Reforming general practice boundaries

GPC review (England only)

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1. Introduction

Reforming the way in which GP practice boundaries divide primary care services between patients is an attractive prospect for politicians and the general public. The current government in England has stated that it intends to remove these boundaries altogether, while the Conservative Party has declared that patients should be able to register with the practice most convenient to them.

It is right that patients should be able to choose which GP practice is best for them. However, to remove boundaries from general practice altogether would have a number of consequences for the organisation, provision and funding of all NHS services and some aspects of social care which need to be considered. It is important that these implications are fully understood so that a balanced and informed assessment of the benefit to patients of removing practice boundaries can be made prior to doing so. This review explores the many consequences and potential opportunities that implementing this proposal presents.

In considering the possibilities of altered boundaries, it is important to clarify which alteration is being made:

- entirely boundary-less practice (beyond English borders?)
- 'fuzzy' borders of current practices
- dual registration with one main and one subsidiary practice
- dual registration with two equal practices
- enhanced temporary resident arrangements where a patient can be seen by another practice away from their home by using a new criterion within the temporary resident arrangements

2. The implications of removing practice boundaries

Free registration – what does this mean?

It is probable that if patients were given the choice of registering with any practice that was convenient for them and met their needs, the majority would wish to stay with the GP with which they had built a personal relationship. However, some patients may choose to register at a practice near their place of work, or at a practice recommended by friends and relatives, or remain registered with their practice having moved outside the original practice boundary. This could result in patients registering at a GP practice outside the PCT in which they live. It also raises the possibility of 'commuter shift', whereby groups of patients may move away from suburban and rural practices to city practices. This could be particularly significant in the major urban conurbations.

If practice boundaries were to be abolished or relaxed, politicians would have to find ways to tackle the potential consequences of these trends for home visiting arrangements, patient funding, health inequalities, premises and other elements as outlined below.

Reforming home visiting arrangements

Currently, patients receive visits from their GP at their home when the GP considers that the clinical condition of the patient warrants this. This is a contractual obligation on GPs, but it restricts patients to registering with a practice near to their home. This also enables the patient to be seen at their home by a GP who understands the social context and environment of the patient, with whom the patient

has a relationship of trust and understanding, and where there is continuity of care. Good general practice is dependent on GPs appreciating these contextual factors. Home visiting in this context provides GPs with the opportunity to spot, for example, hidden alcoholism or early signs of dementia. In caring for the whole patient, whether in the consulting room or the home, GPs can ensure that the psychosocial aspects of the consultation are not neglected, that prescribing is appropriate and hospital admissions only occur when necessary. All these elements would be at risk if the registered GP was not able to visit their patient at home for routine in-hours care.

If patients choose to register near their place of work, or some distance from their home, then home visiting by their registered practice may not be possible. If these patients were still to have access to a home visiting service, then it would be likely that two standards of care would develop in primary care – one for those patients cared for wholly by their registered GP, and one for those cared for by a 'visiting service' when ill at home. By its nature, such a service would be more process-driven and without the contextual benefits of the existing longitudinal model of general practice. Patients that were dual registered would likely experience the same problems as those not visited at home by their single registered GP.

Furthermore, one of the strengths of receiving care from one source is that there is no confusion over where responsibility lies for resolving a problem - as opposed to monitoring a condition until the next organisation takes over the care of the patient. It also is a way of preventing fragmentation and duplication of services and ensuring services are cost effective. This second scenario is not inconceivable if a patient with a long term condition were to regularly visit their registered practice, but also required frequent home visits from a visiting service. If general practice care was disrupted in this way, then the difficult decisions for the terminally ill, those with a long term condition or patients with mental illness, may be avoided to the detriment of the patient; merely by the application of a fragmented process.

