



Churchill Medical Centre and NHS Kingston

EXECUTIVE SUMMARY

1. Following a complaint by Churchill Medical Centre (Churchill), the Cooperation and Competition Panel (CCP) has reviewed NHS Kingston's decision not to allow Churchill to provide NHS services from a new branch surgery at 164 Tudor Drive, Kingston, under the conduct provisions of the Principles and Rules for Cooperation and Competition (Principles and Rules). We have concluded that NHS Kingston's conduct is inconsistent with the Principles and Rules.
2. When considering a conduct complaint, the CCP assesses whether the conduct in question gives rise to an adverse effect (or cost) to patients or taxpayers as a result of a loss of patient choice or competition and, where this is the case, whether this is offset by benefits to patients or taxpayers arising from the conduct.
3. We have found that a significant number of Churchill's patients will benefit from their preferred GP practice opening a branch surgery closer to their homes and that other Churchill patients may also benefit from reduced congestion at Churchill's hub practice in Norbiton, Kingston. We also consider that the new branch surgery may encourage other GP practices in the locality to improve their quality of service so as to prevent patients transferring to the new branch surgery.
4. We considered whether patients and taxpayers may be adversely affected by the opening of the new branch surgery through the range and quality of services on offer at the new branch surgery, financial costs to NHS Kingston and the impact on other GP surgeries in the locality. We concluded that any adverse effects to patients and taxpayers are likely to be small or immaterial, and would not be sufficient to offset the benefits to patients arising from the new branch surgery. In reaching this conclusion we have taken account of Churchill's willingness to develop the new branch surgery at its own cost and the fact that it has not sought reimbursement for this or other ongoing expenses.
5. As a result, we recommend to the Department of Health and London Strategic Health Authority (SHA) that NHS Kingston should allow Churchill to provide NHS-funded services from the new branch surgery located at 164 Tudor Drive.

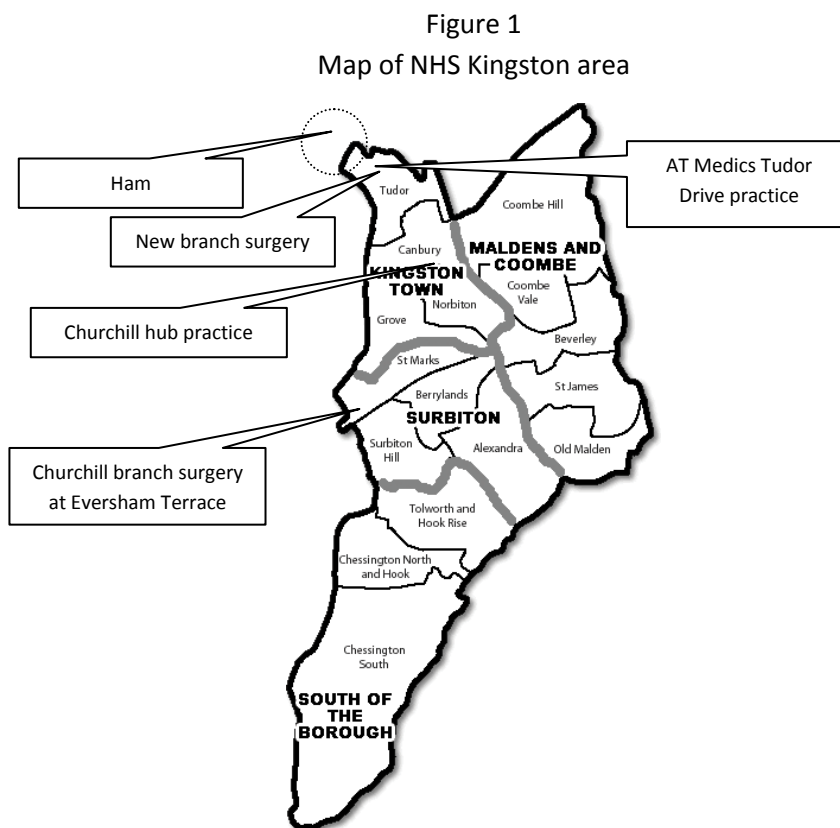
PARTIES

6. NHS Kingston is a Primary Care Trust (PCT) that commissions and delivers healthcare in the Royal Borough of Kingston, London to a registered population of around 187,000. It commissions primary medical care services to the value of around £24 million per annum from doctors, pharmacists, opticians and dentists. There are 28 GP practices in the NHS Kingston area.
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- Churchill is the third largest GP practice in the NHS Kingston area with 12 doctors, six nurses and three healthcare assistants. It has a main 'hub' practice at Clifton Terrace, Norbiton and a smaller branch 'spoke' surgery at Eversham Terrace, Surbiton. Churchill's total patient list was 14,800 (approximately 12,300 at Clifton Terrace and 2,500 at Eversham Terrace) at the end of September 2009 with around 2,000 new patients registering over the year ended September 2009, representing a net increase of around 800 to 1,000 new patients over this period.¹

BACKGROUND

- The NHS Kingston area is divided into four neighbourhoods and sixteen wards (see Figure 1). The Tudor ward, where Churchill wishes to open a branch surgery, is in the very northwest of the area. Churchill's hub practice is in Norbiton and it has a branch surgery in Surbiton. The area of Ham, where a number of Churchill's patients reside, is north of Tudor ward and outside the NHS Kingston area. Further details of relevant GP practice locations are set out in Figure 2 on page 17.



Source: NHS Kingston, obtained from Royal Borough of Kingston upon Thames

- Until 2007, two GP practices were operating at 192 Tudor Drive in Tudor ward. The first of these practices was run by Drs Hans Yadav and Ashok Katiyar. On 1 February 2007, both doctors were suspended from the GP register and Churchill was asked by NHS Kingston to run the practice on a locum basis. The second practice at 192 Tudor Drive was operated by Dr J Thakerar. In October

¹ A GP patient list is reviewed quarterly to remove patients that have moved out of the area, to other GP practices or for other reasons are no longer current patients. Churchill told us that the average turnover in patient lists turnover in England is around five to ten per cent annually.

2007, Dr J Thakerar was suspended from the GP register and NHS Kingston asked Churchill also to act as a temporary locum for this practice until the locum contract was tendered. The tender for this locum contract was won by The Groves Medical Centre in November 2007.

10. On 18 December 2007, Churchill met NHS Kingston and proposed that it open a branch surgery at 164 Tudor Drive, less than 100 metres from the GP practices at 192 Tudor Drive. At this time NHS Kingston had not decided how to proceed in relation to the two practices at 192 Tudor Drive. Churchill offered to open the proposed branch surgery at its own cost (ie without financial assistance from the PCT) and told us that its intention in seeking to open the new branch surgery was to relieve pressure on its hub premises in Norbiton. Churchill told us that it could not expand its Norbiton premises and the proposed branch surgery would give better access to its services for around 1,500 of its patients that are registered at its Norbiton practice but live in the Tudor Drive area. NHS Kingston told Churchill that it could not be stopped from developing the new branch surgery but that it would do so at its own risk.² Churchill received planning approval to use 164 Tudor Drive as GP premises and proceeded to refurbish and equip the premises.
11. On 18 January 2008 (around four weeks after Churchill's proposal to open a branch surgery at 164 Tudor Drive), NHS Kingston told Churchill that a tender would be held for the provision of primary medical services for the combined practice lists of the two practices at 192 Tudor Drive. After a public consultation in February 2008 the tender was advertised on 7 March 2008.
12. Just prior to the tender being advertised, on 29 February 2008, Churchill requested an N3 connection from NHS Kingston for the new branch surgery at 164 Tudor Drive.³ NHS Kingston refused this request on 17 March 2008, and the following day wrote to Churchill setting out that the terms of its PMS contract only allowed it to provide NHS services from premises at Clifton Road, Kingston and Eversham Terrace, Surbiton. NHS Kingston stated that its approval was required for Churchill to provide NHS services from the new branch surgery. NHS Kingston asked whether Churchill intended to seek a variation of its contract to provide services from the new branch surgery, but indicated that such a variation was unlikely to be agreed by NHS Kingston.⁴
13. On 25 March 2008 Churchill wrote to NHS Kingston requesting that the new branch surgery premises be added to the premises from which Churchill could provide services under its PMS contract.⁵ On 14 July 2008 NHS Kingston told Churchill that the new branch surgery would not be added to the premises from which it could provide services under its PMS contract, due to the expected impact on existing GP services and because there was no requirement for additional GP services in the area. On 21 July 2008, the NHS Kingston board announced that AT Medics had won the tender to provide services from 192 Tudor Drive (and it commenced operations on 1 October 2008).

² There is dispute about what was meant by 'own risk', NHS Kingston has suggested it meant that the uncertainty of the upcoming tender process (see paragraph 11) prevented it from supporting the proposal or providing permission for the new branch surgery and Churchill considered this to refer to the financial risk of the new branch surgery being developed at its own cost. In any event, we do not consider this issue to be material to our assessment.

