"Improving General Practice – A Call to Action"

Analysis of responses to the NHS England consultation

Final report provided by CIPFA Research on behalf of NHS England

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1.   INTRODUCTION

In August 2013, NHS England published a national consultation entitled "*Improving General Practice – A Call to Action*", to help shape the future of general practice services in England.

The consultation was primarily aimed at frontline clinicians in primary, secondary and community care, Clinical Commissioning Groups, and professional associations. However, patients and members of the public also took part, reflecting NHS England's aim of stimulating debate within local communities. The consultation closed on 10 November 2013 and received a total of **521 responses**.

In December 2013, NHS England (NHSE) commissioned CIPFA Research to undertake a detailed content analysis of the consultation responses.

This report details the core findings from the consultation.

2.   MANAGEMENT SUMMARY

This section outlines the key consultation findings. These are issues that were highlighted by a significant proportion of respondents. In addition, some respondents mentioned these issues at several stages during the consultation – even if they did not directly relate to the question area, in order to emphasise their importance.

Areas of particular note are:

- **IT systems must be aligned** / streamlined across primary and secondary care

- In order to adequately work with patients with long term conditions (LTCs) and complex needs – including those with learning disabilities – GP appointments **must be extended to a minimum of 20 minutes**. Thus the GP:patient ratio must be reduced in order to facilitate this but with *no loss in funding* as a result

- In order to better enable **integrated working**, practices should consider **pooling/federating** their resources – most notably manager and administration functions

- **Funding** should to be made available for clinical innovation and enhanced services. It also needs to be reallocated from secondary to primary care

- In order for GP practices to evolve and provide outstanding care, **investment *must* be made in estates and facilities**

- **Published information** about GP practices must be set in context and include local demographic information. It should be used to emphasise areas of good practice, and *not* as a 'stick to beat' practices that 'underperform'

- The **Quality Outcomes Framework** (QOF) targets should be clinically-led and capture multiple needs, rather than merely single illnesses

- Most patients do not want choice, but rather **high quality**, **locally available care**.

3. GENERAL FEEDBACK ON THE CONSULTATION

The consultation was primarily open ended in nature, requiring free text responses to a series of nine question areas. Each question area contained a subset of between four and six questions. Many respondents commented that the length of the consultation, the level of detailed response required, and the language used in the consultation pre-supposed an element of insight and expertise, that those working outside the healthcare sector would not have. Thus making it difficult for them to provide a response.

Comments provided by respondents included:

- As a patient I don't know enough to answer

- The questions are too detailed and complex for the average person to engage with

- Some questions are leading and loaded

- I am confused by the survey

- You have provided no background to the questions

- There are too many varied themes per page

- The terminology is too bureaucratic

- This section does not make any sense

- The consultation has presented solutions without allowing respondents to identify a problem

- The consultation has not offered a range of options for a solution

- You are not asking whether the proposed strategies are the best way forward

- The consultation is biased towards the idea that primary care is failing.

"I appreciate that the questions are designed to produce positive answers, having filled DH consultations before: what I am saying is that the ideas you are presenting assume that there is an accepted need for changes - which I dispute - but I cannot see any evidence in the evidence you have put on line to support this."
[Retired GP, East of England]

"The whole premise of this consultation is fundamentally wrong and by pursuing it you risk destabilising possibly the most efficient healthcare system in the world (outcome/£ spent)."
**[Primary Care Services, London]**

4. GENERAL RESPONDENT INFORMATION

The consultation document initially asked respondents to provide the following information: their name, email address, gender, ethnicity and postcode, whether they were responding on behalf of an organisation or as an individual, and what area of healthcare they were representing. They were also asked whether they believed that the current system of primary care in England needed to change and improve. *Appendix A – respondent profiling information*, details the results for these questions (excluding, name and email address).

Note that the vast majority of respondents were **White**, an almost equal proportion of males and females responded, most people responded as an **individual** (even though they then used organisational examples in their responses), and most believed that the current system of primary care in England *does* need to change and improve[1]. As to the area of healthcare that respondents were representing; as this was a multiple choice question, most selected several options.

We used the postcode information provided to break down response by **Strategic Health Authority (SHA)[2]**. This information is displayed in the map below and reveals that a significant proportion of responses came from those in **London** and the **South West**.

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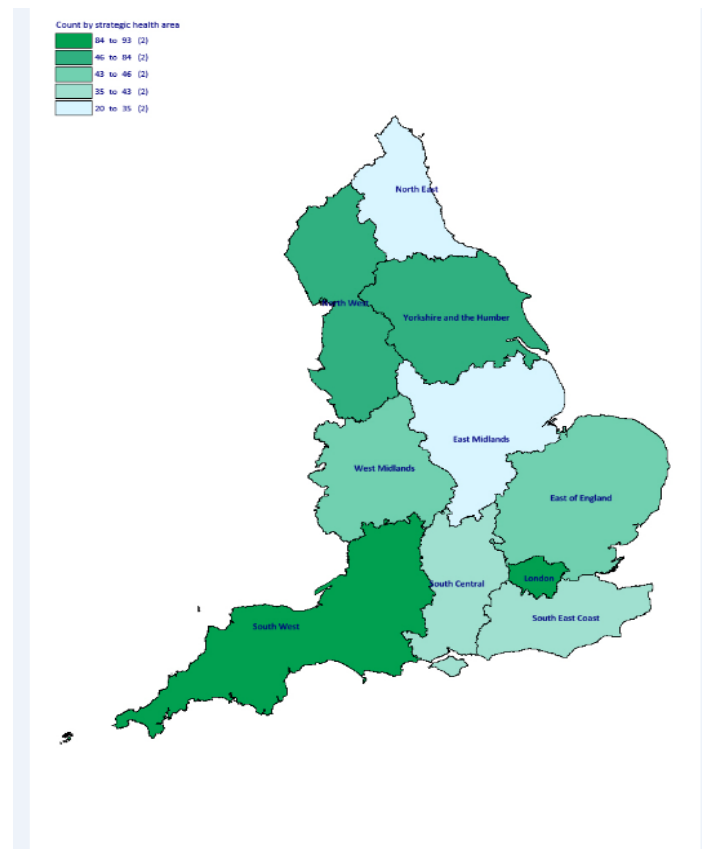
[1] Note that a number of respondents stated that they found this question very hard to answer as it asked two questions in one. They therefore tended to 'hedge their bets' and answer 'Yes'
[2] Appendix A provides an explanation as to the process involved in mapping the postcodes

