



## **Listening to the Capital's GPs - Your Personal Copy**

I have great pleasure in enclosing our response to 'Consulting the Capital'. This has been prepared following very detailed consultations with a wide range of GPs from across Camden, and from all types of practices – multi-doctor, average size partnerships, sole practitioners, PMS and GMS. We have encouraged practices to seek the views of their patients and practice teams.

As you will see from our response, we are supportive of the key principles set out in the Healthcare for London consultation. We welcome the case for change where it is supported by solid evidence.

However, much of the commentary on general practice in the Healthcare for London documents relies more on assertion than on evidence. Our response sets out the case for modern general practice, supported by published evidence. Our very firm conclusion is that the case for polyclinics has not been made, and that a one size approach does not fit all.

A copy of this LMC's 'Consulting the Capital' questionnaire response is included in our document. We hope this is a genuine consultation about London's healthcare but we were not encouraged by how leading some of the questions were. We fear that the document was designed to elicit the answers that were wanted and any unwanted answers will be ignored, as has been the case in so many other so-called consultations. Our PCT, like many others, is already putting into effect plans for polyclinics, even though they are temporarily calling them something else.

In Camden, there are concerns that two of the borough's five planned polyclinics will be sited in major acute hospitals, UCLH and the Royal Free. Far from making health services more accessible to patients, this will mean longer and more difficult journeys for our most vulnerable patients. There will also in our view be a risk to the nature of general practice care: from being a local, personal service offered within a familiar and reassuring environment, and emphasizing holistic and continuous care, care will be delivered in a hospital-type environment, with far greater emphasis on pathways and protocols, and far more use of investigations and secondary care services. Paradoxically then, polyclinics like this might well be both less local and more expensive.

We believe that patients and GPs in Camden would generally welcome more the idea of the 'virtual polyclinic', designed around the health care needs of localities. Services can be provided more locally and, where appropriate, a number of practices can share resources, equipment and services. Where practices and patients wish to relocate to a more centralized unit with better resources and facilities, that should be facilitated; in most cases, however, we believe that a 'hub and spoke' model would suit both patients and practices better.

We are concerned that huge amounts of money may be necessary to fund the single site polyclinic vision, money that could be better spent improving existing GP practice premises. We are concerned also that some PCTs may be tempted to use the private sector to fund this vision and will inevitably cede control of how care is delivered, and by whom.

I very much hope that you will read our response with care. As the recognised representative body for GPs in Camden, we wish to work with the NHS in Camden to help deliver high quality patient care. That is what our GP practices and their patients tell us that they want. We have listened to them – and we ask you to listen to us.

**Dr Stephen Amiel**  
**Chair**  
**Camden LMC**





**Londonwide LMCs**

The professional voice of London general practice

# Listening to the Capital's GPs



**Londonwide LMCs' response to Healthcare  
for London's 'Consulting the Capital'**



## Contents

<b>Introduction</b>	Page 3
<b>Modern General Practice: A UK success</b>	Page 5
<b>A Framework for Action:</b> an analysis of findings and recommendations with major implications for general practice	Page 7
<b>Listening to the Capital's GPs:</b> Londonwide LMCs' collective perspective	Page 11
1. Staying Healthy	
2. Maternity and Newborn Care	
3. Children and Young People	
4. Mental Health	
5. Acute Care	
6. Planned Care including	
7. Long- Term Conditions	
8. End of Life	
9. Where we could provide care: Polyclinics – a closer look	
10. Turning the Vision into reality	
<b>Comprehensive, Continuous and Co-ordinated Care:</b> A critical analysis of the proposed changes	Page 17
<b>Conclusions</b>	Page 19
<b>References</b>	Page 22
<b>Acknowledgements</b>	Page 23
<b>Appendix:</b> Camden LMC's collective 'Consulting the Capital' questionnaire response	Page 25



## Introduction

We welcome many of the proposals in the 'Healthcare for London: Consulting the Capital' consultation document. We fully subscribe to the five principles on how to deliver healthcare that is better, safer and more accessible and helps people stay healthier.

The consultation document follows on from ideas contained in Lord Darzi's report on healthcare in London 'A Framework for Action'. This identified many problems in the provision of high-quality, equitable medical care to the capital's population. Many of the report's proposals have major implications for the ways in which general practice and primary care might be delivered in future, with substantial implications for patient care. The report contains radical proposals for changes in many roles and relationships in medicine and for the physical structures within which care will be provided, with huge implications both for investment and for patients and their carers.

Our response to the consultation includes a critical analysis of the ideas and proposals which the consultation is based on. These proposals have significant implications for general practitioners, general practices, their patients and carers. We propose additional and alternative interpretations of some of the issues identified by Lord Darzi's working groups in drawing up 'A Framework for Action', and draw conclusions which we believe to be in the long term interest of the provision of world-class, patient focused, general practice in London.

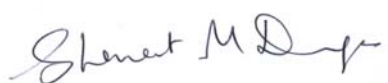
London's GPs are concerned to ensure that the correct balance is struck between continuity of care and convenience. This balance is quintessential to the provision of a comprehensive primary care service within the tight financial limits expected by the taxpayer. Within London, the additional pressures of high mobility and turnover, language and cultural diversity, demographic change and the nature of work and commuting - all point towards the need for ever-more locally sensitive provision.

Networked and federated models of general practice have been promoted by Londonwide LMCs since the Tomlinson report of 1992. This is further exemplified by the energy and collaboration that GPs and their teams are putting in to practice based commissioning.

We look forward to working with London's PCTs in order to ensure the highest quality services for everyone, especially the most frequent service users – the elderly, chronically sick, carers and parents with young children.



**Dr Tony Stanton**  
Joint Chief Executive



**Dr Stewart M Drage**  
Joint Chief Executive



## **Modern General Practice – A UK success**

For many years the system of general practice in the UK has been regarded as the jewel in the crown<sup>1</sup> of the National Health Service. Many international commentators<sup>2</sup> have recognised that the core principles and their implementation of general practice in the UK have been essential components of a high quality health service, in which comprehensiveness, continuity and co-ordination of patient care have been key.

### **Comprehensiveness, continuity and co-ordination**

General practice provides first-contact primary care which is personal, comprehensive, continuous and co-ordinated; and forms the cornerstone of healthcare systems which are effective in clinical and financial terms. General practice in the UK is a good example of this. As healthcare delivery evolves, it is likely to be important to preserve these essential aspects of general practice. The potential impact of some of the recommendations contained in Lord Darzi's report on the ability of primary care to continue to provide continuous and co-ordinated care are discussed in a later section of this document.