³ An N3 connection is a secure data line used between NHS sites including GP practices.

⁴ There is disagreement between the parties as to whether NHS Kingston had approved the premises for NHS use when it responded to an email from the local planning department on 19 February 2009 to say that "the PCT has no objections to this development".

⁵ GMS, PMS and APMS are types of GP contracts and are discussed further at paragraph 34.

14. Following a meeting between Churchill and NHS Kingston on 28 September 2008, where the two parties were unable to progress any resolution on the new branch surgery, Churchill – on the advice of London SHA – initiated a dispute resolution process with NHS Kingston in relation to the tender to operate the practices at 192 Tudor Drive. On 20 February 2009 a meeting was held between Churchill and NHS Kingston’s dispute resolution panel.⁶ The panel concluded that Churchill’s complaint about the tender could not be upheld. However, the panel also said that it needed advice on the competition related aspects of NHS Kingston’s decision, and external legal advice was subsequently sought.
15. On 27 March 2009 a letter from NHS Kingston to Churchill referred to this advice stating “that from a competition law perspective... the PCT was acting within its powers by disallowing [Churchill] to open a branch practice in Tudor Drive”. However, NHS Kingston offered Churchill an opportunity to put forward a business case for opening the new branch surgery. Churchill provided a business case to NHS Kingston on 10 June 2009.

JURISDICTION

16. On 23 June 2009 Churchill asked the CCP to consider whether NHS Kingston’s refusal up to that point to allow Churchill to provide NHS services from the new branch surgery (the Conduct) was consistent with the Principles and Rules. In its application Churchill submitted that NHS Kingston was in breach of Principle 4 Rule 2 of the Principles and Rules by not allowing Churchill to open the new branch surgery. The Conduct could potentially breach this principle by restricting patient choice through not allowing the new branch surgery to open and there being insufficient benefits to patients and taxpayers to offset the adverse effects (or costs) to patients and taxpayers of the Conduct. Principle 4 Rule 2 provides:

Principle 4

Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.

Rule 2

Providers, referrers to and commissioners of NHS services must not restrict choice via collusive behaviour or any other action.

17. The CCP decided that the Conduct met the CCP’s acceptance criteria for a conduct inquiry on 7 July 2009. That is:
 - i. the Conduct falls within the scope of the Principles and Rules, namely Principle 4, Rule 2;
 - ii. the CCP is the most appropriate body to consider the issue;
 - iii. sufficient relevant and applicable information on the Conduct was made available to the CCP by Churchill;
 - iv. no legal proceedings have commenced in relation to the Conduct;
 - v. the Conduct is not trivial, vexatious or an abuse of the Panel’s procedures; and
 - vi. the complainant has previously used all reasonable endeavours to engage at a local level including appropriate engagement with the relevant SHA.

⁶ The dispute resolution panel of NHS Kingston consisted of the Chair, Mr John Tate (a non-executive director of NHS Kingston), Ms Tracie Evans (Finance Director at NHS Kingston) and Dr Ian Spencer (a retired doctor).

18. NHS Kingston has suggested that Churchill, by complaining to the CCP, has tried to circumvent the outcome of the tender process for services at 192 Tudor Drive. NHS Kingston has said that Churchill's complaint only arose after it lost the tender, and that it is an unavoidable conclusion that the Conduct complaint has arisen from this. In essence, NHS Kingston submits that Churchill's complaint is an abuse of the Panel's procedures.⁷
19. We have paid careful attention to the concerns raised by NHS Kingston. The CCP is concerned that NHS service providers do not seek to use the conduct provisions of the Principles and Rules as an alternative to the procurement dispute resolution provisions where the procurement provisions are the most appropriate path for examining a dispute. However, we have concluded that Churchill has not acted inappropriately in making this complaint to the CCP. This conclusion is based on a number of reasons which are set out below.
20. First, NHS Kingston and Churchill agree that Churchill discussed its proposal to provide services from the new branch surgery prior to the tender for services at 192 Tudor Drive being announced. This indicates that the proposal to develop the new branch surgery was not simply Churchill's response to losing the tender to provide services at 192 Tudor Drive.⁸ Second, Churchill has told us that in making this conduct complaint it is not seeking to alter NHS Kingston's decision in relation to the tender for services at 192 Tudor Drive. (In any event, the CCP would only be able to recommend that NHS Kingston's decision in relation to this tender be altered if a procurement dispute appeal had been brought to the CCP following an SHA dispute resolution process, and no such appeal has been brought.) Finally, Churchill made the complaint to the CCP following consultation with and advice from London SHA regarding the most appropriate means of having their concerns addressed.
21. We considered whether our review of the Conduct should be delayed pending the outcome of the business case that has been submitted to NHS Kingston (see paragraph 15). However, given that Churchill had acted on advice from London SHA to initiate a complaint with the CCP, we conclude that it was appropriate to accept the case. In addition, we understand from NHS Kingston that it has put its consideration of the business case on hold pending the CCP's advice and recommendations.
22. NHS Kingston's refusal to allow Churchill to open a branch surgery can be seen as a dispute arising under Churchill's PMS contract with NHS Kingston. Disputes arising under a PMS contract may be dealt with under the dispute resolution procedure set out in Schedule 5, Part 7 of The National Health Service (Personal Medical Services Agreements) Regulations 2004 (the PMS Regulations). Part 7 provides for disputes to be referred to the Secretary of State who has delegated its powers to the NHS Litigation Authority, which is administered by the Family Health Services Appeal Unit (FHSAU). Before referring any dispute to the FHSAU the parties must make every reasonable effort to communicate and cooperate to resolve the dispute (paragraph 93 of

⁷ NHS Kingston told us that Churchill also circumvented NHS Kingston's process of assessing and planning for the needs of patients in its area by Churchill delaying for four months before providing a business plan for the new branch surgery and after Churchill had referred the complaint to the CCP. We note that Churchill was invited to submit its business case on 27 March 2009, and this was provided by Churchill on 10 June 2009, a period slightly more than two months and prior to the complaint to the CCP, and that during this period Churchill undertook a survey of patients in the area (of around 1,500 patients) which we expect would take some time to prepare.

⁸ Further, we understand that the services that Churchill would provide at the new branch surgery differ from the services that would have been offered from those premises if Churchill had won the tender (in order to comply with the tender specification).

Schedule 5 to the PMS Regulations). Where agreement of a contract variation cannot be reached by the parties, a PCT must be able to demonstrate that its decision was reasonable.

23. NHS Kingston told us that it would have been more appropriate for Churchill to use this dispute resolution mechanism to address its concerns rather than complaining to the CCP, and that in any event its decision to refuse Churchill permission to open the new branch surgery was 'reasonable' as required under the PMS contract dispute provisions. Churchill, however, told us that it did not receive information from NHS Kingston on how to access this, or other, dispute resolution mechanisms, and relied on advice from London SHA, which assisted them in accessing the local dispute resolution process and subsequently advised them to bring a complaint to the CCP.
24. In relation to the reasonableness of NHS Kingston's decision, we consider that this must be assessed in the context of the Principles and Rules. The Principles and Rules were published as part of the NHS Operating Framework 2008/09 and came into force in April 2008. The Principles and Rules provide guidance for system managers, commissioners, and providers on the expected behaviours and rules governing cooperation and competition. All PCTs have an obligation to ensure that they act consistently with the Principles and Rules.

CCP INQUIRY PROCESS

25. Following the commencement of the CCP's inquiry on 7 July, NHS Kingston provided its response to Churchill's complaint on 21 July 2009 noting that it had adhered to the requirements of its Standing Orders to achieve best value for taxpayers' money in the commissioning of services to meet the needs of its entire patient population.⁹ The CCP also received a submission from AT Medics, the winner of the tender to operate services at 192 Tudor Drive, which stated that the establishment of a branch surgery by Churchill at 164 Tudor Drive was likely to have a significant impact on its practice at 192 Tudor Drive.
26. On 6 August 2009, after reviewing the complaint, the response, third party submissions and other information the CCP set out the key issues in a letter (the issues letter) to NHS Kingston for their response. The CCP also invited comment from Churchill and London SHA on the letter. The information received by the CCP in response to the issues letter warranted further investigation before the CCP could reach a view on whether or not there had been a breach of the Principles and Rules. As the CCP was not in a position to dismiss the conduct complaint by Churchill at the end of Phase 1, the CCP announced on 1 September 2009 that it intended to proceed to a Phase 2 investigation.¹⁰ The deadline for the completion of Phase 2 is 24 December 2009.
27. Further representations were received from AT Medics and NHS Richmond on 23 September 2009, Churchill on 28 September 2009, and NHS Kingston on 9 October 2009. We also received

⁹ PCTs are required to adopt Standing Orders for the regulation of its proceedings and business in accordance with the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations [SI 2000/89], the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment (No 2) (England) Regulations 2002 [SI 2002/557] and the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment (England) Regulations 2003 [SI 2003 No. 1616]. Standing Orders should also take account of the National Health Service Reform and Health Care Professions Act 2002.

