that bringing GPs together as independent contractors, small business people who have a bigger organisation to belong to, may be stepping into the privatisation model. So that's a worry.

Nevertheless GPs have to move, they have to get bigger, they have to cooperate and the integration agenda forces this on them as well. There is good and bad in this.

RL:
Do you know if these companies are limited by guarantee? Are the shares distributed to the individuals?

RS:
I don't know the details but the big examples are in Birmingham, where they have two mega-collections of GPs, I don't have the details to hand.

Moving on to Barts Health. As you know, it's the largest trust in the country. It's got the largest PFI, it's got the largest debt, and it's got Newham. Newham becomes very important because it is a very big borough with 300,000 plus already, and due to increase by 60,000 over the next year or so, with 30,000 coming from the Olympic site. Newham is going to be under huge strain. Newham also has a very young population.

Now the problem for Barts Health – there are three very good community campaigns working in the area, borough based – and we do not identify Barts Health as the enemy. We identify government policy as the problem if you like, and we are working with Barts Health surprisingly in a fairly cooperative way. There are good relationships between the campaigns and Barts Health. The campaigns have been very successful in highlighting difficulties and issues.

The two most obvious issues that reached the press were over the centralisation of cancer services, when they moved from the London Hospital, they were going to move into UCL: and as the quid pro quo – although this is denied – cardiac services were going to move from UCL into Barts. So in a sense this is subverting competition, and so we should applaud it. But nevertheless a centralisation is a problem for a deprived population; moving services to a centre miles away is a big problem. Particularly at times of stress with cancer and all the rest of it.

The other thing that is emerging is that this centralisation is good for some things and probably not good for all things as we would expect. So it's understandable why strokes and heart attacks are very good examples of ways of providing care in a sensitive way. But it doesn't apply to all services.

The larger the building the larger the cohort of consultants, the less communication goes on. So I was told the other day about Newham Hospital where they have problems of fitting patients into operating theatres and getting intensive care beds, and they solved that by lifting the phone and talking to people that they know. This would not go on in a big teaching hospital, where you book your ICU bed for a possible use by a patient that's going to be operated on, and that bed then cannot be used, so there is an inefficiency built into that. Big is not always best.

There is a major review in progress in East London involving three slightly different boroughs: Hackney, Tower Hamlets, and Newham. The reason it's different is because Hackney relates to the Homerton Hospital which is a foundation trust and is doing very well. Barts Health is not a Foundation Trust and is not doing well financially. There is this major review going on, but they are really finding it incredibly difficult I think because of essentially A&Es.

Because what people do around North-West London is you close an A&E, that's the simple game, apparently, to save money. They have had a go at Newham which is the most vulnerable A&E and it was thought not to be possible to close it because of legal issues in 2010 around the time of the merger of three hospitals into Barts Health. But they had a go again last year and there was a big public campaign in Newham about it and now we think they're having a go again. But the danger this time is that it's going to happen because little bits of Newham services are being picked off. I need to give you one example. I am aware of the time so I'll shut up as soon as I can!

This is in colorectal services. They took cancer colorectal services away from Newham on the argument that it was better to do it in a big unit, which I entirely understand, I'm not sure of the figures that support it but I at least understand it. Non-cancer colorectal was meant to remain at Newham. However, there has not been an operation of the sizeable type that's taken place in Newham since June and yet the powers that be think this service is still going on. The service is not going on.

That has implications for staff keeping up to date, whether they are scrub nurses or whether they are doctors. It has implications for cover of 24 hours at night because people do a lot of walking into Newham with stab wounds and stuff that may need major abdominal intervention. There is a danger that somebody's going to come around and say the training is not adequate any more in Newham so therefore we can't train doctors there. This has huge implications. And indeed the CQC may view an unsupported A&E as unsustainable.

There are now threats coming because of the necessity for Barts Health to save money, taking bits of Newham away – Newham is the smallest of the three units. There is a real problem. The central problem is that there are 300,000 people in Newham who need this A&E, plus people to the East of Newham who rely on it as well. This is a big logistic problem for the area coupled with the demand for services.

The other thing that is extremely worrying has arisen in the last 2 or 3 weeks. This is that the perceptions by the main players in East London vary. An example I've got is that all our figures are published, but there is a paper by Newham CCG saying we have helped to cut the deficit in Barts Health by reducing A&E attendances, so congratulations.

Barts Health say that there are huge financial difficulties but they are investing in Newham University Hospital which indeed in some areas they are – at the same time as pulling bits out. And Newham feels under threat. So in a sense the system is dysfunctional. People are not understanding each other's point of view.

Moving on to general practice. I say things in the paper about the Minimum Practice Income Guarantee (MPIG). It's complicated, the important message I think is that it's not just the GMS MPIG practices, it's PMS practices, and indeed it's the prioritised APMS practices. I will explain that if I need to.

There's an article today in Pulse or GP I think about a practice losing £300,000 of its budget, a PMS practice in Bristol. I think even though PMS reviews are officially stopped I think they will have to go on because of the financial crisis going on in the NHS. So that's a worry.