### **Primary care systems**

There is persuasive evidence, from international studies,<sup>3</sup> to show that the strength of a country's primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality and cause-specific premature mortality from major respiratory and cardiovascular diseases. This relationship remains significant after controlling for determinants of population health at the macro level (including GDP per capita, total physicians per 1,000 population, percentage of elderly patients), and micro level (average number of ambulatory care visits, per capita income, alcohol and tobacco consumption). These conclusions are based on a series of studies by Barbara Starfield's group at Johns Hopkins School of Medicine, Baltimore, USA.<sup>4,5</sup>

A number of analyses demonstrate that these improved health outcomes are also associated with increased patient satisfaction and, critically, with reduced aggregate health care spending. Interestingly, these relationships appear to hold both in developed countries when primary care orientation also supports equity in access to services, and in low income countries where a strong primary care orientation tends to be more equitable, accessible and appropriate for people living in poverty.<sup>2</sup> The cost effectiveness conclusions are based on a number of studies, including those on general practitioner-led hospitals in Norway and on the role of general practitioners in hospital accident and emergency departments in the UK.<sup>6,7,8</sup> In low-income countries, the World Bank has found that selected primary care services (including infant and child health, nutrition programmes, and immunisation) represent good value for money compared to hospital care. Primary care-focused services appear, therefore, to be associated with good health, social and health economic outcomes, irrespective of their setting. Countries with weak primary care infrastructures tend to have poorer performance on major aspects of health. Furthermore, Starfield and Shi concluded, in an analysis of health care systems in thirteen industrialised

countries, that the stronger the primary care sector, the lower were the health care costs. Good primary care avoids the need for more costly and less coordinated secondary care, not least because investigations and interventions in primary care can be better targeted in the context of the background knowledge about patients held by primary care teams.<sup>9</sup>

### **Registration and continuity of care**

There is persuasive evidence to support the hypothesis that continuity of care remains an essential element of modern general practice, and is a pre-requisite for high-quality consultations and effective management.<sup>10</sup> There is also some evidence that personal continuity, as opposed to organisational continuity, is associated with greater patient satisfaction with care and more efficient use of resources.<sup>11,12,13</sup> This is likely to be further enhanced, particularly in terms of inter-organisational continuity, by the use of a shared electronic patient record.<sup>14</sup>

A further key function of a registration system of care is the link between individual care and the public health function of primary care. Interventions that make most difference to the public health are those that involve doing small things for large numbers of people, such as primary prevention (eg. immunisation), secondary prevention (eg. cervical screening, hypertension management), or tertiary prevention, (eg. rehabilitation after myocardial infarction). Delivery of these interventions depends critically on having accurate patient denominators, derived from registers, so that call and recall systems, audit and follow-up can all be achieved. It is difficult to see how this crucial contribution to the public health can be delivered effectively without a patient registration system.<sup>15</sup>

### **Primary care research**

Because between 80%-90% of all medical encounters take place in primary care,<sup>16</sup> research is essential to inform the effective delivery of care. Much of this research has depended, in the past, on researchers' ability to access patients and patient data through the registration systems for general practice in a number of countries. As well as helping to develop the evidence base for high quality care of acute and chronic disease, research in primary care has also been of great importance in understanding patients' behaviour in relation to health promotion and disease prevention, with significant work being undertaken in areas such as diabetes, vascular disease and colorectal cancer.<sup>17</sup>

### **Building on our success – not destroying the foundations**

Prior to the publication of the Darzi report, a number of recent government initiatives aimed at widening patient choice and improving quality, (including proposals for new health care providers to compete in the provision of primary care services), were introduced, which may have unintended adverse consequences on the core aspects of general practice. There is a robust evidence base supporting the development and retention of health care systems focused on primary care services. 'De-construction' of general practice and primary care in the UK runs the risk of producing disbenefits to patients, professionals and the NHS.<sup>18</sup>

## **A Framework for Action - an analysis of findings and recommendations with major implications for general practice**

The proposals in 'Healthcare for London: Consulting the Capital' are based on ideas presented in 'Healthcare for London: A Framework for Action', written by Professor Lord Darzi and published in July 2007. This section is an evidence based response to those proposals particularly as they affect General Practice and Primary and Community Care (references throughout are to Framework for Action).

### **1. The need for change. (pp.16-28)**

The report makes a compelling case for the need to improve the health of London's population. However, the initial comments about the quality of general practice in London (p.18, para 19) should be balanced by an acknowledgment of the many examples of excellent general practice provision; also of the challenges of meeting the needs of a diverse population, many of whom are unfamiliar with the way in which the NHS works. The Report's comments about getting GP appointments in advance (p.18, para 19) probably largely reflects the arbitrary Advance Access System introduced by the Department of Health.

The Report strikingly highlights major health inequalities, the importance of health care research, the need to use NHS buildings effectively and to spend NHS money wisely. Recent changes in the city's demography and in medical technology provide a clear background to proposed future developments (pp.29-35).

### **2. The proposed changes. (pp.41-86)**

The five principles laid down at the beginning of this section (see below) are commendable, although as we shall see 'localise' is a term open to interpretation.

1. Services focused on individual needs and choices
2. Localise where possible, centralise where necessary
3. Truly integrated care and partnership working, maximising the contribution of the entire workforce
4. Prevention is better than cure
5. A focus on health inequalities and diversity

Of course, integration and co-ordination of care are crucial – but the report ought to acknowledge that co-ordination of the contribution of multiple agencies to a patient's package of care has, for years, been regarded as a core function of general practice. A number of specific points relating to general practice are raised in this section:

- a. The role of GPs in **pre-conception care** is highlighted, and there is a suggestion that this responsibility be reflected in the GP Contract. (p.44, para 22). The nature of this proposed responsibility is unclear.
- b. Proposed improvements in **antenatal care** are set out on (p.46, paras 24-28) and for postnatal care (p.46, para 35), but the role of GPs and their attached midwives is not mentioned, and should be considered.
- c. **Staying healthy** (p.49, paras 53 and 54) includes some commendable aspirations. These could be better linked to an acknowledgement of the established role of GPs, practice nurses and other primary care staff in initiating and sustaining behaviour change, such as smoking cessation, reduction of obesity and encouraging physical exercise.  
**Health improvement** is mentioned briefly (p.52, para 70), and once again there is no acknowledgement that the general practice consultation has always been a key opportunity for health promotion and disease prevention. The suggestion (p.53, para 72), that new roles might be created such as 'lifestyle practitioners' and 'GPs with a special interest in health improvement' does not recognise this role. Such proposals threaten to fragment the well-established whole-person approach to patient care encouraged in GP training and practice.
- d. Proposals for improving **sexual health** (p.53, para 75), particularly in relation to sexual health services for young people should, once again, recognise and support the important role of GPs and practice nurses in this area.
- e. **Non-pharmacological approaches** to mental health and psychological problems receive a welcome mention (p.58-59, paras 102-103.) We would strongly support increasing the availability of these services for patients with these problems and also for the treatment of the large numbers of patients with medically unexplained physical symptoms (chronic fatigue, irritable bowel syndrome, chronic headache etc.).
- f. **Urgent and acute care** is considered (p.61-66) and we strongly support the Report's call for better co-ordination of urgent and out-of-hours services. It might, however, have been appropriate to mention the contribution that GPs currently make to this sector of care by their work in major accident and emergency departments. We are also concerned that suggestions that GPs should develop special interests in urgent care and emergency medicine (para 127) and in acute paediatrics (para 153) may not be realistic and could well lead to further fragmentation of services and de-skilling within general practice.
- g. **Access to GPs** is discussed (p.67, para 160). Whilst we entirely support flexibility in surgery opening hours, the workforce implications of providing greatly increased access for non-urgent conditions need to be carefully thought through.
- h. The question of **immediate access to on-site diagnostic services** requires more thought. This is discussed in relation to polyclinics later in the report. Given the proximity of most of London's population to a central hospital the cost implications of moving endoscopic, ultrasound and other services into the community, with substantial implications for space, buildings, supervision, quality assurance and staffing, require careful consideration. The suggestion that such referrals should be made according to 'standardised London-wide pro formas' (para 165) needs more thought.