¹⁰ <http://www.ccp-panel.org.uk/content/cases/Churchill-Medical-Centre-and-Kingston-Primary-Care-Trust/Intention%20to%20proceed%20to%20Phase%202.pdf>.

letters from Susan Kramer MP and Mrs Grace Edwards in support of Churchill opening the new branch surgery and three from the Tudor Ward (Kingston) Patients Association (one of these provided by NHS Kingston on behalf of the association) that opposed the opening of the new branch surgery.

28. The CCP evaluated carefully all of the evidence received during the course of the case. On 24 November 2009 the CCP provided to Churchill, NHS Kingston, AT Medics and London SHA its analysis and provisional view of the case and invited each of the parties to provide further evidence and submissions. Churchill, NHS Kingston and London SHA provided further submissions, which were reviewed by the CCP prior to its final decision and adoption of this report.
29. The Department of Health and London SHA will receive the CCP's advice and recommendations on the Conduct, which they will consider. At its discretion, and under the Secretary of State's authority, the Department of Health may require the implementation of any recommendations made by the CCP.¹¹

FRAMEWORK FOR ASSESSING THE CONDUCT

30. The framework that the CCP uses to assess the conduct of healthcare providers and commissioners is set out in the Principles and Rules and the CCP's draft interim conduct guidelines. The relevant provision in this case is Principle 4, Rule 2.
31. The CCP's draft interim guidance on the assessment of conduct sets out a cost-benefit framework for the assessment of conduct under this Principle.¹² That is, where conduct may adversely affect (or impose costs on) patients or taxpayers as a result of a reduction in patient choice or competition, then this will be balanced against any benefits to patients or taxpayers arising from the conduct so as to determine whether the Conduct gives rise to a net cost or benefit to patients and taxpayers. We next set out some relevant policy background and the role of the PCT when commissioning primary care services in its area.

Relevant policy background

32. Most patients register at a GP practice to access primary healthcare and this is an important process for the delivery of healthcare in England. Once a patient is registered a GP has certain responsibilities for that patient (including the provision of treatment at home).
33. Patients have the ability to choose their GP practice but any GP practice may refuse patients who are not resident within their 'practice boundary'.¹³ The status of a GP's list can also allow a GP practice to refuse to accept new patients. A GP's patient list must be classified as 'open' or 'closed' under the terms of a GMS contract or a PMS agreement. If a GP practice, with the agreement of the PCT, is classified as having a 'closed' patient list it cannot accept new patients

¹¹ Section 8 of the NHS Act 2006 provides that the Secretary of State may give directions to SHAs and PCTs about their exercise of any function and section 20(1) that an SHA may give directions to a PCT about its exercise of any function.

¹² Particular conduct might give rise to costs to patients and taxpayers if it diminishes patient and commissioner choice and competition. As set out in the *Framework for Managing Choice and Competition*, patient choice and competition in the NHS can be expected to improve quality and safety in service provision, improve health and well-being, improve standards and reduce inequalities in access and outcomes, lead to better informed patients, generate greater confidence in the NHS, and provide better value for money.

¹³ A practice boundary is a defined geographical area which is agreed between a PCT and a GP practice.

unless they are an immediate family member of an existing patient.¹⁴ A GP practice with an 'open' patient list is permitted to register anyone from inside or outside its practice boundary but can, where it has reasonable non-discriminatory grounds to do so, refuse new patients. Some GP practices have what is referred to as an 'open but full' patient list where, although not formally closed, the practice does not usually accept new patient registrations.¹⁵ This may make it harder for patients to find a convenient local practice, particularly in areas with low levels of primary care provision. Practice boundaries and the status of GP lists in a particular area may therefore impact on the choice available to patients.

34. New contractual mechanisms for service providers have been developed to increase access and capacity as well as improve the quality of services provided by GP practices. Negotiations between the British Medical Association (BMA) and the NHS Confederation acting on behalf of the Department of Health concluded in 2004 and established three major contract types:

- **General Medical Services (GMS):** This contract contains nationally agreed terms, service requirements and funding allocations. The contract is negotiated centrally by the Department of Health and BMA, and managed locally by PCTs.
- **Personal Medical Services (PMS):** This provides for locally negotiated contracts, subject to certain mandatory criteria set out in the NHS (Personal Medical Services Agreements) Regulations 2004 (as amended), under the direction of PCTs with flexibility to tailor services to meet local population needs. PMS contractors must still provide the essential primary care services set out in the GMS contract where the contractor provides services for a list of registered patients.
- **Alternative Provider Medical Services (APMS):** This allows PCTs to contract with a range of providers including corporate, third sector and other public sector organisations. Contracts are locally negotiated, subject to certain mandatory criteria set out in the Alternative Primary Medical Services Directions 2009, and can be used to commission essential services and/or specified additional, enhanced or out-of-hours services. There are no statutory requirements for pricing under APMS contracts and the price of each service can be negotiated locally by the PCT and the provider. Payment can be on the basis of a fixed price, volume or performance related.¹⁶

35. The Department of Health has set out the right of patients to choose their GP practice in the NHS Constitution. It has also said that it is opening up more choice for patients that wish to register with a GP practice. This approach has been supported through its proposal to remove GP practice boundaries and the development of the NHS Choices website, which now provides

¹⁴ Across England four per cent of GP practices have 'closed' patient lists, Primary Care Access Survey, 2008/09.

¹⁵ An 'open but full' list does not have a statutory definition or legal validity but is a commonly used term to describe GP practices that have an 'open' patient list but nonetheless refuse to register new patients for an extended period of time. The Department of Health believes that around ten per cent of GP practice lists might be operating 'open but full' patient lists. The Department of Health does not accept that 'open but full' is an appropriate designation of a GP practice's list status under the terms of GMS or PMS contracts.

¹⁶ These services can be commissioned from any individual or organisation (including independent sector and voluntary sector providers, NHS trusts, foundation trusts and GMS or PMS providers) that meets the provider conditions set out in the Alternative Provider Medical Services Directions 2009.

information on GP practices aimed at facilitating patient choice.¹⁷ The Department of Health states the ability of patients to make informed choices will help drive up quality across the board and is another step in ensuring the NHS reflects the needs of the patient.¹⁸ We note that the Department of Health continues to develop policy in the area of patient choice and primary care and that patient choice is only one of a number of policy levers that are being used to drive ongoing improvements in primary care services.

The role of the PCT in primary care services

36. The PCT is responsible for evaluating needs, commissioning services and monitoring the quality of primary care services in its area. NHS Kingston has raised a number of points in its response to this Conduct inquiry that concern the obligations of a PCT and the relationship between these obligations and the Principles and Rules.
37. NHS Kingston has submitted that by making a complaint under the Principles and Rules Churchill has sought to circumvent NHS policy by disputing the PCT's statutory responsibility to manage the local primary healthcare market.¹⁹ A PCT has discretion to decide how to secure sufficient services for its population in accordance with its statutory obligations and relevant strategy documents like the Joint Strategic Needs Assessment, which identifies current and future health and wellbeing needs of a local population and informs the priorities and targets that will improve outcomes and reduce health inequalities.²⁰ NHS Kingston has told us that any incursion on its discretion is a matter for Parliament and should only follow a change in legislation.
38. However, we note that section 2(1)(b) of the NHS Act 2006 provides the Secretary of State with a broad discretion to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of his duty to promote a comprehensive health service in England. The Secretary of State, acting through the Department of Health, is therefore acting within his powers in giving policy guidance to NHS bodies, for example by way of operating frameworks. The Principles and Rules are part of the 2008/09 Operating Framework for the NHS and are designed specifically for the NHS. All PCTs have an obligation to ensure that they act in a manner that is consistent with the Principles and Rules.
39. NHS Kingston also stated that because the provision of GP services is tightly regulated and controlled by legislation it is not appropriate to approach the concept of choice and competition in the same way as for other markets. It submitted that, in contrast to other markets, the primary health care market is a managed market with limited resources. It suggested that without control there is a significant risk that unpopular areas (such as inner cities) would not be appropriately doctored as providers would only establish in profitable areas, which is not in patients' best interests. We are conscious that the primary care market is appropriately subject

¹⁷ Policy announcements in September 2009 have suggested that practice boundaries may be abolished to allow patients to register with any GP, for example, to register with a GP practice near the patient's workplace rather than home (see the speech by the Secretary of State for Health, the Rt Hon Andy Burnham on 19 September 2009: www.dh.gov.uk/en/News/Speeches/DH_105366). In addition, since October 2009 the NHS Choices web site allows patients to rate and compare their GP which gives patients greater information when choosing between GP practices www.nhs.uk/Pages/homepage.aspx.

