PRIMARY CONCERN

Despite government promises of local involvement, proposals for polyclinics and alternative providers of general practice services have upset both doctors and patients.

Nigel Hawkes investigates

P rimary care, for so long denied the pleasures of NHS reorganisation, is finally facing a showdown. At risk is the deal under which primary care is supplied by general practitioners (GPs), who combine public service and private entrepreneurship within a protected market.

The private sector is being invited to tender for polyclinics and for primary care services across England. GPs complain that these changes have been sprung on them with little warning. Who voted for polyclinics, they ask, or for open tendering for primary care services and the awarding of contracts to private companies? GPs feel that they have been sandbagged by a reform that lacks political legitimacy or an evidence base.

The BMA has launched a Support your Surgery campaign, while health minister Ara Darzi has promised local people involvement and consultation in any changes to their services.¹ But this promise has been made when the changes are already under way.

Lord Darzi's principles are positive (box), says Hamish Meldrum, chairman of the BMA Council. "In fact they're impossible to disagree with," he says. "The problem is that the public and healthcare staff alike have yet to see much evidence of these principles being delivered up to now."

Local voice

These changes to primary care come at a time when the public lacks a mechanism for approving or opposing them. The dismantling of the successors to community health councils, the patient and public involvement forums, has left the NHS without a formal system of patient representation. The new local involvement networks started only last month and are not yet up and running.

When primary care trusts (PCTs) were first set up in 2002 it was claimed that they would be more responsive to local needs. PCTs meant an end to central diktats and the rebirth of localism. As recently as January this year, David Nicholson, the NHS chief executive, promised: "Much more emphasis on localism; much more emphasis on local people talking to their populations to identify what is needed for them."³

Yet it is these very trusts that are now rushing to set up polyclinics and awarding alternative provider medical services contracts, both centrally mandated policies. The disquiet about these changes to primary care is compounded by the sense that there is little anybody can do about it.

In Camden, north London—once a byword

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for leftist orthodoxy—the local PCT has awarded UnitedHealth a contract to run three general practices. The company told two GPs that their services were no longer needed. At a stormy public meeting last month John Carrier, the trust's chair, defended the decision.

"I don't think this is privatisation if you look at the principles here," he said. "Is it going to have comprehensive coverage? The answer is yes. Is there going to be equal access to services? Yes. Is it going to be free at the time when it is needed? Yes."

Camden councillors have referred the decision to the secretary of state, Alan Johnson, claiming that the trust had failed to flag up the possibility of a new type of provider being appointed to run the practices.

Councillor David Abrahams, a Liberal Democrat who chairs Camden's health scrutiny committee, told *Camden New Journal*: "As far as the public is concerned, this has come out of the blue . . . The public were not asked whether or not they approved of a new type of private sector provider." If he had been aware sooner, Mr Abrahams said, he would have called in the proposal to the council's overview and scrutiny committee.⁴

Critics such as Laurence Buckman, chairman of the BMA's General Practitioners Committee, believe that private companies will be motivated by profit whereas traditional general practices are not. But this is tricky territory, as some GPs admit.

James Hickling a salaried London GP put it succinctly in a recent letter to the *BMJ*. "It is an incredible achievement" he wrote, "that 60 years after general practices first contracted to provide services for the NHS, the profession has convinced the public, and sometimes even itself, that there is no profit motive involved in the way traditional partnerships run surgeries. There is."⁵ In fact, general practice principals have for years managed the feat of operating as private contractors while enjoying the benefits of the NHS pension scheme: nice work if you can get it.

Command from the top

GPs may be on stronger ground when they attack the way the changes are being implemented. The order that all of the 152 PCTs in England should procure a polyclinic (or health centre, the term now favoured) was laid down centrally in the 2008-9 operating framework, published in January. This order appears to prejudge both Lord Darzi's "once in a generation" review, the localism that PCTs are supposed to represent, and his new promises of consultation.

Will any trusts disobey the command?

Don't bet on it. "The policy has taken on a life of its own" says Roy Lilley, external relations officer for the National Association of Primary Care. "Wider and more extensive debate is required on this unpopular policy, which ignores the whole idea of patient choice and convenience. There are many unanswered questions and yet already some PCTs are planning to build Darzi palaces."

David Stout, director of the PCT Network, says that the consultation underlying the health centres came from Lord Darzi's review of the future of the NHS⁶ and the 2008-9 operating framework made it policy.