- i. **Rehabilitation at home** (p.69, paras 173-177) contains proposals with significant implications for the role of primary care teams and district nurses which need to be thought through.
- j. **Long term care** (p.72, paras 193-196) is, of course, a core function of general practice. Assuring the quality of chronic disease management is a major component of the GP Contract through the Quality and Outcomes Framework (QOF), and this needs to be considered in any proposed new arrangements. The 'web of care' diagram on p.74 should, undoubtedly, recognise that many serious, long term conditions are looked after almost exclusively by general practice teams. In this respect we greatly welcome the suggestion that in order to provide care for these conditions, as the locus of care increasingly shifts from the hospital to the community, additional investment in GPs and nurses will be required (p.76, para 213).
- k. The discussion on **end of life care** is welcome. We entirely support the aspirations of the Report to improve and co-ordinate palliative and terminal care and to ensure that these services are properly integrated. We are concerned, however, about the concept of 'end of life service providers' (ELSPs) (p.80, paras 239-241) to co-ordinate this care. This function for many years has been appropriately and effectively discharged by primary care teams working closely with community nursing, social services, palliative care nurses and specialists.<sup>19</sup>

### 3. **Future models of healthcare provision.** (pp.87-112)

- a. Whilst we recognise the dislocation between primary and secondary care services in parts of London and the advantages of larger practices in providing a full range of services, the argument for developing **polyclinics** as 'the future base for most GP services, community care, diagnostic services and outpatient activity', requires further consideration and is discussed in the next section of this report. We believe that in developing the arguments for polyclinics, the authors of the report should have recognised the range of models of excellent practice currently afforded by well-run practices across London. It is just as important to sustain and build on these models, rather than abandoning good practice (and good premises) by moving to polyclinics. The Report states (p.95, para 26) that 'high-level modelling' indicates that most patients would be within 1-2km of a polyclinic serving a population of 50,000, but a very substantial proportion of London's population are already resident within a similar distance from a fully-equipped large hospital.
- b. **Academic medicine and research** across London receives welcome attention on pp.104-5, paras 55-65, and we entirely endorse the support given in the Report for continuing to develop London medicine (primary as well as secondary and tertiary care) in the ways proposed.

### 4. **Implementation**

- a. This section contains important proposals to develop the healthcare workforce, to provide **clinical leadership** and new **training opportunities**. We are concerned, however, that rather than build on core activities of general practice, as described in earlier sections, there are continuing proposals (p.50, para 119) to develop roles which threaten

to fragment the core functions of general practice in hitherto untested ways. The same comments apply to the proposal (p.120, para 52) to consider creating '**consultants in the community**', particularly when most studies of consultant outreach services have failed to show clinical or cost benefits.<sup>20,21</sup>

- b. **The QOF** is criticised (p.120, para 56), as containing targets which are 'too easy to achieve'. Rather than disregard this important innovation (which has attracted extensive interest in countries with health expenditure problems, particularly North America), it would be more appropriate to build on it. When introduced in 2004, the QOF targets were widely believed to have been set too high. For the first time it had become possible to measure the performance of all GPs against a wide range of quality indicators. Once data from the first year of QOF were released, it became clear that GP performance had far exceeded expectations. Subsequent performance as measured by the QOF has strengthened the evidence that GPs achieve high levels of clinical and organisational care when measured against an expanded series of measures. QOF, in its current configuration, represents the most demanding set of performance indicators available anywhere in the world. Whilst further evolution of the shape and specific targets within the QOF is undoubtedly needed, we now have an independent system for scrutinising individual indicators and the overall direction of the QOF.
- c. **Choice of general practitioner** is briefly discussed (p.122, para 67). It is not clear to us whether the foregoing proposals, particularly in relation to polyclinics, are intended to provide more choice or to encourage patients to move between GPs.
- d. **Polyclinics** are considered again (p125-6, paras 90-92), where opportunities to build on excellence, which is what some of the LIFT proposals were doing, are threatened with being abandoned in favour of a dominant polyclinic model.

## **Listening to the Capital's GPs - Londonwide LMCs collective perspective**

The following main themes reflect the questionnaire headings from 'Consulting the Capital'. They are derived from an analysis of all the responses made by all LMCs. Both the collective Londonwide analysis and individual LMC responses can be viewed on our website ([www.lmc.org.uk](http://www.lmc.org.uk)). We encourage all readers to take particular note of the open text comments, as these form a very informative and substantial basis of our response.

### **1. Staying Healthy**

LMCs were strongly supportive of measures aimed at smoking cessation, weight loss and increasing exercise levels, through the provision of exercise referral schemes, subsidised gym membership and measures to facilitate the use of bicycles. Better access to sexual health services, including prevention and health education, and advocacy related to housing and alcohol and substance abuse were also regarded as important.

### **2. Maternity and Newborn Care**

LMCs expressed strong support for the provision of services to enable women to give birth in a midwife-led unit, with a doctor-led unit on the same site, conveniently situated and with a senior doctor present at the place of birth. There was also strong support for the current system of midwives seeing women at home after the birth, particularly in relation to assessing how the mother and baby are coping.

### **3. Children and Young People**

The majority of respondents strongly agreed with the provision of specialist care for children being centralised in order to provide a higher standard of care. However, there was concern that centralisation might lead to lower standards of care in local hospitals and also about transport difficulties in accessing centralised units, especially for disadvantaged families.

All respondents agreed that immunisation should be a mandatory pre-entry requirement for schools, possibly linked to child benefit and supported by the provision of better information, publicity about immunisation, and an increase in health visitor capacity.

### **4. Mental Health**

The main themes were the need to improve access to non-pharmacological treatments such as cognitive behavioural therapy and other talking therapies and better resources and higher priority for child and adolescent mental health care.