An alternative model may assume that healthy patients would have no need of a home visiting service and that they could freely register away from their home. This cannot in reality be the case. Serious illness is, by its nature, unpredictable and any patient may require their GP to manage a condition at their home at any time. The long-term care of a patient may be compromised if they are forced to change practice to enable convalescence or end of life care close to their home.

It should also be noted that the provision of a home visiting service benefits the full practice population, whether a patient utilises the service or not, by maintaining a GP's experience in unplanned and domiciliary care. Practices that no longer provide a visiting service may lose these acute skills and gradually become centres for the management of chronic illness. This would be to the detriment of all patients seeking the full range of general practice care. This could also affect the future recruitment of doctors into general practice as a specialty.

If practice boundaries are to be removed, a framework must be determined that provides care to patients at home while preserving the fundamental elements of general practice: effective continuity of care and record; informed diagnosis taking account of the medical and social context of the patient; and appropriate risk management on the part of the GP.

The funding of GP services

If the removal of practice boundaries does lead to a 'commuter shift', this may involve healthy patients changing practice, while vulnerable, older and chronically ill patients may be less likely to switch. Although the formula for distributing funding to practices (the Carr-Hill formula) would respond to such changes in the patient population, this process would take time. A patient can receive care at their new practice from the day of registration, but funding for this new patient would arrive up to three months later. This problem would be particularly acute if a previously healthy patient moves from a practice near their work to one near their home when they fall seriously ill.

The Carr-Hill formula provides funding to practices by weighting the patients that are registered on the practice list. There are a number of factors that affect the patient weighting, but taken as a whole, the formula is broadly designed so that the funding for healthy patients subsidises the care of less healthy patients. One of the ways in which this is done is by grouping patients into averagely weighted age and sex bands. However, these bands, and thus the Carr Hill formula, are not sensitive enough to reflect large movements of certain types of patients, for example commuters, within the bands. Cross subsidisation of patient funding will be disrupted.

The Carr-Hill formula also includes a rurality adjustment dependent on the distance the patient lives from the practice. If patients are able to register with a practice some distance from their home, then using the distance to the practice as a measure for rurality payments would no longer be appropriate. This has already been recognised by the Formula Review Group in 2007.[1]

Therefore considerable questions arise over the suitability of a weighted capitation formula that depends on a patient's address, given that patients would have no restriction as to where they registered. A review of the Carr-Hill formula in preparation for the removal of practice boundaries would be essential to ensure that practice funding responds sensitively to patient movements and changing practice demographics. In addition, predictable funding would be necessary to plan the provision of services effectively. It would also need to be determined where responsibility for providing practice funding lies – with the Primary Care Trust (PCT) of the practice or the PCT where the patient lives.

All practices must be provided with sufficient funds to care for their registered populations – whether healthy commuters or the old and sick. The alternative is the widespread destabilisation of practices. In the worst case, rural and suburban practices that have been significantly affected by 'commuter shift' may find that they are forced to revise the patient services they are able to offer. Those patients that choose not to change practice must not be adversely affected by the consequences of others who do choose to move.

1 The Formula Review Group produced the report 'A review of the General Medical Services global sum formula' in 2007. The Formula Review Group is led by NHS Employers and comprises senior colleagues from the GPC and the four UK Health Departments. The review was supported by independent academic research. The report can be found here: http://www.nhsemployers.org/SiteCollectionDocuments/frg_report_final_cd_090207.pdf

Widening health inequalities

Removing practice boundaries and providing patients with a free choice of registration may have the unwanted outcome of widening health inequalities. Apart from in dense urban areas, patients will only be able to choose to register with a practice outside their local area if they have access to private transport or affordable regular public transport. Similarly, those too frail to travel very far will be unable to exercise their choice effectively. Indeed, immobile patients may have difficulty registering with their local practice if it is popular enough to attract high numbers of patients from a wide area. For many, choice of registration will thus be determined by their economic status, level of existing health, or age. This could widen existing health inequalities within general practice, particularly if those practices destabilised by the loss of commuter patients are also those that the frail, old or poor attend.