"But PCTs still have the responsibility to consult on service changes," he says. "They will have to go through some form of consultation, not on the concept but on siting, and so on."

The Department of Health has issued guidelines on what form consultation should take.⁷ It says that the level of patient and public involvement should be matched to the circumstances and context in which changes take place.

At one extreme, it says, it might involve NHS organisations in no more than "giving information"—telling the local press, for example. At the other extreme might be full scale partnerships with other local bodies. Somewhere in between are citizens' panels, focus groups, public meetings or seminars, and citizens' juries.

But, the Department of Health says, "It is important to be clear if people are being asked for their views on how the change can be best implemented rather than whether the change will happen."

There are some clear obligations in law. The 2001 Health and Social Care Act places a duty on NHS organisations to consult local authority overview and scrutiny committees on any proposal that is a substantial development or variation. But there is no definition of substantial.

Does the awarding of a local practice to a private company amount to a substantial

change? To local people, perhaps it does; but the process has already been going on quietly for years.

Private provision

The market leader may be a surprise to many people. It is a company set up in 2002 by a doctor and a nurse, ChilversMcCrea Healthcare, which now runs 38 practices, three of them walk-in centres. It won its first contract in 2003. Cofounder Sarah Chilvers says it has "crept in under the radar," deliberately keeping a low profile. Its founders' expertise in public involvement may have helped smooth

any ruffled feathers in areas where it operates, but Dr Chilvers recognises the mood is changing. "I went to a patients' meeting recently and found the local medical committee were there and a team from *Panorama*," she says. "We do get some flak, and the market is now getting very competitive and GPs are nervous and worried. But all we are doing is what they should have done."

Their most controversial practices are in Derbyshire. Cresswell and Langwith practices were originally awarded to UnitedHealth, but the contracts were thrown out after a

legal battle. North East Derbyshire PCT was forced to re-advertise, and the contract went to ChilversMcCrea.

Normally, PCTs bring in private companies in areas where traditional general practices are hard to sustain. Mark Hunt is a former GP and now managing director of primary care services for Care UK, which runs general practices for Hackney and for Barking and Dagenham PCTs.

"They are open 365 days a year between 8 am and 8 pm," Dr Hunt says. "In Hackney, we have 25 patients signing up every week, and we're up to 4300 patients. In Barking and Dagenham we're providing primary care to a lot of people who hadn't had access before."

"The PCTs had explored other routes for providing service, including running them

LORD DARZI'S FIVE PLEDGES ON CHANGE IN THE NHS²

1. Change will always be to the benefit of patients. This means that change will improve the quality of care that patients receive, whether in terms of clinical outcomes, experiences, or safety
2. Change will be clinically driven. We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence
3. All change will be locally led. Meeting the challenge of being a universal service means the NHS must meet the different needs of everyone. Universal is not the same as uniform. Different places have different and changing needs—and local needs are best met by local solutions
4. You will be involved. The local NHS will involve patients, carers, the public and other key partners. Those affected by proposed changes will have the chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively
5. You will see the difference first. Existing services will not be withdrawn until new and better services are available to patients so they can see the difference

themselves. But it hadn't worked. We provide an alternative that works."

Local practices have equal rights to bid for these contracts, says Mr Stout, and there are cases where they have won them. But some GPs claim that the tendering process is not a level playing field, with private companies being favoured even when local GPs put in competitive tenders.

Currently, there are 152 PCTs, responsible for planning, organising and commissioning healthcare in England, and 80% of NHS spending passes through their hands. They are supposed to shape local services to suit local people. They are answerable to 10 strategic health authorities that act as the local agents of the NHS central management.

But some people believe that the PCTs are simply acting as a conveyor belt for plans hatched by the NHS and pushed forward by strategic health authorities.

Mr Stout disagrees. "APMS [Alternative Provider of Medical Services] is not being imposed, except in the under-doctored areas" he says. "Money for those comes from central funds, with the proviso that it be spent on APMS contracts."

The 100 new general practices, announced last year as part of Lord Darzi's interim review, have provided "a brilliant opportunity" for the private companies, says Dr Chilvers. "But it's a bit of a deluge—nobody can go for all of them."

Who wants change?

The issue that remains is one of political legitimacy. Surveys regularly show that GPs are held in high esteem by their patients, who may well ask why the traditional pattern is being eroded.