¹⁸ See the Department of Health press release at www.dh.gov.uk/en/News/Recentstories/DH_107002.

¹⁹ Under Section 83(1) of the National Health Service Act 2006, each PCT must, to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to provide primary medical services within its area, or secure their provision within its area.

²⁰ A PCT is required to assess regularly the healthcare needs of its registered patient population.

to significant regulation and control, but there is also clearly a degree of patient choice and competition in primary care services. The Principles and Rules have been established to ensure that patient choice and competition, including in primary care services, is effective in delivering benefits to patients and taxpayers. NHS Kingston suggested that patient choice in primary care services is taken into account through patient consultation during the tender process for new practices. However, we do not consider that patient choice (as set out in government policy) is adequately addressed in this way. In respect of competitive tendering generally, we do not consider that this is a substitute for patients choosing their GP practice.²¹

40. NHS Kingston has told us that it is concerned about the consequences that a CCP decision finding its Conduct inconsistent with the Principles and Rules may have on its plans for the future provision of primary care in its area. In particular, NHS Kingston said that it is facilitating meetings between all local practices, including the one in Ham, to discuss these practices working collaboratively in an alliance to develop clinically-led service redesign in the area. NHS Kingston is concerned that that the trust which is developing between GP practices may be negatively impacted by Churchill opening the new branch surgery without following due process. As noted in paragraphs 17 to 23, we have not accepted that Churchill has not followed due process in bringing this case to the CCP.
41. NHS Kingston has pointed out that it followed the Principles and Rules when it ran a formal competitive procurement process to fill the need that was identified when the two GP practices at 192 Tudor Drive were vacated. NHS Kingston has suggested that if it were to agree a contract variation with Churchill allowing it to open its branch surgery, this would have the effect of circumventing the formal competitive process and might leave the PCT open to challenge from AT Medics. Churchill told us that the decision to tender the services now provided by AT Medics did not alter the need perceived by Churchill to provide better services for 1,500 patients already on its patient list and living in the Tudor Drive area. As we set out above, Churchill is not seeking to alter NHS Kingston's decision in relation to the tender for services at 192 Tudor Drive, and the CCP is unable to recommend any such change in the absence of an appeal from an SHA decision. We acknowledge NHS Kingston's point that the opening of the new branch surgery by Churchill may have the practical effect of altering the tender outcome if AT Medics were to close following the opening of the new branch surgery by Churchill. We discuss this possibility in paragraphs 53 to 60, and conclude that such an outcome is unlikely.
42. When exercising its discretion in deciding whether or not to allow a GP practice to open a branch surgery we would expect NHS Kingston to have regard to the Principles and Rules, in addition to any other relevant policies and regulations. We recognise that at times interpreting policy may not be straightforward and a decision in any individual case may require a PCT to weigh up sometimes apparently conflicting considerations.

²¹ Patients having the ability to choose GP practices and PCT commissioners undertaking competitive tenders for new GP practices are complementary mechanisms for delivering benefits to patients and taxpayers. Competitive tenders allow PCTs to select providers that offer a good standard of patient care and a high level of efficiency, and allow the PCT to ensure taxpayers receive good value from the contract. Competitive tendering is also a mechanism for a PCT to ensure there are a range of providers in its area, which may be a necessary consideration if there are an insufficient number of local providers. As the Department of Health has said (see paragraph 35) patient choice is an important lever which encourages service quality improvements over and above the minimum requirements specified in a GP contract. Patient choice has this impact by creating additional incentives for GP practices to improve the way they meet the needs of their patients.

ASSESSMENT OF THE CONDUCT

43. In this section, we assess the impact of the Conduct on patients and taxpayers through reviewing the arguments that have been put to us concerning:

- the impact of the new branch surgery on access to services for patients registered with Churchill;
- the quality and range of services that would be offered at the new branch surgery;
- the impact of the new branch surgery on patients not currently registered with Churchill;
- the financial cost to NHS Kingston of the new branch surgery opening; and
- the need for additional GP services in the area that would be served by the new branch surgery.

Impact of the new branch surgery on access to services for Churchill's current patients

44. The new branch surgery is likely to provide better access to their preferred GP practice for patients registered with Churchill and living in the Tudor Drive area who are closer to the new branch surgery than to the existing hub practice in Norbiton. The new branch surgery does not necessarily improve Churchill's patients' access to GP services as a whole as these patients could, in principle, access GP services from other GPs located closer to their home. However, it would improve access to their preferred GP practice.

45. Both Churchill and NHS Kingston told us that if the new branch surgery opens they expect approximately 1,500 of Churchill's patients to attend the new branch surgery instead of the hub practice.²² We understand that this number represents those patients registered with Churchill who live in Ham or the Tudor Drive area where the new branch surgery would be more convenient than Churchill's hub practice.²³

46. Mrs Edwards, a patient registered with Churchill, told us of a petition signed by 800 patients supporting the opening of the new branch surgery, although we do not know the GPs with which these patients are currently registered. Mrs Edwards told us that she supported the opening of the new branch surgery because it would reduce by half the distance she needed to travel to her doctor. As part of the business case that it submitted to NHS Kingston in support of the new branch surgery Churchill undertook a survey of residents in the Tudor Drive and Ham area. In that survey of around 1,500 patients in just under 700 households around 45 per cent

²² AT Medics told us that it expected most patients at the new branch surgery would be patients switching from AT Medics' practice and this would impact on the viability of its practice. We discuss this issue further in paragraphs 52 to 59.

²³ NHS Kingston told us that Churchill used its position as a locum at Tudor Drive to build up its patient base in the area as Ham and the Tudor Drive area are outside of the practice boundaries for Churchill's hub practice. NHS Kingston provided a table setting out the monthly additions to Churchill's patient list from patients located in these areas when Churchill was locum. There are two points to note in relation to this argument. First, the way or grounds on which patients have previously decided to register with Churchill is not relevant as to whether or not the new branch surgery would provide them with improved access to their preferred GP practice, and second, it is not clear that NHS Kingston is correct in its view that Churchill acquired these patients as a result of it temporarily managing the practice at 192 Tudor Drive. While Churchill did increase the number of patients on its list from these areas while it was temporarily operating this practice, this rate of increase continued after Churchill completed its locum role. Churchill also told us that the majority of new patients that it accepts from all over the Royal Borough of Kingston and Ham are new residents and are not registering with its practice as a result of leaving another GP practice in the area. However, we did not receive any evidence with which to review this assertion. Churchill told us that 6,677 patients (of its patient list of 14,800) reside within the practice area noted in its contract.

responded.²⁴ Churchill tells us that 89 per cent supported the new branch surgery opening, seven per cent did not have an opinion and four per cent were against the opening.

47. The new branch surgery may also benefit Churchill's other patients by reducing congestion at the hub practice for those patients that do not transfer to the new branch surgery. Around 12,300 patients use Churchill's hub practice (see paragraph 6), including the 1,500 patients that might transfer to the new branch surgery. If the new branch surgery opened then there would be reduced congestion at the hub practice due to 1,500 patients using the new branch surgery instead. This means that 12,300 patients are likely to find it easier to get an appointment at their preferred GP practice.

Quality and range of services at the new branch surgery

48. NHS Kingston told us that the small size of the new branch surgery, which according to Churchill has a floor space of approximately 70 sq metres, would adversely impact the quality of services offered from it, and that as a branch surgery the smaller range of services compared to a main GP practice might also adversely affect patients. NHS Kingston told us that it is NHS policy to encourage larger, centralised service provision, which it is working to implement; and supporting the new branch surgery would be inconsistent with this policy.
49. NHS Kingston referred us to guidelines issued in 1997 that set out recommended dimensions for new buildings being built for use as GP premises.²⁵ These guidelines indicate that a new surgery for a sole GP should have floor space of 164 sq metres with an additional 100 sq metres for each additional GP. NHS Kingston told us that in view of these guidelines and the increasing range of services the NHS aims to provide from primary care premises, they would not commission services from smaller GP premises. There are two points to note in relation to this.
- i. The new branch surgery is expected to provide services for approximately 1,500 patients which is a comparable ratio, of patients to surgery size, with other surgeries in the area. Of the other surgeries in the Tudor Drive area there is a range of 13 to 32 patients per square metre. The Churchill hub practice has the highest ratio at 32 patients per square metre. The new branch practice would have 21 patients per square metre which is the same as the average amongst the practices in the area.²⁶
 - ii. The Department of Health told us that the 1997 guidelines referred to by NHS Kingston were replaced in 2002, again in 2003 and most recently in September 2009. The current guidance issued by the Department of Health sets out how new healthcare buildings can be organised to create efficient, flexible and user-friendly environments and how to quantify the space needed to deliver primary care services. These calculations are based on the number of patients in the area, the number of rooms available and the utilisation of the premises. There is no minimum practice size set out in this guidance. Instead, it indicates how to build rooms that will be appropriate for the provision of a wide range of primary care services. Churchill also told us that by extending its consulting hours it has successfully managed to meet patients' needs from a smaller building footprint at its hub

²⁴ This is slightly less than 700 patients from 300 households.