Protecting vulnerable patients

A central element of general practice is ensuring that vulnerable patients at risk (including children, the elderly, those with learning difficulties, those in palliative care, etc.) are protected through continuity of care in a stable, familiar, practice where the GP fully understands the context of the patient's care. Access to local knowledge as well as the records of such patients is essential for this. Meanwhile, home visits to vulnerable patients by the registered GP are an opportunity to detect the soft signs of potential abuse. If these patients, or their guardians, were free to register with any available practice as often as possible, there would be a significant risk that concerns attached to these patients, and the continuity of care that is important in identifying concerns, would be lost. The removal of practice boundaries must not present an opportunity for abuse to go unchecked.

Coordination of commissioning functions

The provision of care in the NHS is based on a framework of care pathways. Many of these start with the GP, who refers a patient to hospital, where they are treated and then referred back to the GP for any follow-up care or recovery. Other pathways may start at Accident and Emergency, but almost always involve referral back to the GP for management of the condition with, for example, possible referral on to additional community therapy services. The registered GP practice is the only constant figure in patient care, and the gateway through which most other services are accessed. Through practice based commissioning (PBC), GP practices also develop new care pathways in the community. As such, GPs direct how NHS funds are spent on caring for their patients through their referrals and their commissioning initiatives.

NHS funding for primary care, and secondary and tertiary care referrals, is allocated to PCTs on the basis of the resident populations within the PCT. If practice boundaries are removed and patients are able to register with a practice outside of their PCT area, this will have the effect of dislocating the existing NHS funding and commissioning structures. Within this current framework, it is not clear how PCTs would fund a practice attended by a patient outside its own boundaries. To put this in context, some PCTs have sought to prevent GPs with a PMS contract from registering patients who live outside of the PCT area because of the funding and commissioning difficulties this presents. It is not clear how PCTs will be funded, if they can no longer recognise 'their' local population, because it has registered elsewhere.

It is also not clear who would be responsible for paying for secondary care referrals – the PCT where the referral was made by the GP or the PCT where the patient lives? Similarly, would a practice be able to commission services for patients who lived outside its own PCT boundaries? Would a PCT pay for a service provided by another practice which they would not have prioritised for commissioning themselves? What is local commissioning in the context of boundary-less practice? There are many similar scenarios that could be explored. However, the current funding framework for the NHS is based on patients accessing services local to them or purchased on their behalf by their local commissioning body; if patients are to be given a choice of GP that is not local, then the existing NHS care and funding pathways must be transformed to make this possible.

In whatever way this is done, GPs remain responsible for the care of their patients and must have ownership of the commissioning and referral decisions relevant to that patient, based on their clinical needs. GPs must also be involved in the decisions which have consequences for the economy of the local NHS system with regard to that patient.

Contractual change

If patients were to be given a right to register with any practice of their choice wherever it is, it would require significant reform of the GMS contact. This would include removing the contractual requirement for a GP to visit a registered patient at home during the in-hours period if they resided outside the practice boundary. Not only would the financial arrangements need to be revised to respond to patient movements better, while still allowing effective planning, but regulations would be required governing the free movement of patients. National negotiations would need to determine how long a patient should remain registered with a certain practice. For example, would a patient be able to register with a GP for a single appointment, and then move to another practice? How would the practice be funded for this short term care? How would temporary residents be defined in this new situation? We believe that this would require a new kind of temporary consultation arrangement that did not depend on where the patient lived.

It would also be necessary to explore whether a practice can refuse to accept new patients, and under what non-discriminatory circumstances. For popular practices, there would come a point where practice expansion is no longer possible – the infrastructure would be operating at capacity while no further GPs could be employed. In such circumstances, the practice would have to refuse further patients and request that their PCT close the practice list. Furthermore, it will be necessary to determine how GP performance investigations will be conducted by a PCT when the patient lives in the area but the GP is based elsewhere, and vice versa.