### **5. Acute Care**

There was strong support for telephone services for urgent care needs being linked to a transfer system to health care professionals. However, most LMCs did not want the service to have the facility for direct booking of GP or other health care professional appointments – concern that this

would not help those patients personally known by practice staff or for the GP advocating on behalf of their patient/carer. There was some concern about the definition of urgent care. There was strong support for the provision of specialised care for trauma, stroke and complex emergency needs, accompanied by concerns about distance and accessibility and the need for an expanded air ambulance service to allow rapid transfers. There was support for ambulance staff taking the most seriously ill and injured patients directly to specialist centres. This should increase survival chances providing that there is adequate resources and appropriate training in clinical decision making for ambulance staff.

## **6. Planned Care**

Only a minority of respondents considered extended GP surgery hours as being useful for the majority of patients who regularly access their GP in the daytime. Areas of concern included possible adverse effects on continuity of care, low patient demand for these extended services and anxieties about the safety of staff working extended hours, which were also unlikely to be 'family friendly' for practice staff. A further concern is that of patient/carer safety.

## **7. Long-Term Conditions**

There was strong support for investment in more general practitioners to support people with long term conditions, accompanied by expansion of specialist nurse and other health professional services. Most LMCs stated that general practitioners are best placed to manage chronic conditions by providing continuity of care, local access and early intervention which are likely to be associated with fewer hospital outpatient appointments and greater cost-effectiveness.

## **8. End of Life**

The concept of new 'end of life service providers', responsible for co-ordinating terminal care was considered likely to lead to worse care for patients, although there was uncertainty about exactly what was being proposed. Many felt that it would be better to strengthen and improve existing services, with better resources to improve quality of care, choice and continuity.

## **9. Where we could provide care: including Polyclinics – a closer look**

There was little support for the proposal that 'almost all GP practices should be part of a polyclinic', with almost all LMC respondents tending to either 'disagree' or 'strongly disagree' with this idea. Factors likely to be most important in the proposed polyclinics were access to investigations, the co-location of social services with general practitioner services, minor procedures facilities, pro-active management of long term conditions and healthy living classes. There were major concerns about access to polyclinics for elderly and vulnerable patients who might become marginalised and would not receive adequate continuity of care. There was, however, general support for the view that the care of some conditions should be moved to specialist hospitals and of the idea that more out-patient care, minor procedures and tests should be provided in

the community. Many LMCs highlighted the importance of the continuing contribution of local hospitals.

### **Polyclinics: A closer look**

The consultation document asks the question whether almost all GP practices in London should be put into a polyclinic, either networked or same-site. "Health care for London" is recommending the development of 10 pilot polyclinics, envisaging that in 10 years time there could be 150 across London. The different types of polyclinics are showed in the diagram on page 41 of 'Consulting the Capital'.

While this opportunity for flexible planning is welcome, and should not be lost, we have a strong impression that some PCTs are concentrating solely on the 'merger model', looking for large premises into which to move a number of practices.

When measured against the five principles which emerged from Professor Lord Darzi's work with patients, public, staff and partner organisations on how to deliver healthcare that is better, safer and more accessible and helps people stay healthier, the polyclinic proposals throw up a number of serious problems:

- 1. Services focused on individual needs and choices.** Geographical convenience, particularly for elderly, parents of young children, chronically sick and disabled patients and carers is of the utmost importance. Locally-accessible general practices provide these important aspects of care, whereas merging practices will considerably increase the distances and travel times involved in seeing GPs. Whether or not Lord Darzi's comments about the preservation of personal continuity of care are realistic is, we believe, seriously open to question. Many small and medium-sized practices provide services of particular value to specific communities, and it is easy to see how these 'practice cultures' will be lost in a much larger organisation.
- 2. Localise where possible, centralise where necessary.** General practices already provide local services, and polyclinics will make the services less, not more, local. Additionally, many patients already live conveniently near hospitals capable of providing outpatient and investigative facilities, and, for them, newly-sited polyclinics may be less convenient.

The other, perhaps more worrying, aspect of localisation is the proposal that specialist outpatient services and investigative procedures will be moved out of hospitals into polyclinics. As well as the diseconomies of smaller scale investigative facilities and the likely opportunity costs of fragmenting specialist services by moving them into the community, it is likely that the close proximity and ready availability of these services will simply increase their use. As discussed earlier in this document, the gatekeeper role of general practice frequently involves protecting people from unnecessary

investigations and specialist interventions by taking a measured approach to diagnosis and a parsimonious approach to the use of services. Instant access for patients with self-limiting conditions to blood tests and radiology may have unpredictable effects, including over-use of investigations and over-referral for specialist opinions.

- 3. Truly integrated care and partnership working.** There are good proposals in the report for bringing community services, including pharmacists, therapists and others closer together; for developing the ideas such as 'healthy living centres'; and also integrating out of hours with day-time primary care services. However, integration and partnership working within primary care teams are seriously threatened by the polyclinic model.

Partnerships within general practice are also of great importance. The 'buck stops' with the partners. In a salaried service the function of GPs tends to be confined to surgery duties alone. When further clinical input is required, the salaried GP looks to a partner or a PCT manager for funding and for guidance. PCT funded salaried doctor practices tend to perform less well. It is unclear to us how partnerships are going to work in polyclinics. If everyone retains their individuality as partnerships in the polyclinic, each new patient is likely to be offered a bewildering array of practices-within-a-polyclinic to register with when they first set foot inside the new building. Polyclinics may also be a recipe for partner disputes. Partnerships of the sort usually formed by GPs are unlikely to work in large groups of 25 GPs.

- 4. Prevention is better than cure.** This is, of course, true but healthy living, health promotion and disease prevention are not available off the shelf. The important role of a continuous doctor/patient relationship in promoting healthy lifestyles and avoiding risk factors should not be underestimated. Public health interventions depend ultimately on changing the behaviour of individuals.
- 5. A focus on health inequalities and diversity.** A polyclinic population of 50,000 patients undoubtedly provides an opportunity to think realistically about population-level interventions and the identification and redress of health inequalities. It is not clear that a larger organisation, lacking the cultural sensitivity and close relationships found in many group practices, is likely to be any better at achieving these goals. In addition, general practices are often the only thriving businesses within deprived areas. They provide strong, local employment opportunities and are an asset in terms of skills training and the provision of supportive environments for public sector workers. Closing these practices risks blighting a local community.

If the 'problem' is seen to be a series of small independent businesses then polyclinics are unlikely to be the solution. Instead, the solution is more likely to be provided by professional leadership from bodies such as the Royal College of General Practitioners

(RCGP) and its practice accreditation scheme, particularly in terms of the access and multi-disciplinary team standards currently set by the College. This, rather than a centralising vision, should be the next driver of quality improvement.