²⁵ See Letter dated 27 October 1997 (FHSL(97)41 providing details of a schedule of space and cost limits for GP premises under the Cost Rent scheme in the Statement of Fees and Allowances (the "Red Book"). The Schedule set out revised maxima for the size and building cost allowances for GP premises approved under the scheme.

²⁶ This data was based on the floor space of seven GP practices in the Tudor Drive area.

practice than would otherwise be the case and that, as a branch practice, many of the administrative functions carried out by a GP practice will be performed at the hub practice which also reduces the space needed at the new branch surgery.²⁷

50. In relation to the range of services on offer from the new branch surgery, Churchill told us that it will offer a smaller range of services compared to its hub practice and that it will open during core hours only (8.00am to 6.30pm). Patients already registered with Churchill that use the new branch surgery may have a smaller range of services available in more limited hours compared to the hub practice. However, these patients are already choosing to travel to the more distantly located hub practice, so being able to access most services closer to home would represent an improvement compared to their current situation.
51. Patients not currently with Churchill that register at the new branch surgery and are either new to the area or were previously with another GP practice in the area may need to travel to the hub practice for additional or enhanced services or services outside of core hours. Churchill has estimated that only a few patients would need to travel to the hub practice for additional or enhanced services (or services outside of core hours).²⁸

Impact of the new branch surgery on other GP practices in the area

52. We have looked at two possible ways in which the new branch surgery might affect other GP practices in the vicinity and thus affect patients and taxpayers. First, by offering a more attractive service to patients it could result in patients currently registered with other GP practices in the area switching to Churchill. This, in turn, might affect the viability of other practices in the area or the range of services that are offered by these practices. Second, in response to the possibility of patients switching to the new branch surgery, it may result in service improvements at other GP practices in the area to reduce the incentive for their patients to change their GP practice.

Extent of patient switching to the new branch surgery and financial impact on other GP surgeries

53. As set out in paragraph 45, both Churchill and NHS Kingston estimate that around 1,500 of Churchill's existing patients are likely to access services at the new branch surgery. However, AT Medics told us that it expects most of the patients at the new branch surgery to be drawn from its own practice at 192 Tudor Drive. AT Medics told us that the viability of its practice would be doubtful if it were to lose [X] patients to Churchill's new branch surgery (in the absence of the minimum income guarantee that it currently has from NHS Kingston).²⁹

²⁷ The National Audit Office report, *NHS Pay Modernisation: New Contracts for General Practice Services in England*, February 2008, mention Churchill in a case study where the extended hours that were offered had resulted in consultations that were better and more productive as well as increasing patient satisfaction.

²⁸ Churchill told us that it will provide essential services and most additional services (as defined in GMS contracts) from the proposed new branch surgery but will not provide urgent after hours care, anticoagulation services and minor operations as provided from its main hub practice.

²⁹ We have not been provided with the contract between AT Medics and NHS Kingston, but we assume that AT Medics and NHS Kingston have standard contractual rights to terminate the contract

54. We also received correspondence from the Tudor Ward (Kingston) Patients Association which is concerned that if Churchill opens the new branch practice the continued functioning and level of service provision at AT Medics will be jeopardised.³⁰
55. NHS Kingston also told us that the new branch surgery may threaten the viability of AT Medics (although this appears to be at odds with its view that services at the new branch surgery would be limited in range and quality – see paragraph 48). It said that AT Medics may be unable to maintain the desired comprehensive range of services for patients, at appropriate levels of quality and availability if the new branch surgery were to open.
56. In our view the number of patients switching from AT Medics to Churchill’s new branch surgery is likely to be limited as the new branch surgery is primarily intended to provide services to 1,500 patients already on Churchill’s patient list (see paragraph 45). There are also a number of other reasons why the number of patients switching is likely to be limited.
- i. AT Medics is an established practice, while Churchill will be a new entrant on Tudor Drive. Patients (unless they are moving house) are relatively unlikely to switch GP practices unless the quality of service provided by their existing GP practice becomes unacceptable for some reason. AT Medics has high Quality Outcomes Framework (QOF) ratings and so there is no obvious reason for patients to switch. (We discuss AT Medics’ likely competitive response to the new branch surgery in paragraph 62.)
 - ii. It seems likely that many of the patients inclined to leave the practice at 192 Tudor Drive have already done so. NHS Kingston told us that the number of patients registered at 192 Tudor Drive was ‘static’ in the period leading up to the suspension of the doctors working there, but following the suspension of the doctors the size of the patient list reduced from around 3,850 in January 2007 to around 2,400 in April 2009. NHS Kingston told us that this was due to patients switching to other practices, including Churchill, and an updating of the list to remove patients who had died or moved away.
 - iii. The new branch surgery is located so close to AT Medics that it can have no location-based advantage for existing AT Medics’ patients.
 - iv. The new branch surgery is likely to offer fewer services than AT Medics (see paragraph 50). Thus the service of the new branch surgery is not likely to be more convenient or comprehensive for existing AT Medics’ patients.
 - v. AT Medics have staff permanently based in its Tudor Drive practice, while the new branch surgery would revolve GP staff between the new branch surgery and its hub practice. Thus AT Medics will offer patients a more familiar GP, which patient surveys show is valued by some patients.³¹
 - vi. AT Medics told us that in the event of patients leaving their practice they would seek to provide any additional services that might keep existing patients registered and satisfied

³⁰ The association was formed for the specific purpose of representing patient interests on the NHS Kingston panel that was evaluating tenders for the provision of services at 192 Tudor Drive.

³¹ The annual patient satisfaction survey asks whether the patient was able to see their preferred doctor. The survey showed that the average GP practice had 57% of patients who “always or almost always” saw their preferred doctor. We observe from this survey that where a GP scored lower than average on this question, overall patient satisfaction was also lower and conversely where a patient has better regular access to their preferred doctor then the higher their overall satisfaction with that GP practice.

(see paragraph 62). By taking this approach AT Medics is likely to prevent patients from switching to the new branch surgery.³²

57. AT Medics receives a guaranteed minimum income under its contract with NHS Kingston until [X].³³ This means that below a minimum patient number threshold AT Medics' core practice income would not be affected by any loss of patients. However, AT Medics told us that they could be closed by NHS Kingston if they failed a 'value for money' test or if their contract was terminated. In addition, some enhanced services offered by AT Medics require a certain throughput of procedures (for example IUD insertion / removal).³⁴ Certification to provide those types of services is lost if a prescribed number are not carried out by a particular GP. Further, in the event of patient numbers and the number of procedures reducing, it may also be the case that AT Medics earns less revenue from the Quality Outcomes Framework (QOF) because fewer enhanced services are being provided.³⁵

58. NHS Kingston has told us that a GP practice can take at least a year to establish itself and build its patient list sufficiently to be financially viable (putting to one side any minimum income guarantee). NHS Kingston and AT Medics told us that a practice would largely be established once the following tasks were completed:

- i. the patient list is accurate to allow identification and recall of patients with long-term conditions and essential services are being provided to this registered population;
- ii. new staff have been trained in the new systems;
- iii. physical infrastructure is improved to plans agreed at the time of winning the tender; and
- iv. patient groups have been organised for surveys and strategic planning.

We understand from AT Medics that these tasks have been completed, and AT Medics can now reasonably be regarded as an established practice.

59. A number of other reasons also suggest that the AT Medics practice at 192 Tudor Drive is unlikely to become financially unviable in the near future:

- i. The minimum efficient scale for a GP practice is estimated to be approximately 1,900 patients.³⁶ AT Medics had 2,433 patients on its patient list in April 2009. This implies that it could lose a significant number of patients before its viability was threatened.
- ii. More than 1,000 of the 8,500 GP practices in England have fewer patients than the AT Medics practice at 192 Tudor Drive.
- iii. NHS Kingston told us that AT Medics currently operates with 1.3 working time equivalent GPs. This gives it a patient to GP ratio of 1,872. This is higher than a number of nearby practices including the Churchill hub practice (1,481), Brackendale (818) and

³² We note that this beneficial effect, of GP practices improving services, can be achieved without any patients actually switching GP practice. By providing a high level of service we would also expect that AT Medics may also attract new patients, including from Churchill, as well as potentially losing patients to the new branch surgery.

³³ We discuss the Minimum Income Guarantee provided by NHS Kingston at paragraphs 75 to 77. The services contracted by NHS Kingston and provided by AT Medics are set out in Appendix 1.