I've mentioned the age-related stuff that we're working on in terms of a new formula for general practice to get rid of MPIG. That will take 2-3 years so a fifth of the practices are currently being destabilised. We are in the GP crisis, we are not waiting for it to happen. It has already started.

There is poor practice. It will be interesting when tables are published of GP income exactly how this sort of pans out in terms of relating it to quality, because Tower Hamlets/Newham have proved that you can produce good quality general practice.

But there are nevertheless pockets of poor practice and it would be interesting to cross-correlate GP's take-home pay with their performance of their practice. I think there will be good and bad in that, because I think a lot of GPs working in East London I know take home far less than the national average pay for general practice and yet are probably working harder.

PT:
Can you explain why? I thought there was a standardised payment? Why are some paid less than others?

RS:

This is the nub of the problem of independent contractor status, because GP practices have an income that is derived from a formula whether they are GMS or PMS or APMS but they have a formula. That formula is meant to enable the practice to provide services and for the GPs to take what is left after providing services as profit. So they are profit-shares in the business.

GP income relates to – to put it crudely – if you are a practice that has a large population and provides poor service because you don't employ many nurses or whatever you will have a large profit, and that would be the end. On the other hand, if you want to provide quality and you have nurses and receptionists and all the rest of it, you will have less profit. It is assumed at the moment that until we see the figures, the good practices in Tower Hamlets and Newham will actually take home less than the average, whereas the poorer performing practices may well take home more.

LI:
Can I interject, on a point of information? It's not profit in the sense that in a private company goes to the shareholders. It's the salary equivalent, it's pay for their labour, it's the idea of working. But not the way people say, it's not the same concept. They are paid for the actual work of doing their job.

RS:
I think that is very important, because of the battle over the 2004 contract, which the government lost, in the sense that the BMA increased GP income considerably (although that's whittling away). Nevertheless at the time there was a conception of this whole thing about the £300,000 GP and the rest of it, which is very unfair – except that you can see why people get into it, precisely because of what Louise has said. It's the profit left over in the business. This is difficult for people to understand. GPs feel very much part of the NHS, yet in a sense they've always been contractors to the NHS. Coupled with that, more than 30% of GPs and I think 50% in London are actually salaried.

RL:
I don't want to interrupt your flow but I was going to say we had evidence earlier, I can't find my notes now, but it was 55%. I don't really want to interrupt your flow, but does it matter?

RS:
Well, for someone who has been salaried as a principal to a PCT it does matter, because it's a much better way of organising services. It's a much better way of dealing with workload. So yes it does matter – but the profession is nowhere near a salary option or a salaried service; but nevertheless some GPs are determining their own futures by becoming salaried.

RL:
I think it's in East Anglia is it, where the local doctors in the CCG have voted to all become salaried? I don't know how they are going to do this – they are just going to have to walk away I suppose.

RS:
GPs have tried that manipulation on a small-practice level in the North-East, where they'd tried to become salaried to a trust. There are moves I know of in London where bodies of GPs are in negotiation with boards to see whether there's mileage in being salaried.

RL:
So that's the vertical integration that Simon Stevens talks about? That will be very interesting to listen to.

RS:

Simon Stevens is saying exactly that isn't he? And he's not being prescriptive, he's saying – this horrible phrase and he hasn't said it actually – let a thousand flowers bloom.

RL:
No, he has deliberately said 'not a thousand flowers bloom'. There are two main options. One is the multi-professional – and not the multi-skilled – groups; and the other is the vertical integration group. The third is the complete re-jigging of out of hours around primary care.

RS:
I've finished really, and I've noted down some suggestions just because you have to have some sort of conclusion. But I think a new funding formula both for CCGs and general practice now comes on to the agenda because we can get the data, and although care.data now has a very bad name and is in difficulty, nevertheless there is the opportunity to begin to stratify populations very specifically over their morbidity versus their age.

RL:
That's a very good point.

RS:
I think there is the opportunity and that will take 2-3 years to bring on line. As far as where we are at the moment there has been £2 billion promised, or made available, or not new money and so on. There is this rather awful auction going on in the general election which everyone knows about but there needs to be an immediate stabilisation both at hospital level and particularly in general practice in stressed areas. And remember that something like 40% of the identified MPIG losers are in East London. It's extraordinary.

RL:
NHS England did change their mind, didn't they, and say they were going to continue funding – or what happened?

RS:
What they did was they said that they would introduce an interim 2-year assistance to practices that could prove that they were losing more than £3 per head, and then there were a list of other criteria, including interestingly that no partner could earn more than I think it was £150,000 per year or something like that. There are lots of other criteria which made it actually very difficult for practices to get hold of the money.

RL: It was in the small print, yes.

PT: Is £150,000 a year standard?

RS: The average is about 90-95 so that would be exceptional.

PT: So that shouldn't have been an obstacle?

RS: That shouldn't, but it's interesting that they are already on to this whole thing about capping GP income.

RL: And don't forget, that figure is before tax.

RS: It is before tax.

JL: I hadn't actually seen it this way before. Irrespective of whatever you want to call it – profit or income surplus – it is reduced by actually employing more staff to improve the quality of care. Is it the case that the GP representative organisations are so internally divided between themselves that they haven't raised this as a clear disincentive to improve the quality of primary care services?