The polyclinic models proposed in the report are based on a number of untested assumptions and may have unpredictable and adverse effects on patient care and the costs of care. There are many parts of London in which general practice standards are high and where practices already work together as commissioning clusters, and where enforced merger and co-location would undoubtedly have disruptive and adverse effects. We do, however, recognise that there are parts of London in which newly-built premises could not only replace unsatisfactory GP premises but could also act as an aid to the recruitment of GPs and primary care staff. The 'federated' or distributed model, in which a cluster of practices work closely together, commissioning and sharing services and engaging in joint strategic planning, without the need for new buildings or co-location, is likely to be the preferred option in many locations across London.

### **Affordability**

Lord Darzi's original report discusses the affordability of the proposals, commenting that at baseline growth rates, maintaining the status quo in terms of healthcare provision would cost London £14.6 billion, as against a projected London PCT total allocation of £13.1 billion by 2016/17. It states that the alternative model will save £1.5 billion, partly because of the polyclinic being able to provide services more cheaply than hospitals, with the provision of A&E services and a reduction in outpatient appointments being given as examples of cost savings.

We believe that these assumptions are unsafe, for many of the reasons mentioned above, although we do acknowledge that economies of scale in terms of IT infrastructure and management structures could be achieved in larger units. Whether or not this will outweigh the considerable extra costs of building and maintaining diagnostic facilities; providing outpatient clinics in relatively small community settings; the likely increase in the use of these services because of their proximity and ready availability; should be subject to further, more detailed analysis.

### **10. Turning the Vision into reality**

Whilst there was agreement with the principles on which the report was based, with the greatest strength of agreement being on the reduction of health inequalities and the importance of preventive care, there was also general support for ensuring that whatever changes occurred, continuity of care should be maintained and general practice, as the gateway to healthcare, should be preserved. There were calls for the demonstration of an evidence base and the cost effectiveness of the new proposals.

There was reiteration of the disadvantages of moving primary care away from patients, leading to increased travel time, affecting the most disadvantaged and vulnerable patients. There was also insufficient

evidence to support the case that the proposed changes would, indeed, improve access and health for people from deprived communities and disadvantaged groups. Solutions to these problems included the provision of more resources within deprived areas, focused, for example, on the healthcare of migrants; the need to provide better interpreting services and English lessons to empower those unable to speak English; and the clearer provision of information and 'signposting' within the healthcare system.

## **Comprehensive, Continuous and Co-ordinated Care: A critical analysis of the proposed changes**

How does the range of proposals contained in the consultation document measure against these three essential characteristics of effective primary care?

**Comprehensiveness** represents the ability of GPs to deal with the entire range of physical, psychological and social problems, and all their interactions, presented to them by their patients. The biopsychosocial model of illness is central to diagnostic decision making and management in general practice. GP training has, for many years, successfully delivered doctors capable of taking on this role. The proposals contained in the Tooke Report, to increase the length of vocational training for general practice provides an excellent opportunity to further strengthen the clinical skills of GPs to enable them to discharge their generalist role. Although the pursuit of individual interests and the development of expertise within group practices is not only inevitable but desirable, any further fragmentation of services, particularly those suggested by the range of new roles for GPs proposed at various stages in the Report, are likely to have a serious de-skilling effect on GPs. This would not only lead to sub-optimal patient care but also to de-motivation, as has been observed in other healthcare systems in other parts of the world. With an increasingly challenging and diverse patient population, an increasing workload in terms of the care of complex chronic diseases, and all the problems of inner-city medicine, preserving the generalist core in general practice, rather than breaking it up, should be regarded as a priority.

**Continuity of care**, both in terms of having a personal doctor and also of organisational continuity within a practice, is highly valued by many patients and is regarded by many health service analysts as an essential component of general practice which is associated with high-quality clinical care and the appropriate use of resources. A merged polyclinic model seriously threatens this key aspect of general practice. A large organisation with many staff and many doctors is unlikely to provide an environment in which long term relationships between individual patients and their doctors will be sustained. This is likely to have significant adverse effects on patient care and may well be associated with rising, rather than reduced, healthcare costs.

**Co-ordination** of services has, as already discussed, long been regarded as a key role of GPs. The electronic record held by most GPs is probably the most comprehensive healthcare document available to record and guide patient care, and it is unnecessary to re-invent co-ordinators of care for patients with chronic diseases and long term conditions. This is something that should remain firmly in general practice and it is unnecessary to devise new roles and titles for doing this.

It is, of course, recognised that not all patients need continuity and not all patients present complex problems. Intense doctor/patient relationships may actually inhibit patients' disclosure of important information and other patients may value convenience in terms of getting an appointment quickly above a desire to see the doctor of their choice. These, however, are not the patients who are at the heart of the debate. We are concerned about the very large

numbers of individuals with on-going physical, psychological and psychosocial problems who require comprehensive and co-ordinated care and for whom continuity with an individual GP or practice, where their needs are well-recognised and appropriately met, is a priority.

## Conclusions

In order to deliver healthcare that is better, safer and more accessible and helps people stay healthier, our conclusions to each of the five principles set out in the consultation document are as follows:

### **1. Services should be focused on individual needs and choices**

London's GPs believe that priorities for London's NHS should ensure that resources are increasingly targeted at the effort made by the 6000 GPs and their practice staff. Each practice manages the balance between illness care and health promotion. Practices provide services for patients on a daily basis, delivering safe and cost-effective care. This service for the citizens of the capital is envied by the world.

Each practice population will vary in its needs to access services at different times of the day within the core hours of 8.00am - 6.30pm, Monday – Friday. Access needs to be appropriate to meet the reasonable health needs of patients. A 'one size' approach does not 'fit all' and GPs and their patients should be making joint decisions on the delivery of services.

### **2. Services should be localised where possible, or regionalised where that improves the quality of care**

London's GPs are strongly supportive of speedier centralized hospital services for serious illness where evidence proves that such a move will be beneficial for patients. However, they are worried that moves to centralise specialist and primary care services will affect the availability and quality of training of future doctors, and the viability of existing hospitals which require sufficient throughput of conditions to ensure adequate experience.

The overriding consideration in planning maternity and newborn care must be the safety of mothers and babies. We support enabling women to give birth in a midwife led unit with a doctor-led unit on the same site, conveniently situated. There is a vital continuing role for midwives in supporting the mother, baby and family at home in the post natal period. There is a need for more midwives.

We continue to need convenient local access to paediatric services with more specialised paediatric care being concentrated in fewer hospitals.

### **3. There should be joined-up care and partnership working, maximising the contribution of the entire workforce**

Education and Training must be at the very centre of implementing change. We need to increase our funded and physical capacity for GP training. NHS London needs to fully recognise this. Londonwide LMCs and the London Deanery already have an Education/Service partnership and we intend to build on this foundation.

Long-term conditions are thoroughly managed by London's general practices through routine consultations, guided by the quality and outcomes framework, which is integral to the GP contract. Far from being too easy to achieve, the performance-managed QOF places high demands on practice teams, doctors, nurses and administrative staff alike, and the world-class scores reached by the vast majority of London's practices reflect their commitment to the health of the capital. This commitment should be applauded, not undermined, by those who run the NHS in London.