³⁴ Churchill suggested to us that there may be some flexibility in the required number of these sorts of procedures in the case of small practices.

³⁵ At paragraphs 75 to 77 we refer to the Minimum Income Guarantee which is contracted to be paid until [X] and guarantees AT Medics income at a minimum level for that period regardless of the number of patients registered on its patient list.

³⁶ See Deloitte's March 2006 report to NHS employers: *Adjusting the General Medical Services Allocation Formula for the unavoidable effects of geographic-dispersed populations on practice sizes and locations.*

Lock Road Surgery (1,413), which indicates that AT Medics cost overhead per patient is lower than these other GP practices (all else being equal).

60. As a result, we conclude that the opening of the new branch surgery by Churchill is unlikely to lead to significant numbers of patients switching from AT Medics to the new branch surgery, and that the financial impact of the new branch surgery on AT Medics is likely to be very small or immaterial not only because of the minimum income guarantee (discussed further in paragraphs 75 to 77), but also because of a range of factors that we have identified that mean that it is unlikely that a significant number of patients will switch practices. Given that AT Medics has the practice most closely located to the new branch surgery (see paragraph 62), we consider that the effect of the new branch surgery on other GP practices in the vicinity will be even less than that on AT Medics.

Impact of the new branch surgery on quality of services at other GP surgeries

61. To assess whether there may be any benefit to patients from the new branch surgery opening, we looked at whether the quality of service provided by AT Medics and other GP practices in the vicinity might be maintained or improved if the new branch surgery opened. GP practices that are near to one another will each be under pressure to maintain or improve their quality of service in order to retain or increase the number of patients that choose them.

62. Table 1 sets out the distance of other GP practices from AT Medics. AT Medics has one other practice within 1,000 metres (to the west), and three additional practices to the south within 1,500 metres, but no practices within 1,500 metres to the north (in the direction of Ham). The location of these GP practices is also shown on the map in Figure 2.³⁷

TABLE 1: GP practice by distance

	List size at April 2009	metres				
		0-250	250-500	500-750	750-1000	1000-1500
AT Medics	2,433	0	0	1	0	3
Churchill	11,850	0	0	3	0	2
St. Albans	6,825	0	0	2	1	3
Richmond	6,581	0	1	1	1	3
Canbury	10,589	0	1	1	2	5
Lock Road	6,500	0	0	0	0	1
Fairhill	6,400	0	0	2	0	4
Brackendale	982	0	0	2	0	3

Source: CCP analysis

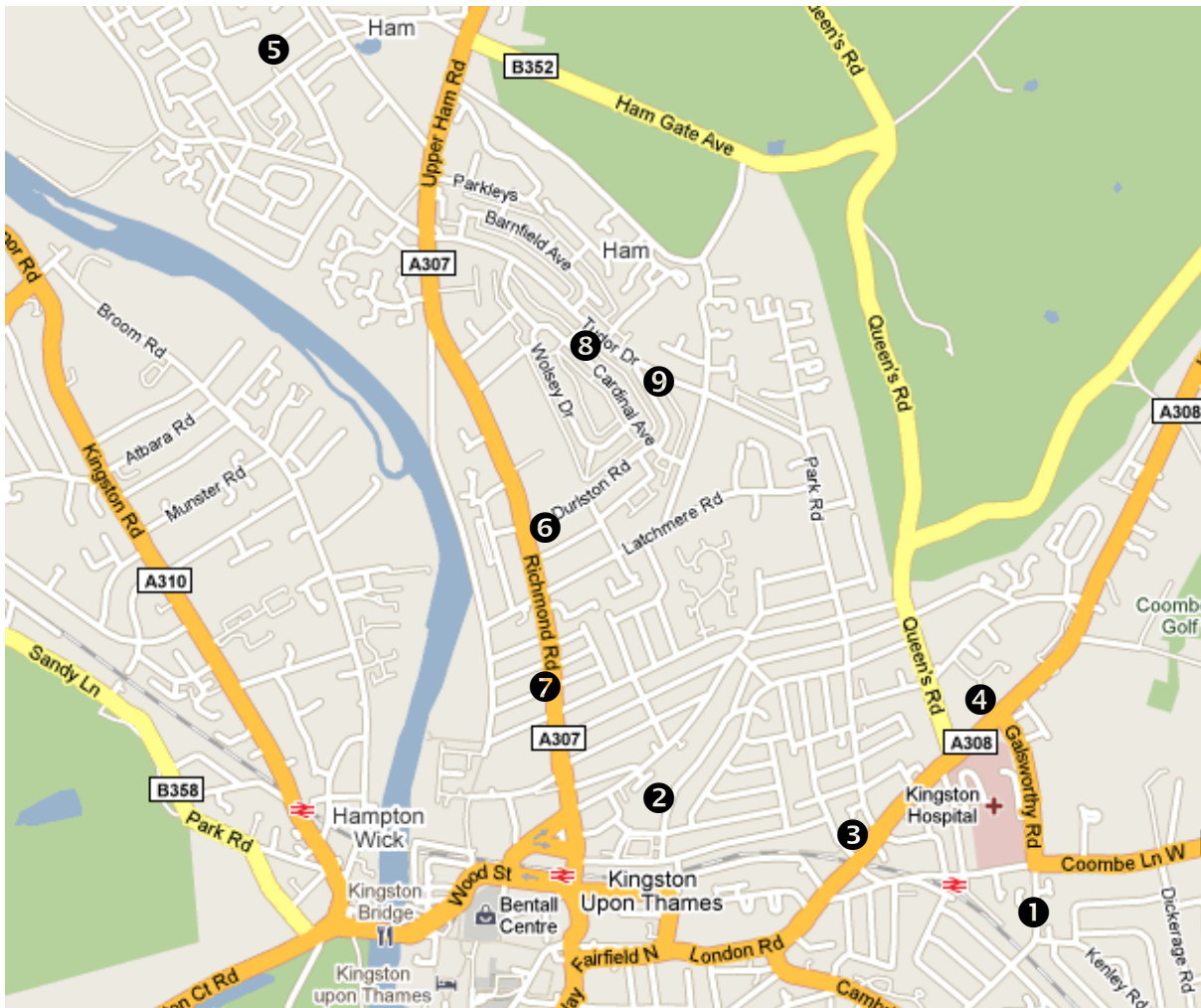
³⁷ As the CCP's conduct guidelines make clear, market definition is a tool for the analysis of competition. In this case we have focused on the direct competitive effects of the Conduct which has not required a formal market definition. This approach limits the scope for two common mistakes: treating services outside the defined market as exerting no constraint and treating all differentiated services inside the market as exerting equal constraint. As GP practices are geographically differentiated services they should not be analysed as a commodity product with equal constraint on each other. The approach used in this case treats different GP practices as providing a range of constraints, depending on how close they are to the GP practice being analysed.

63. The new branch surgery proposed by Churchill would not change the total number of practices within the wider area (because Churchill already has its main practice 1,500 metres from the new branch surgery).³⁸ However, the development of the new branch surgery would introduce a new surgery within 100 metres of AT Medics and within 750 metres of St. Albans surgery. A more closely located surgery may be expected to have a larger impact on AT Medics than more distant surgeries, such as the Churchill hub practice. This is because 30 to 50 per cent of patients register with their nearest practice.³⁹ The NHS choices website reflects this preference through the order in which it presents search results for GP practices in an area.

³⁸ NHS Kingston told us that the opening of a branch surgery would result in a decrease in the number of providers in an area and result in an associated decline in patient choice between different providers if the patients of existing providers move to branch surgeries of providers already present in an area. NHS Kingston told us that if the viability of AT Medics were threatened the tender process would be undermined and the tender would be unlikely to be repeated (in the event of AT Medics failing) because it would be costly and new providers would be less likely to tender to provide the level of service desired by NHS Kingston if the new branch surgery was nearby. In addition, we were told that the closure of AT Medics would result in Churchill holding a monopoly position in the area and the range of contracted services on offer would not increase within the PCT area because the same services are already offered under the existing contract with Churchill. We were told that, in NHS Kingston's view, it is not the number of premises but an increased number of GP practices which generates increased competition and a wider range of contracted services, to the benefit of patients and taxpayers.

³⁹ See Deloitte's March 2006 report to NHS employers: *Adjusting the General Medical Services Allocation Formula for the unavoidable effects of geographic-dispersed populations on practice sizes and locations.*

FIGURE 2
Map of Competitors



- ❶ Brackendale
- ❷ Canbury
- ❸ Churchill (KT2 6PG)
- ❹ Fairhill
- ❺ Lock Road
- ❻ St. Albans
- ❼ Richmond Road
- ❽ Churchill's new branch surgery
- ❾ AT Medics Tudor Drive

Source: Google Maps

64. Given the closeness of the new branch surgery to AT Medics, we might expect patients to benefit from increased quality of service as AT Medics seeks to prevent patients from switching to the new branch surgery. The new branch surgery would also be likely to give some impetus to the nearby St. Albans GP practice to maintain and improve its standard of services.