All these issues would need to be addressed by national negotiation to revise the GMS contract. Local negotiations with the PMS and APMS contractors in each PCT would be required to ensure full implementation of this proposal across GP practices in England.

IT in general practice

Increased movement of patients across the country would involve more frequent transfer of patient records. Similarly, the provision of a home visiting service by a GP other than the patient's registered GP would require ease of access to patient records. It is therefore imperative that the GP2GP electronic patient record transfer project is accelerated. Without access to full patient records, GPs would not be able to make safe clinical decisions in the context of their patient's medical history. It is crucial that GPs are able to do so. However, access to a patient's records may solve short term mobility problems, but the risk remains that the GP would not be aware of the patient's local context when viewing an electronic record in isolation. Improved records access would still be inadequate compared to the breadth and depth of the normal GP-patient relationship.

Irrespective of this, the removal of practice boundaries poses considerable logistical difficulties for IT in practices, particularly in relation to the QOF and the use of the new GPES (General Practice Extraction System). A patient may register with several practices over a year, but the NHS would only recognise one at the end of the 'quality accounting year' when assessing QOF payments. The recent announcement that NHS IT funding is to be significantly cut means that it is essential that the IT logistics be resolved before practice boundaries are removed. Without appropriate IT systems, it is not clear how this proposal could be administered safely or practically.

Prescribing

The potential demographic movements described as part of the 'commuter shift' trend could also have a significant impact on local prescribing formularies and prescribing budgets, particularly in urban areas where the numbers of registered patients may increase significantly. It will be important that this is understood before boundaries are removed, so that prescribing budgets are able to respond to changing patient populations. Quality and Outcome Framework (QOF) prevalence figures would also be affected by changing demographics, especially if practices register large numbers of healthy patients. Contact tracing would become a much harder task if patients were able to move practice frequently. Clearly, the rate and frequency of such practice changes have a bearing on how much of a problem this might become.

It should also be noted that patients may seek to register with practices in the devolved administrations where prescriptions are cheaper or free. Meanwhile patients with addiction problems may attempt to serially consult with different practices in order to obtain excessive supplies of prescription drugs.

Violent patients and mentally ill patients

Free choice of practice cannot be universal. Special arrangements must be made for patients on a violent patient scheme. These patients require a stable environment that provides continuity of care as well as a safe setting for the individuals involved in delivering their treatment. In a similar vein, vulnerable mentally ill patients may be at risk from registering far from their home or their local community mental health team where their care histories and warnings signs of relapse may be better understood.

Premises

A central assumption within the removal of practice boundaries is that practices would be able to react to patient movements. For those who gain new patients, and for those that lose patients, this may not be true.

There is a natural limit to the number of patients that one practice can take on. Although new GPs can be employed if patient demand increases, it is not so easy to increase the size of premises, nor improve the facilities available to offer new services in a short space of time. Similarly, where practices lose patients as a result of commuter shift, they may be limited in improving the services they are able to offer patients by historically inappropriate premises. Investment in the development of premises significantly lags behind the registration choices that patients make, and in both cases practices would have difficulty responding to their patient movements. If patients are given a free choice of practice, this initiative must be matched by one to allow practices to improve their premises and infrastructure in response to patient choices. To do otherwise would compromise patient's ability to make an informed choice. Solving this problem would require significant new funds, as well as much more rapid changes in premises funding to be delivered to expanding practices.

Homogenous practice populations and GP training

There is a risk that the demographic movements associated with 'commuter shift' would lead to increasingly homogenous practice populations. GPs in urban practices may be more likely to see local professionals and workers, while rural and suburban GPs might tend to see the young, old and less mobile more often. This may lead to GP de-skilling as practices begin to provide care to the same groups of people for the same conditions. This would also limit GP trainees' exposure to different types of patients, while trainees would also potentially miss out on valuable home visiting and unplanned care experiences. Such changes in GP and trainee exposure would need to be considered in the context of the general practice curriculum.