As we have seen, it is largely up to PCTs how much consultation they engage in. There are some successful examples, such as in Liverpool, where consultation was on an "industrial scale," according to the PCT chief executive. The result, says a recent NHS Confederation report, is a solution that has met with overwhelming public, political, and professional support.⁸ But elsewhere, consultation has been less intensive. The timetable for establishing polyclinics and the new APMS practices in under-doctored areas is tight, and PCTs are being driven hard to get on with it.

Juliet Dunmur, chair of the BMA's patient liaison group, says: "The involvement of patients and the public has been patchy, and the quality of consultation has varied considerably. At the moment, there simply isn't the infrastructure to give patients a genuine voice in these changes. The new patient organisations introduced last month have not yet had an opportunity to get under way with their work." Yet the evidence that the public want to be consulted is abundant. Research by the Department of Health in 2006 found that 90% of the public thought that they "ought to have a say in how local health services are run."⁹

The King's Fund has recently published a review on whether PCTs should be more locally accountable.¹⁰ It is premature to write off the existing arrangements, it says, but warns that achieving real local accountability will be "very challenging."

The authors of the report give two reasons for this: the unwillingness of enough members of the public to be involved in decision making or to mount a significant challenge; and the unwillingness of NHS institutions to change in response to challenge.

The report considers a variety of changes

that might make PCTs more accountable, from electing the members of their boards through cross membership of councils and PCT boards, to transferring PCT functions wholesale to local authorities. But it concludes that the public has no huge appetite for any of these changes and there is no evidence that the NHS would be better managed as a result. The least bad option is probably to engineer closer links between PCTs and local authorities, it concludes. But it is scarcely a ringing endorsement.

Lord Darzi's five principles for changes in the NHS suggest that he, at least, is worried that reforms will be derailed on a wave of public opposition unless they are better explained, locally led, and justified by improvements in services. But, the secondary sector might argue, when have such principles been applied to the multitude of changes it has been exposed to? And can anybody seriously believe Lord Darzi's promise that existing services will not be withdrawn until new ones have proved they are better? PCTs will not relish the cost of "double running."

And better consultation is no panacea. NHS London conducted a £4m consultation in the capital, with 37 roadshows, a website, and a media campaign. The result? A small majority (51%) supported Lord Darzi's polyclinics.¹¹

Nonsense, retorted Londonwide local medical committees, which conducted its own cheaper survey of 1500 people in London and found that 70% of them had never heard of the consultation and that only one in ten was in favour of polyclinics.¹² Almost 60% did not even know what a polyclinic was.

"This is a centrally driven agenda, and the PCTs have to do what NHS London tells them," said Tony Stanton, joint chief executive of Londonwide LMCs. "A third of the people who responded to the NHS London consultation were actually employed by the NHS, and the survey asked a very leading question."

But David Sissling, programme director for Healthcare for London said: "We are delighted with the outcomes of the consultation. We have been struck by the quality of the contributions we have received, and the general enthusiasm for change."

So is there enthusiasm for change or general contentment with existing services? It depends entirely on whom you ask and what you ask them.

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References are on bmj.com

FOUR CONTRACTING ROUTES FOR PCTS TO COMMISSION SERVICES

General Medical Services (GMS)—Evolved in partnership between the government, the NHS Confederation, and the BMA's General Practitioners Committee (GPC). It is a UK-wide contract with the protection of national negotiations. Single handed GPs, partnerships, and some limited companies with at least one general medical practitioner shareholder can hold a GMS contract

Personal Medical Service (PMS)—A locally agreed alternative to GMS for providers of general practice. Almost half of general practices have PMS agreements. Unlike GMS contracts, they are negotiated between the primary care organisation and the practice and are not subject to direct national negotiations. PMS operates in parallel with GMS and allows for more flexible arrangements. A participating practice could agree a contract directly with the PCT specifying the services it would provide and pricing those services

Alternative Provider of Medical Services (APMS)—The list of potential providers from which primary care organisations can commission services has expanded. The independent sector, the voluntary sector, and traditional providers can now hold primary medical services contracts. The APMS agreement is used to commission services for which GMS/PMS practices have opted out, such as enhanced and out of hours services. However, a practice can hold an APMS contract alongside its GMS or PMS contract. APMS contracts can be for a whole practice or for specific services and are regulated by the APMS Directions 2004 to ensure a minimum level of service

Primary Care Trust Medical Services (PCTMS)—Enables PCTs to provide services themselves by directly employing staff