RS:
No they haven't raised it because they were waiting to the end of having the contractor-status model. So therefore they are happy receive both money for patients and money for themselves in the same allocation.

JL:
But when it starts to work against the doctors who do a better service surely there's a reason to actually challenge it. You can still be in favour of a contractor model and say 'look, let's turn this around so that it's the other way'.

RS:
We have a history of deprivation payments which are repayments. We have a history of the 2004 contract, which means to be workload sensitive to address this issue; they failed. And so yes the BMA is on to this. I was at a meeting with them yesterday. What is also not taken into account, which is obvious when you think about it, is that there are fixed costs that every practice in the land has just to set up in business. We used to have a thing called basic practice allowance. That accounted for that base. That base may work out to something like between 40 and 60% of a practice's expenditure. If every practice received pro rata the same basic practice allowance and then had another one, it would reduce some of the inequalities hugely and very quickly.

RL:
Ron I'm very concerned we've only got a couple of minutes left. We've got the change to funding formula in the light of better access to data which I think is something we should think about. The stabilisation fund, is that listed in your suggestions?

RS: Yes.

NK: This isn't part of what you were saying, but I heard a couple of months ago from one GP, who said in the next few years there's likely to be an exodus of about 20,000 GPs across the country, with I think quite a small minority being brought in from the EU, Eastern Europe in particular. What do you think needs to happen? Because from the things you are talking about – the age-related illness, the deprivation and so on – the fewer GPs there are in the system the more difficult it's going to be to have anything that's proactive in terms of ensuring that those who need it most get it as early as possible rather than when the problem has exacerbated.

RS:
I should have mentioned, there is a recruitment crisis. Doctors are not choosing to be GPs. There is a perception that GPs are overwhelmed, that morale is very low and pressure and so on, which has all been said before. Quite right. There is a crisis in people who want to be GPs and the GPs that are left are finding it very difficult. In East Anglia they can't get locums to have holidays and stuff like that. It is becoming very difficult.

RL: The solution is?

RS: The solution is that Simon Stevens is in a sense doing it. He's turning over the pyramid where we've got tertiary care at the top and primary care at the bottom. He's getting around to it and putting primary care at the top which has always been the answer that people like me have been batting on about for decades. That if you invest in primary care and get people sorted before they get ill you will have less need for secondary services.

SR: Just to re-visit the state of play, let's take you back to the Barts Health trust issue. Has Barts Health taken on board the 60,000 growth in Newham's population? Has that altered its planning for the trust as a whole?

RS: It sees that more as a primary care education problem that needs to be addressed by the local authority.

SR: So people will still have to go to many services out of their area too?

RS: No I think they are just saying that that's something they can't avoid. But what's worrying them in a sense more is people getting picked up by a very pressurised primary care system.

RL:That's all there is. Most illuminating. Thank you very much for your time.

Appendix 1

An Update from General Practice – Dr Ron Snger

1 Since 2004 when the new GP contract was introduced there has been a perception in government that GPs now earn too much. This has resulted in steady downward pressure on practice (and therefore GP) income and in the last 5 years a reduction in the percentage of the NHS budget spent on general practice.

2 The reduction in practice income has been coupled with 'tweaks' to QoF that have resulted in practices having to work harder for less income. The planned phasing out of MPIG, a correction factor added to many practices from 2004 till last April, is merely the most explicit reduction to practices, the potentially largest and probably the most discriminatory.

3 The withdrawal of MPIG is confined to some GMS practices as opposed to PMS or APMS practices. But these other practices are coming under similar financial pressure. For MPIG practices there is now evidence that NHS England has miscalculated the financial effects on practices and has used flawed methodology.

4 After the initial uproar over the destabilisation of some GMS practices NHS England were forced into introducing transitional relief for the first 2 years of MPIG withdrawal. This scheme is inadequate and probably only applied to a minority of practices that are likely to be eligible now that the calculations have come under question.

5 There is a further perception that general practice is 'luddite' and languishes in a by-gone NHS era. The clearest example of GP resistance, Care.data, shows that GPs have a high ethical standard rather than resisting change.

6 Of course there are practices and GPs that perform badly and offer a poor service to patients and are therefore not 'value for money'. Most GPs work an 11-12 hour day and are truly overwhelmed by the demand for their services. If GP inco,e is worked out over a 50-55 hour week, and given the through put of patients seen by doctors as opposed to nurses, and the job weight they are value for money

7 It is no surprise that there is a shortage of trained GPs and of trainees. Plans to increase the relevance and scope of primary care and reduce the use of A&E departments are totally compromised by this.

8 Simon Stevens' 5 year plan states that primary care will be expanded, that practices can be run by Trusts and majors on integration within the NHS (but not so clearly with social services). Where will the required GPs come from?

9 There is a crisis in general practice just as in the rest of the NHS. If the Stevens plan is to re-engineer the NHS it will take time and require some double running. Running the NHS from primary care could well result in a better, more efficient service but is unlikely to be cheaper but who knows?