Devolved administrations

The proposal to remove practice boundaries applies only to England at present. Patients in England who live near the border have already begun to take advantage of differences in health policy between England and Wales and Scotland, for example by seeking cheaper prescriptions. If practice boundaries were removed, this would have the effect of making every patient in England a potential border patient. It would therefore be essential that the operation of the interface between general practice in England, and that in the devolved administration, was clarified for patients. All of the implications of removing boundaries that are discussed above must also be considered from the perspective of their affect on the devolved nations.

The cost of free registration

Offering patients the opportunity to register with the GP of their choice would enable them to have greater control over this aspect of their care. It may increase competition between practices and it is suggested that it could potentially raise standards of care, although the opposite is also possible. However, to provide this level of flexibility, beyond the local choice of practices already available to patients, would come at a cost to the NHS in terms of increased bureaucracy and duplication of services.

Several discrete costs are described above – improved access to electronic patient records, new IT solutions for the QOF and practice finance administration, responsive investment in practice premises, systems to protect and track vulnerable patients and a new commissioning/funding framework. However, if the implementation of a free choice of registration is a two GP solution – a registered GP and a home visiting GP – then it is clear that providing each patient with access to two GPs in the in-hours period would cost more than the current model of a registered GP who visits local patients at home when necessary. Both GPs would require sufficient funding to be able to respond to the primary care needs of the patient. It would not be possible to remove a portion of the funding to the registered GP and re-allocate it to the home visiting GP without harming the services offered at the original practice. Regardless of the contracting arrangement, this option would involve increasing funding into general practice. Free choice of registration is a laudable ideal, but it is also an expensive one.

3. Opportunities to improve GP choice and access

Providing patients with greater choice of GP practice and improving patients' access to their GP are two of the commonly held aims of removing practice boundaries. However, there are alternatives to the universal removal of practice boundaries that still achieve some of the objectives of this proposal.

Remote consultations

One of the simplest approaches to avoiding the numerous concerns outlined above would be to employ telephone, videophone or webcam consultations. This would allow the patient to access the registered GP (who understands all aspects of the patient's care) when they were outside of their local area without need to change registration. This approach would not require a substantial increase in funding (if any at all) nor a re-organisation of the delivery of primary care.

Although there are obvious limitations to this method, it would nonetheless maintain continuity of care for the patient, while a remote consultation could be followed by a face-to-face consultation if this were necessary. The technology already exists to provide such services, while it is part of the current government's wider technology agenda to increase the UK's capability in this area.

Extended and 'fuzzy' boundaries

In many densely populated urban areas, the application of practice boundaries can appear inflexible, sometimes only encompassing a few streets. Although there may be numerous physically accessible practices in the PCT area, access to some may be restricted by the practice boundaries. In these circumstances, it may be feasible to widen the boundaries of all the practices in the urban area to the limit of practical home visiting by the registered GP. Such an initiative would improve the practice choice available to patients while avoiding many of the complications explored above. Nonetheless, additional premises investment would still be required to assist practices in responding to local patient movements.

Another common scenario involves existing patients moving just outside the practice boundary. The GP could request that the patient registers elsewhere, however where the GP could reasonably visit the patient at their new home, then it would be possible for the boundary to be extended, or become

'fuzzy' for this patient. It would be important for all parties to agree what is 'reasonable' in these circumstances. This arrangement would only apply for existing patients to maintain continuity of care and an established doctor-patient relationship; it would not normally be available for patients seeking to register with a practice in the first instance. There would need to be procedures put in place to ensure that such an arrangement carried no risk of discrimination. If this were to be desirable, then there would have to be controls over PCT allocation of patients beyond the practice's normal boundary. Some practices informally offer this opportunity already, but the formalising of this process across the country would benefit all patients by maintaining long term care and preserving the contextual understanding that underpins good general practice.