End of life care would best be improved by all NHS organisations involved in this crucially sensitive area meeting existing best practice guidelines. This means building on what we have, through extending the use of best-practice techniques to all GP practices, rather than looking for "new providers".

#### **4. Prevention is better than cure**

We strongly agree with this maxim. Many of the elements which would help people to stay healthy are public health initiatives, under the responsibility of the Mayor, the Greater London Authority (GLA), individual boroughs and central government.

For example: boosting childhood immunisation rates is primarily a matter of public policy for central government, practices having made sterling efforts to maximise uptake. London's GPs are concerned to ensure that the right balance between illness care and illness prevention continues to be encouraged. The personal consultation with the appropriate healthcare professional in the practice team provides the best opportunity for health promotion and disease prevention in a way which reflects the holistic health needs of individuals and the public. Health improvement is an essential element of modern general practice. The public will not thank any system which prioritises and resources this above the needs of the sick. Over 65,000,000 consultations take place within London's general practices every year, with only 10 percent of these reaching a secondary care setting. The remainder of patients receives the illness care and health promotion advice they need within their practices, through skilled risk management by their general practitioners and practice nurses. That is true local health service.

#### **5. There must be a focus on reducing differences in health and health care**

While we strongly support this principle, we see little in the consultation document which will achieve this and fear that imposition of a rigid polyclinic model will further disadvantage deprived groups.

We believe that a greater proportion of future additional spending should go to supporting people with long term conditions by investing in GPs, specialist nurses and other health care professionals and the services that

they provide. This is contrary to what the NHS London has been doing over recent years, namely reducing real terms investment in the infrastructure, both premises, practice staff and community staff needed to underpin these sensible ways of working together.

We need more resources targeted at existing infrastructure not expensive new-builds in out-of-locality settings where patients will have to make complex, awkward and inconvenient journeys to receive a less personalised service. Eastern European and American models of delivery may have an appeal to those who value a 'white-coat' approach to their care, but that is not the nature of patient valued, UK general practice. Our holistic and integrated approach to medical, social and psychological care is envied and emulated by the very countries from which the polyclinic approach emanates.

## References

---

- <sup>1</sup> Timmins N. The jewel in welfare's crown. The NHS will glisten still if it retains middle class support. *BMJ* 1998; 317; 2-3
- <sup>2</sup> De Maesneer J, Hjortdahl P. Fix what's wrong, not what's right, with general practice in Britain. *BMJ* 2000; 320; 1616-7
- <sup>3</sup> Atun R. Health Economic Network/WHO report: What are the advantages and disadvantages of restricting a health care system to be more focused on primary care services? WHO, Copenhagen, 2004
- <sup>4</sup> Starfield B. Primary care and health: a cross national comparison. *JAMA* 1991; 266; 2268-2271
- <sup>5</sup> Starfield B. Is primary care essential? *Lancet* 1994; 344; 1129-1133
- <sup>6</sup> Baker JE, Goldacres M, Muir Gray JA. Community hospitals in Oxfordshire: their effect on the use of specialist in-patient services. *J Epidemiol Comm Health* 1986; 40; 117-120
- <sup>7</sup> Dale J et al. Cost effectiveness of treating primary care patients in accident and emergency: a comparison between general practitioners, senior house officers and registrars. *BMJ* 1996; 312; 1340-1344
- <sup>8</sup> Murphy AW et al. Randomised controlled trial of general practitioner versus usual care in an urban accident and emergency department: process, outcome and comparative cost. *BMJ* 1996; 312; 1135-1142
- <sup>9</sup> Starfield B, Shi L. Policy relevant determinants of health: an international perspective. *Health Policy* 2002; 60; 201-218
- <sup>10</sup> Freeman GK, Olesen F, Hjortdahl P. Continuity of care: an essential element of modern general practice. *Fam Pract* 2003; 20; 623-627
- <sup>11</sup> Hjortdahl P, Laerum E. Continuity of care in general practice: effect on patient satisfaction. *BMJ* 1992; 304; 1287-1290
- <sup>12</sup> Schers H, vanden Hoogen H, Bor H et al. Familiarity with a GP and patients' evaluation of care: a cross-sectional study. *Fam Pract* 2005; 22; 15-19
- <sup>13</sup> Hjortdahl P, Borchgrevink CF. Continuity of care: influence of general practitioners' knowledge about their patients on use of resources in consultations. *BMJ* 1991; 303; 1181-1184
- <sup>14</sup> Helleso R, Lorensen M. Inter-organisational continuity of care and the electronic patient record. *Int J Nursing Studies* 2005; 42; 807-822
- <sup>15</sup> Starfield B. Public health and primary care: a framework for proposed linkages. *Am J Pub Health* 1996; 86; 1365-1369
- <sup>16</sup> R&D in primary care: national working group report. London, UK. Dept of Health 1997.
- <sup>17</sup> Mant D, del Mar C, Glasziou P et al. The state of primary care research. *Lancet* 2003; 364; 1004-1006
- <sup>18</sup> Jones R. Dismantling general practice. *Brit J Gen Pract* 2007; 544; 860-861
- <sup>19</sup> Burt J, Shipman C, Addington-Hall J, White PT. Palliative Care: perspectives on caring for dying people in London. King's Fund, London 2005
- <sup>20</sup> Jones R. Expanding community-based health services. *Clin Med* 2006; 6(4); 368-373
- <sup>21</sup> Bowling A, Bond M. A national evaluation of specialists' clinics in primary care settings. *Br J Gen Pract* 2001; 51; 264-269

---

## **Acknowledgements**

Londonwide LMCs would like to acknowledge and express our huge thanks to Professor Roger Jones, King's College London School of Medicine, chief author of this document. Conclusions however, have been drawn by the Joint Chief Executives.

We are particularly grateful to Jon Ford at the BMA's Health Policy Economic Research Unit for their analysis of Londonwide LMCs' collective 'Consulting the Capital' questionnaire responses.

Our warm thanks to members of Londonwide LMCs' Healthcare for London Reference Group including the RCGP and the London Deanery.

We have had very useful input from LMC members and other GPs from across London.

---

Camden LMC's collective 'Consulting the Capital'  
questionnaire response

Healthcare for London is keen to receive your feedback on the proposals and invites you to complete the following questions –

**you may answer as few or as many as you wish.**

## COMPLETING THE QUESTIONNAIRE

Where you are given options, please indicate your preference by highlighting it in **bold**.

### CONFIDENTIALITY

Responses from individuals will be shared with Healthcare for London and the consulting PCTs to enable them to consider respondents' views fully but will otherwise be kept confidential.