65. AT Medics told us that they consider that they can improve their service despite having achieved a good score under the Quality Outcomes Framework (QOF) of 985.98 points less than a year

after winning the tender. AT Medics told us that in the event of patients leaving their practice they would seek to provide any additional services that might keep existing patients registered and satisfied (see paragraph 56). Further, as we do not expect many existing patients would choose to switch away from AT Medics (see paragraph 60), we do not expect that the range of services offered by AT Medics would be unduly affected by the opening of the new branch surgery.

66. Given the number of patients registered at AT Medics and St. Albans approximately 9,500 patients may enjoy improved quality of primary care if the new branch surgery opens.

Financial costs to NHS Kingston of the new branch surgery

67. We considered three possible sources of financial cost to NHS Kingston arising from the new branch surgery. These are:

- i. premises and other reimbursable operating costs associated with the new branch surgery;
- ii. higher patient treatment costs arising from the minimum income guarantee that NHS Kingston has extended to the AT Medics practice at 192 Tudor Drive; and
- iii. the relative cost of patient treatment at Churchill and AT Medics in the absence of the minimum income guarantee for AT Medics.

Premises costs for new branch surgery

68. The *NHS (GMS – Premises Costs) (England) Directions 2004* provide for a system of reimbursement for GP practices (including development and improvement costs, mortgage grants, rental costs, and notional rent costs for premises that are owned outright). The directions set out minimum standards for practice premises (eg relating to ease of access for wheelchair users, proper equipment of treatment and consultation rooms, adequate fire precautions and adequate security for drugs and records) and the method for calculating market rents and any abatement. Pursuant to Part 5 of these directions, holders of GMS contracts have the right to apply for reimbursement in respect of premises costs and the PCT “must consider the application and in appropriate cases (having regard amongst other matters, to the budgetary targets it has set for itself) grant that application”.

69. These Directions only apply to GMS contracts, although we were told by the Department of Health that when negotiating PMS contracts, they are often used as a basis for negotiations. Churchill has a PMS contract. PMS contracts are locally negotiated so terms can differ from contract to contract, subject to compliance with the *NHS (Personal Medical Services Agreements) Regulations 2004*. However, it is our understanding that unless Churchill’s contract is expressly varied there are no contractual payment obligations upon NHS Kingston to pay for the establishment or operation of new premises.

70. NHS Kingston has estimated that its potential expenditure from the operation of the new branch surgery is in the region of £20,500 per annum to cover rent, rates, water and IT support. NHS Kingston also noted that there may be other financial costs that are currently unforeseen.

71. NHS Kingston told us that it believed that the cost of premises reimbursement, ‘list cleansing’ required to reduce possible double payments from patients being listed at more than one practice, monitoring and contract management for the new branch surgery did not represent value for taxpayer money given the proximity of the new branch surgery to an existing practice.⁴⁰ London SHA told us that small additional costs to a PCT can have a negative impact on other patient services.
72. NHS Kingston told us that they are required only to commission services which fulfil the reasonable requirements of the area; commissioning services over and above those reasonable requirements would have unacceptable financial implications for the taxpayer.
73. However, Churchill told us that they are not seeking reimbursement for any development costs or ongoing expenses associated with the new branch surgery (ie rent reimbursement, rates, water or IT support).⁴¹
74. Given that the reimbursement of financial costs associated with the new branch surgery would need to be agreed by both parties, there is no legal obligation upon NHS Kingston to reimburse those financial costs and Churchill has said that they are not seeking reimbursement for any development or ongoing expenses, we consider that the direct financial cost to NHS Kingston of the new branch surgery would be small or immaterial. We note that if Churchill were to request reimbursement of its outgoings, if the new branch surgery were to open, NHS Kingston is only required to consider the application and continues to have discretion to refuse any application made.

Minimum Income Guarantee

75. NHS Kingston and AT Medics, the winning bidder for the contract at 192 Tudor Drive, negotiated a [§<] year minimum income guarantee. This guarantee was offered by NHS Kingston during the procurement process after it was discovered that the size of the patient list at 192 Tudor Drive was smaller than advertised in the tender documentation. (Bidders taking part in the tender had been asked to provide pricing for the number of patients and range of services that had been set out in the tender documents.) The guarantee means that AT Medics is paid a fixed fee of £263,500 per annum for the [§<] years beginning 1 October 2008 regardless of how many patients (below a threshold of 3,130 patients) are on AT Medics’ patient list. The number of patients registered at April 2009 was around 2,400.⁴² NHS Kingston told us in the event of the contract running satisfactorily it expects to renew the contract. However, no minimum income guarantee would be offered as AT Medics would be fully established.

⁴⁰ We understand that monitoring and contract management refers to those administration and monitoring duties that PCTs undertake in respect of all GP practices in its area. NHS Kingston has not told us that this is a major cost in its operations when we have asked for its anticipated costs of opening the proposed new branch surgery (ie the incremental cost of providing the monitoring for one more premises in addition to the 28 GP practices in the area).

⁴¹ Churchill told us that it has already paid for the establishment costs of the new branch surgery of approximately £250,000, from its retained earnings. NHS Kingston has suggested to us that these funds could have been directed to other patient services and should be included in our analysis of the Conduct. Churchill told us that using these funds on developing the new branch surgery has prevented it from investing further into its business, for example, delaying the introduction of Sunday opening hours at their main hub practice. However, this issue is not directly relevant to our analysis and we have not considered further the benefits that patients might derive from alternative uses of these funds.

⁴² In the event of the patient list size increasing beyond 3,130 an adjustment of £[§<] per additional patient above or below that threshold will be made by NHS Kingston.

76. The effect of guaranteeing the minimum income payment for a [X] year period is that NHS Kingston does not make any payment in addition to the agreed sum of £263,500 per annum for each time a patient registers with AT Medics, up to and including the 3,130th patient. For the 3,131th patient, and each additional patient, NHS Kingston would have to make an additional payment to AT Medics of £[X]. The corollary of this is that if any patient registered with AT Medics switches to another GP practice within the NHS Kingston area then NHS Kingston will until [X] have to pay the cost of the patient being registered with the other GP practice, having already paid AT Medics for that patient's cost. In effect NHS Kingston pays twice for any patient that switches from AT Medics to any another GP practice in the area before [X]. The current cost of the minimum income guarantee (over and above the contracted patient-based income) is approximately £[X] per annum given that AT Medics has approximately 700 patients less than the guaranteed minimum.
77. Given the minimum income guarantee, by preventing Churchill from opening the new branch surgery NHS Kingston avoids the possibility of incurring additional costs as a result of patients switching to the new branch surgery (although it would still incur these costs if patients switched to other GP practices in the area). However, as we do not consider that the number of patients that will switch from AT Medics to the new branch surgery will be significant (see paragraph 60), any additional cost to NHS Kingston arising from the minimum income guarantee it has extended to AT Medics is likely to be small.

Higher cost per patient treated

78. Putting to one side the effect of the minimum income guarantee, NHS Kingston told us that it costs more for patients to be treated by Churchill than by AT Medics.⁴³ If a patient moved from AT Medics to the Churchill branch surgery then we were told that the cost to the NHS Kingston would increase from £[X] to £[X] per patient. The average cost per patient is a simplistic calculation derived by dividing the total cost of the service by the number of patients registered on a patient list and varies as the number of patients on the patient list changes.⁴⁴ It is difficult to compare the per patient cost directly because most GP practices offer a different range of services and are paid in different ways pursuant to different contracts.⁴⁵
79. We were not persuaded that the costs of treating patients at each GP practice, provided by NHS Kingston, were directly comparable. In any event the relative cost of each practice is less

⁴³ NHS Kingston told us that in general public funds 'follow the patient'. This means that a PCT receives the same amount of funding for patients registered in its area, regardless of which particular GP practice the patient is registered with or if the patient resides in an area outside of the PCT boundary. NHS Kingston noted that there can be delay of up to three years where a PCT has a net increase in patients which will not result in an increase in budget until the next triennial budget is set. In respect of patients moving between GP practices in the same PCT area, there will be no impact on the funds that the PCT receives. A PCT is not generally responsible for patients living outside its boundary, although a patient registering with a GP practice within the PCT boundary is an exception to this.

⁴⁴ For AT Medics the £[X] per patient is calculated by [X]. However, because there are only around 2,400 patients on AT Medics patient list it is equivalent to around £[X]. The contract value includes 'Essential' 'Additional' services as defined in GMS regulations only and excludes Quality Outcomes Framework (QOF) payments, enhanced services payments, rent reimbursement, rates, water and IT support as well as any capital development expenditure applied for and approved by NHS Kingston.