'Open but full' practice lists

The management of practice lists can present difficulties for some GPs, and they are sometimes forced to employ the concept of an 'open but full' practice list. This can be understandably frustrating for patients, but reflects the fact that GPs can reach a point at which they have no further capacity to care for patients. PCTs should work constructively with practices to see how these problems can be resolved locally and access to these lists improved. This may be achieved by PCTs assisting practices with medium-term support for premises development and staffing shortages, by seeking to relax parking regulations for GPs in areas of high density population or by offering appropriate Local Enhanced Services (LESs). Enhanced Services that target specific patient populations such as nursing homes, homeless patients or ethnic minorities, for example through the assistance of an interpreter, can be very effective in encouraging practices to open their list to take on new patients.

Primary Care Federations

The concept of Primary Care Federations remains in its infancy. However, it has the potential to offer patients a variety of access points to a network of GPs when they register with a practice in a federation. Federations would likely operate over a local area, and avoid many of the complications involved in removing practice boundaries nationally. However, investment in the IT infrastructure would still be necessary.

Improving choice in rural areas

Some rural patients live within the boundary of only one GP practice. This obviously restricts their ability to choose which GP provides their care. In many areas, this situation is a product of the progressive amalgamation of smaller practices into one large practice, with the consequence of limiting the choice of GP practice for some rural populations.

In many respects, the perception of the benefits of larger practices can be misleading. Small practices, when co-ordinating and commissioning services together are just as able to provide the range of services that one larger practice can offer, while it is often acknowledged that patients prefer to be registered with a smaller practice. Moreover, where a number of small practices exist in one area, patients will be able to exercise their choice and determine which GP practice best suits their needs, which is an important part of providing effective primary care. We think the time has come to recognize the worth of multiple small providers in an area where the alternative is a single large provider.

Reforming the temporary resident arrangements

All of the options discussed above attempt to provide local solutions to the task of widening choice of practice and improving access to primary care. The most sensible national solution to this issue is to reform the contractual arrangements governing the treatment of temporary resident patients. This would enable patients to seek the full range of general practice services on an immediate basis when they are away from their registered practice more effectively than at present.

Under the current GMS contract, GPs have an obligation to provide immediately necessary or emergency treatment to temporary residents. However, the funding for these services is based on a single historic allocation that is in many areas outdated. Temporarily resident patients are considered as those whom will reside in a place for more than 24 hours but less than 3 months.

A fair and transparent revision of these arrangements would see GPs offering to treat all unregistered patients on an ad hoc basis as well as a temporarily resident one, with a 'payment by results' funding mechanism to ensure that practices are rewarded for each episode of care. This would mirror payment mechanisms to A&E attendances and walk-in centres but would likely to be more cost effective. This would reassure practices that they would be funded appropriately for providing this service and encourage them to improve access to GP services. It would also encourage patients with acute minor ailments to visit a GP as a temporary resident patient rather than inappropriately attending A&E.

This concept is not without difficulties – access to patient records electronically would remain a problem. The funding arrangements may also cause complications – it would need to be determined whether the practice's PCT or the PCT where the patient was a resident would fund the temporary resident episode of care. Furthermore, investment in general practice may still be necessary to provide the additional capacity required to offer extra appointments to temporarily resident patients. However, this avoids the main hurdles to removing practice boundaries: revising the NHS commissioning framework, the risk of losing contact with vulnerable patients, the potential widening of health inequalities and the fragmentation of GP home visiting services.

This proposal would provide patients with the opportunity to access general practice treatment when they needed it while they were away from their registered practice. Their home practice would still provide routine care, as well as maintaining the long term continuity of care and understanding of the social context of the patient that is so important in providing good quality general practice. If the reform of temporary resident arrangements was combined with solutions to increase local choice of GP practice, then this would service patients far better than the upheaval and unwelcome consequences caused by the removal of practice boundaries.

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