### PERSONAL DETAILS:

**QA Please tell us your name**

**QB Are you -**

- |   |                 |
|---|-----------------|
| <input type="checkbox"/> Providing your own response                                      | <b>GO TO QC</b> |
| <input checked="" type="checkbox"/> Submitting your response on behalf of an organisation | <b>GO TO QJ</b> |

We would be grateful if you could provide the following information as it will enable us to check we have received personal responses from a representative group of people:

**QC How old are you?**

PLEASE **HIGHLIGHT** ONE OPTION ONLY

- Under 25
- 25-34
- 35-44
- 45-54
- 55-64
- 65 or over
- Prefer not to say

**QD Are you...?**

PLEASE **HIGHLIGHT** ONE OPTION ONLY

- Male
- Female
- Prefer not to say

**QE Which ethnic group do you consider yourself to belong to?**

PLEASE **HIGHLIGHT** ONE OPTION ONLY

- White
- Mixed
- Asian or Asian British
- Black or Black British
- Chinese
- Other (please write below)
  
- Prefer not to say

**QF Using the Disability Discrimination Act definition below, do you consider yourself to have a disability?**

**“A physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities”**

PLEASE **HIGHLIGHT** ONE OPTION ONLY

- Yes
- No
- Prefer not to say

**QG Please can you give your full postcode below. This will be used to assess whether we are receiving responses from across London.**

**QH Are you employed by the NHS?**

PLEASE **HIGHLIGHT** ONE OPTION ONLY

Yes

No

**QI Have you or your family used any of the services below provided by the NHS within the last year?**

PLEASE **HIGHLIGHT** ALL THAT APPLY

Staying healthy (e.g. smoking cessation clinics)

Maternity and newborn care

Children and young people

Mental health

Acute care

Planned care

Long term conditions

End of life care

Prefer not to say

## **DETAILS OF YOUR ORGANISATION**

Please complete this section if you are responding on behalf of an organisation. If you are submitting a personal response please go to Q1a.

**QJ What is the name of the organisation you are submitting this response on behalf of?**

**Camden LMC: Chair, Dr Stephen Amiel**

**QK Please tell us who the organisation represents and, where applicable, how you assembled the views of member:**

**The Local Medical Committee is an elected body established through statute which represents the interests of all local NHS GPs and their practice teams. Londonwide LMCs is the umbrella body for 24 local medical committees of which Camden LMC is one.**

**Views were assembled at the meeting of the Camden LMC, held on Tuesday 18 December 2007, and included views expressed and collated at a joint Open Meeting on 2 October 2007, when all GP constituents in Camden and Islington were invited.**

## Staying healthy

### Question 1a

Looking at the list below, which of the following changes, if any, would you like to make in the future to improve your health? Please choose up to 4.

- Improve your diet
- Increase your level of exercise
- Lose weight
- Give up smoking
- Reduce your alcohol intake
- Improve your sexual health
- Reduce your stress
- None of these
- Other **Reduce poverty and health inequalities**

### Question 1b

How could the NHS in London best help you to make these changes?

**Resource general practice based services for:**

- alcohol cessation
- sexual health screening and prevention
- access to cognitive behavioural therapies (CBT)
- welfare, legal and housing advice

**General practice working more closely with housing and education agencies**

### Question 1c

What else could the NHS in London do to help you stay healthy?

**Influence policy on availability of alcohol and recreational drugs**

### Question 2

To what extent do you agree or disagree with the following statement... “I would welcome advice on staying healthy when I come into contact with healthcare professionals (for example, advice on losing weight or stopping smoking)”.

- Strongly agree

- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

### Question 3

Please give us any other comments on the proposals in this section.

**GPs need to have sufficient time to fulfil their core role in prevention, capitalising on their ongoing relationships with patients. Prevention advice by other team members, and the provision of prevention advice materials in GP practices need to be adequately resourced.**

**This would involve structures and policies that encourage continuity of care; training of staff; improvements to premises and back filling of staff time.**

## Maternity and newborn care

### Question 4

We are trying to balance various factors when deciding on maternity care in London. We would like to know what **three** factors are most important to you. Please choose up to three:

- Giving birth in a doctor-led unit in a hospital
- Giving birth in a midwife-led unit in the community
- Giving birth in a midwife-led unit with a doctor-led unit on the same hospital site
- Being given a choice of a home birth
- Time taken to travel to the place where you will give birth
- Having a senior doctor present on the unit where you will give birth

Please tell us why.

**Women need maximum safety without travelling excessive distances by ambulance should emergencies occur.**

### Question 5

To be able to give high quality care, we need to balance the time that midwives can spend with mothers after the birth of their baby, with the time taken to travel to women's homes. Which of these options would you prefer?

- a)  as now, midwives seeing women at home after the birth of their baby
- b)  most women travelling to a GP or health centre for care following the birth of their baby, and midwives having more time to spend with them. (home visits would be available to women when necessary)
- c)  Don't know

## Question 6

Please give us any other comments on the proposals in this section.

**Midwives need to be resourced to spend adequate time with mothers post natally, particularly for breastfeeding support.**

**Shared ante natal care is and should continue to be provided by GPs; and this should not pre-suppose it be done in polyclinic alone.**

**Care before birth, particularly for vulnerable mothers, should involve health visitor support.**

## Children and young people

### Question 7

The majority of care for children, including urgent care, will continue to be provided locally. We are proposing that specialist care for children will be concentrated in hospitals with specialist child care. This may mean that they are further away from your home. To what extent do you agree or disagree with this proposal?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Please tell us why

## Question 8

What, if anything, could we do to encourage more parents to immunise their children?

**Make immunisations compulsory before school or nursery school acceptance.**

## Question 9

Please give us any other comments on the proposals in this section.

**Resource health visitor teams to promote and deliver advice and immunisations.**

**Rationalise data collection for immunisations to avoid waste of time and resources.**

## Mental health

### Question 10

We have established a new mental health working group including more clinical representatives. The results of this work will be published in summer 2008. In the meantime, please give us your views on the recommendations shown in this section to help us with the more detailed work.

**Welcome proposals for developing services for 14 - 25 year olds and plan to improve access to evidence based treatments such as CBT.**

**Camden GPs would support:**

- Seamless service for both ongoing and urgent mental health problems with easy access for patient, carer and GP**
- Increased number of intermediate care beds and places of refuge for seriously mentally ill and suicidal 14 - 25 year olds**
- Increased resources for difficult to manage patients eg personality disorders and patients with dual pathology (mental health/substance misuse)**

## Acute care

## Question 11

If there was a telephone service to treat your urgent care needs, what facilities would you like it to have? (Please choose up to 3)

- A.  Provide general medical advice
- B.  Book an appointment with GP
- C.  Book an appointment with another healthcare professional
- D.  Transfer callers to emergency services
- E.  Transfer callers to a healthcare professional
- F.  Give directions to a polyclinic, pharmacy or hospital
- H.  I would not use a telephone service for the treatment of urgent care needs

## Question 12

We propose developing some hospitals to provide more specialised care to treat urgent care needs of the following conditions. These would probably be further from your home than your local hospital. If these proposals are adopted, the number and locations will be subject to later consultation:

- Trauma (severe injury) - approximately three hospitals in London
- Stroke - approximately seven hospitals in London providing 24/7 urgent care with other hospitals providing urgent care during the day and rehabilitation
- Complex emergency surgery needs – we need further work to assess the number of hospitals required.