⁴⁵ To the extent that this reflects a difference in the negotiated price between a PCT and a GP practice it should not correctly be considered a benefit or cost of the Conduct. Differences in the amounts negotiated are likely to represent different balances of other income and or difficulties in delivering services to patients. The amount negotiated and paid is usually the subject of annual review by a PCT and even where discrepancies arise between contracts with primary healthcare contractors, PCTs are in the best position to identify and remedy these.

relevant to our assessment of the Conduct given that low net switching of patients between the practices is expected (see paragraph 53).⁴⁶

Need for additional services in the area

80. NHS Kingston told us that that there was no 'unmet need' for GP services in the area that would be served by the new branch surgery that justifies the expense of contracting for additional services.⁴⁷ NHS Kingston told us that all practices in the Tudor Drive area have open lists and it has not been necessary to allocate patients to GP practices (as a result of closed patient lists) in this area in the last two years.⁴⁸ NHS Kingston explained that if an unmet need was identified then it would use a competitive tender to procure additional services rather than allowing Churchill to open a new branch surgery without a tender. NHS Kingston said that, in general, it would commission additional services where the Joint Strategic Needs Assessment identified a need for substantial additional services (eg in response to a major new housing development). NHS Kingston also told us that there is a range of alternative service providers (ie other than GPs) that might be used to meet patients' needs. NHS Kingston told us that in the event of the Conduct being found to be inconsistent with the Principles and Rules, the CCP would be sending out a message that any provider can simply establish premises where it chooses.⁴⁹
81. Churchill told us that patients in Ham are in need of additional services as the area is not well served by public transport making it more difficult for these patients to access GP services. Ham is part of the NHS Richmond area and the needs of these patients are assessed in the NHS Richmond Joint Strategic Needs Assessment.⁵⁰ NHS Kingston is not expected to consider the needs of patients outside its area, although it is required to assess the needs of all patients registered with GP practices within its area (including those patients that live outside its area).⁵¹
82. NHS Kingston's view that there is no need for additional GP services in the area might be relevant if the new branch surgery were to impose a financial cost on the PCT, which in turn could impact on funding for other services. However, as we have set out above (in paragraphs 67

⁴⁶ We note that we have not, in this case, considered the relative cost effectiveness of PMS or APMS contracts. Some GP practices are paid an amount that is more than other practices when averaged across each patient. These differences in payments may reflect the relative efficiency of different GP practices, but may also reflect a different range in services or agreed tariffs. To the extent that some GPs are more efficient and can retain a greater portion of their income, they have a similar competitive advantage to any other company that benefits from having a low cost base. Within their area PCTs have some ability to negotiate and review GP contracts to control the competitive advantage that one GP practice might have over another.

⁴⁷ NHS Kingston told us that by 'unmet need' they meant the reasonable needs of patients for primary healthcare services in the area and is more than the need or wish of any individual patient.

⁴⁸ Churchill stated in its tender documents, provided to NHS Kingston for the tender in June 2008, that it was one of the few GP practices in the local area at that time that was accepting all new patients (in contrast to operating an 'open but full' patient list, see paragraph 33). Churchill told us that it considered all nearby GP practices had been operating open patient lists over the past two years.

⁴⁹ NHS Kingston also told us that the number of GPs when compared to the number of patients in the Kingston area is comparable to London and better than England as a whole. We were also told that areas where there are more than the average number of doctors compared to patients incur greater taxpayer expense and cause some GP practices to become 'compromised' due to a lack of critical mass required to support particular services and or insufficient income, resulting in less choice for patients. NHS Kingston said that, in general, this resulted in unnecessary expenditure being incurred and could also deter entry by new GP practices. London SHA told us that this ratio is often one of a range of factors that PCTs and SHAs use when ascertaining areas which may benefit from additional GP practices. The Department of Health told us that there was no definition of an under or over doctored area and it was a poor indicator of primary healthcare services which can be significantly influenced by the number of nurses and the particular primary healthcare services being provided. Given the limited use of this indicator we have not used it in our analysis.

⁵⁰ We reviewed a 2005 Joint Strategic Needs Document produced by NHS Richmond (they are due to publish a revised document in December 2009). In the 2005 document a high need for GP services was identified in Ham by NHS Richmond.

⁵¹ Churchill told us that on 3 November 2009 NHS Kingston asked GP practices located in its area to include the practice in Lock Road, Ham within the NHS Kingston area which suggests that the PCT is taking a more direct role in the provision of primary care services to the Ham area.

to 79) we do not consider that that the new branch surgery would impose material financial costs on NHS Kingston and, as a result, we do not consider the fact that the PCT has not identified an unmet need in the relevant area to be a justification for the Conduct.

ADVICE AND RECOMMENDATIONS

83. The CCP has assessed whether the Conduct may be expected to give rise to an adverse effect (or cost) to patients or taxpayers as a result of a loss of choice or competition and whether this is offset by benefits to patients or taxpayers.
84. We have found that a significant number of Churchill's patients will benefit from their preferred GP practice opening a branch surgery closer to their homes, and that other Churchill patients may also benefit from reduced congestion at Churchill's hub practice in Norbiton, Kingston. We also consider that the new branch surgery may encourage other GP practices in the locality to improve their quality of service so as to prevent patients transferring to the new branch surgery.⁵²
85. We considered whether patients and taxpayers may be adversely affected by the opening of the new branch surgery.⁵³ In doing so we assessed the range and quality of services potentially on offer at the new branch surgery, the impact on other GP surgeries in the locality, and the financial cost to NHS Kingston of the new branch surgery. Our conclusions on these issues are set out below:
- i. We note that patients already registered with Churchill that use the new branch surgery may have a smaller range of services available in more limited hours compared to the hub practice. However, these patients are already choosing to travel to the more distantly located hub practice, so being able to access some services closer to home would represent an improvement compared to their current situation.
 - ii. We expect that the opening of the new branch surgery by Churchill is unlikely to lead to significant numbers of patients switching from AT Medics to the new branch surgery. We also expect the financial impact of the new branch surgery on AT Medics is likely to be very small not only because of the minimum income guarantee, but also because of a range of factors that we have identified that mean that it is unlikely that a significant number of patients will switch practices. Given that AT Medics has the practice most closely located to the new branch surgery, we consider that the effect of the new branch surgery on other GP practices in the vicinity will be even less than that on AT Medics.
 - iii. In refusing Churchill permission to open the new branch surgery, we have found that NHS Kingston has not avoided any material financial costs (ie costs to taxpayers) it would otherwise have been liable to pay because:
 - a) there is no legal obligation upon NHS Kingston to reimburse any financial costs associated with the new branch surgery and Churchill has said that they are not seeking reimbursement for any development or ongoing expenses;

⁵² These benefits will not occur if NHS Kingston continues to refuse to give Churchill permission to provide NHS services from a new branch surgery. Accordingly, NHS Kingston's conduct gives rise to an adverse effect on patients.

⁵³ If patients or taxpayers were adversely affected, the Conduct would give rise to benefits.

- b) any additional cost to NHS Kingston arising from the minimum income guarantee it has extended to AT Medics is likely to be small as we do not consider that the number of patients that will switch from AT Medics to the new branch surgery will be significant; and
- c) the relative cost of each practice is less relevant to our assessment of the Conduct given that low net switching of patients between the practices is expected.

86. Weighing up the adverse effects of the Conduct to patients and taxpayers against the claimed benefits of it, we have concluded that NHS Kingston's conduct is inconsistent with Principle 4 Rule 2.

87. We have considered whether we should recommend that the Department of Health and NHS London take any action to address the situation. In light of the fact that the new branch surgery is financially cost neutral to NHS Kingston and there is detriment experienced by patients while the new branch surgery remains closed, we recommend to the Department of Health and London SHA that NHS Kingston should allow Churchill to provide NHS-funded services from the new branch surgery located at 164 Tudor Drive. This is likely to be carried into effect through a variation to Churchill's existing contract with NHS Kingston.

18 December 2009

LIST OF SERVICES PROVIDED BY AT MEDICS FROM 192 TUDOR DRIVE

1. These services were listed in the Memorandum of Information and contracted for by NHS Kingston with AT Medics.

Essential services (as defined in the GMS contract);

Additional services (as defined in the GMS contract);

- Cervical screening;
- Child health surveillance;
- Minor surgery;
- Maternity medical services (excluding intra-partum care);
- Contraceptive services;
- Childhood immunisations and preschool boosters;
- Vaccinations and immunisations;
- Directed Enhanced Services;
- Childhood immunisations;
- Influenza and Pneumococcal immunisations;
- Access;

Choice and Booking;

- IM&T;
- Minor Surgery

National Enhanced Services for patients registered with the practice eg;

- IUCD

Locally Enhanced Services eg;

- Practice Based Commissioning
- Others that may become available to apply for from time to time