To what extent do you agree or disagree with the proposals to create more specialised centres for the treatment of severe injury, stroke and complex emergency surgery needs?

a) Trauma (severe injury)

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

b) Stroke

- Strongly agree
- Tend to agree

- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

c) Complex emergency surgery needs

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Please tell us why

**Although persuaded by the three areas of speciality, Camden LMC has concerns about capacity and total numbers of hospitals being adequate.**

### Question 13

If you agree that there should be specialist centres for the treatment of trauma, stroke and complex surgery, to what extent do you agree or disagree that ambulance staff should be given the power to take seriously ill and injured patients directly to these specialist centres, even if there is another hospital nearby?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Please explain your reasons

**Agree, but see concerns in Q12.**

### Question 14

Please give us any other comments on the proposals in this section.

**Centralised telephone system can introduce unacceptable delays for patients accessing appropriate advice.**

## Planned care

## Question 15

How useful, if at all, would you find it for GP surgeries to be open for routine appointments in the evenings and at weekends?

- Very useful
- Fairly useful
- Not very useful
- Not at all useful
- Don't know

## Question 16

Please give us any other comments you might have on the proposals in this section.

**Increased hours of GP availability threatens continuity of care and carer.**

**This would be even more threatened by dual registration.**

**For above reasons, extended hours could threaten the most vulnerable ie non-working population.**

## Long-term conditions

### Question 17

Thinking about how the NHS in London is balancing the resources it spends on long-term conditions, (e.g. asthma, diabetes), do you think (please choose one response only):

- a)  a greater proportion of future spend should go to supporting people with long-term conditions by investing in more GPs, specialist nurses and other health professionals and the services they provide
- b)  the current balance of investment between hospitals and community support for people with long-term conditions is about right
- c)  a greater proportion of spending should go to supporting people with long-term conditions through investing in hospital care

Please tell us why

**GPs are best placed to manage chronic conditions by providing continuity of care and coping with multiple morbidities, and by building on long term relationships with patients and families.**

### Question 18

Please give us any other comments on the proposals in this section.

**Community matrons have not proved to be clinically effective or cost effective, so we support investment in core district nursing services along with adult health visitor services.**

## End of life care

### Question 19

Do you think that new end-of-life service providers responsible for co-ordinating end-of-life care will result in better or worse care for patients than the current arrangement?

- Much better
- A little bit better
- No change
- A little bit worse
- Much worse
- Don't know

Please tell us why

**Although fully supportive of the adoption of the gold standard framework in general practice, Camden LMC believes end of life provision should be locally based, working between primary and secondary care and palliative care services, for the benefit of patient, family and carers.**

### Question 20

Please give us any other comments on the proposals in this section.

## Where we could provide care

### Question 21

The proposed polyclinics would have a number of features. We would like to know what five factors are most important to you. (Please choose up to 5)

- GP services
- Social services
- Leisure services (for example a gym or swimming pool)

- Outpatient appointments (including care before birth and following birth)
- Minor procedures
- Urgent care
- Tests – blood tests, scans, radiology
- Healthy living classes
- Proactive management of long-term conditions
- Pharmacy
- Optician
- Dentist

## Question 22

To what extent do you agree or disagree that almost all GP practices in London should be part of a polyclinic, either networked or same-site?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Please tell us why

**Even with networked polyclinics, there is a risk of increased fragmentation of care and potential to lose local and personal GP services. Evidence suggests the polyclinic model will lead to more investigations and secondary care referrals.**

**We do not accept that any polyclinic should be part of an acute hospital site.**

## Question 23

We are proposing moving the treatment of some conditions (e.g. trauma, stroke and complex emergency surgery) to specialist hospitals and providing more outpatient care, minor procedures and tests in the community. Local hospitals would continue to provide other types of care as they do now. Which of these statements most closely fits your view:

PLEASE CHOOSE ONE RESPONSE

- A  We should continue to provide services in the same way as now, with most hospitals providing most services
- B  The treatment of some conditions (e.g. trauma, stroke and complex emergency surgery) should be moved to specialist hospitals and local hospitals should continue to provide other care as they do now
- C  More outpatient care, minor procedures and tests should be provided in the community and local hospitals should continue to provide other care as they do now
- D  The treatment of some conditions (e.g. trauma, stroke and complex emergency surgery) should be moved to specialist hospitals; and more outpatient care, minor procedures and tests should be provided in the community. Local hospitals will continue to provide other types of care as they do now
- E  Don't know

## Question 24

Please give us any other comments on the proposals in this section.

**The "community" should include GP practices, health centres and community centres, and should not exclusively be home or a polyclinic.**

## Turning the vision into reality

### Question 25

In the front of this booklet we described five principles. Now that you have seen how these principles will be applied throughout the proposals, please tell us whether you agree or disagree with each of these principles?

- a) A focus on individual needs and choices
- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know
- b) Localise where possible, centralise where necessary
- Strongly agree
- Tend to agree
- Neither agree nor disagree

- Tend to disagree
- Strongly disagree
- Don't know

c) Joined-up care and partnership working, maximising the contribution of the entire workforce

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

d) Prevention is better than cure

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

e) Reduce health inequalities

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Please tell us why

**Individual choice may hinder population needs and others' choice and be contrary to evidence-based and cost effective practice.**

## Question 26

What, if any, other principles do you think there should be?

**Evidence-based cost effective practice and the current UK GP model meets both these criteria. Over centralisation will increase health inequalities and costs**

## Question 27

To what extent do you agree or disagree with the following statements?

The proposed changes to healthcare services in London will improve access to health services for people from deprived communities and disadvantaged groups.

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

The proposed changes to healthcare services in London will improve the health of people from deprived communities and disadvantaged groups

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Please tell us why

**Agree, but subject to principles as set out in Q26.**

## Question 28

What else could be done to improve access to health services and improve the health of deprived communities and disadvantaged groups?

**Universal access to health services for all eg asylum seekers.**

## Question 29

Please give us any other comments you might have on how health services in London could be improved over the next ten years.

**End change for own sake**

**Reduce drive to competition and increase collaboration**

**Abolish internal healthcare market**

## Returning the questionnaire

Email to: [info@raffertys.co.uk](mailto:info@raffertys.co.uk)

Post to: FREEPOST, Consulting the Capital

# Ipsos MORI

You can also fill in this questionnaire online by visiting:  
[www.healthcareforlondon.nhs.uk](http://www.healthcareforlondon.nhs.uk)