5. CONTENT ANALYSIS OF THE CONSULTATION RESPONSES

The following sections illustrate the key findings from the consultation, ordered by question area and the major themes within each of those areas. Question areas were as follows:

- Information, choice and control
- Clinical leadership and innovation
- Freeing up time and resources
- Defining practice accountabilities
- GP contract: incentives for outcomes
- Safe, controlled investment
- Market management
- Workforce development
- Other comments made.

We have included respondents' own words to highlight some of the central issues raised, and have also included relevant case study examples at the end of each section.

Respondents' comments are identified by **SHA region**. Where a respondent has responded on behalf of just one area of healthcare (e.g. primary care services), then this information is also provided to support the quote.

5.1 Information, choice and control

Respondents were asked to feedback on four question areas regarding **information, choice and control**.

5.1.1 How do we go further in publishing – and getting practices to publish – an increasing range of comparative public information?

In general, respondents were in favour of publishing general practice information, as long as the **information was used appropriately** and **published in context**. Some commented that current data was often not published in context and that this led to data being misinterpreted.

It was felt that any decision as to hast information should be published and how, should be **clinically-led**. In addition, practices needed to be provided with the requisite **financial resources** to ensure that they are able to invest the **required time** in collating and making their data available for publication.

According to respondents, the NHSE needs to be clear about *why* they are publishing comparative data and ensure that the **data is used in a constructive way**. Furthermore, information should be **meaningful**, **accurate** and **up to date** (which it often is not at present).

Information sharing should be about **sharing good practice** rather than punishing practices or using it as a **stick to beat** 'poor' performers or to undermine practices.

It was suggested that local Clinical Commissioning Groups (CCGs), Local Medical Committees (LMCs), Practice Managers' Groups and Healthwatch work in collaboration to create and publish their data. Before data are published, practices would like to see **how the data will be presented** and in **what context**.

Comparative data needs to be relevant and usable, not just interesting. There needs to be a commitment from all practices to publish their data to make the process worthwhile.

Suggestions as to the **type of information** that should be available included:

- Good practice case studies
- Evidence from all health and care services for example social care, health care and public health services
- Information about good innovations
- Healthcare outcome information rather than process-related – i.e. not just satisfaction and relationship with choice
- Consistent Quality of Life (QOL) and Patient Reported Outcome Measures (PREMs)
- Evidenced based data – e.g. waiting times, doctor:patient list sizes, number of appointments provided in a week per population, clinic hours, patient feedback, and outcomes
- Survey data on clinical pathway experience / Mapping of patient pathways
- Metrics of deprivation, demographics, and morbidity – share at network level and group similar practices for comparative purposes
- Rural v non-rural data.

Suggested places **where information could be published** and viewed by practices and members of the public included:

- NHS England website – where all data could be consolidated (e.g. CQC, QOF, GP survey)
- Email newsletters comparing national data from local CCG to practice managers
- Via practice websites; NHS Choices website; local health centre websites; social media
- Available in hard copy and other formats so can be understood by all.

"Collate all data that currently exists regarding practices and make easily available to patients in one central place. Would help practices review one source for accuracy."
[Source unknown]

"Many of the factors affecting performance and outcomes are dependent on a whole range of variables and factors, many of which are not directly in a practice's control."
[Primary care services, South West]

"The important thing about data is that it is used to drive innovation rather than people feeling that the data is just an end in itself."
[Primary Care Services, London]

"To get practices to publish data they need to be reassured that it will be used constructively, formatively and set in context."
[London]

"LMC's have traditionally opposed any sharing of quantitative data from practices to PCT's. Ironically qualitative data sharing is and has been fine. Quantitative data sharing is important as in reality NHSE and CCG's have absolutely no idea how many patients are seen daily except perhaps in APMS contracts. NHSE and CCG's are not aware of dr:patient ratio stats, only principal dr stats, via performers list. Patient facing GP time is a mystery."
[Primary care services, North West]

5.1.2 How can we best work in partnership with CQC and the new Chief Inspector role whose inspections and ratings regime is designed to improve transparency?

Some respondents felt that NHSE had made an **incorrect assumption** that there is a **lack of transparency** in general practice, and furthermore, that publishing data does not equate to transparency. Respondents felt that what was *most needed* was transparency regarding the **relationship between the Care Quality Commission (CQC) and NHS England**, with clearly defined roles and responsibilities on both sides.

Other respondents commented that the **role of the CQC added another layer of bureaucracy**, and that CQC was performing the role of the CCG. Instead, what is needed is more **light touch regulation** and **high trust/professionalism**. There were also concerns that the increasing administrative burden on practices would impact on the quality of care they were able to deliver to patients. At present, most respondents did not feel that the CQC was doing anything to improve general practice and that the CQC is in fact largely viewed as hostile and unsupportive, where it should be consistent, realistic and supportive.

There were arguments that there was little value in the CQC and Chief Inspector role except to waste more public money. CQC therefore needs to work hard to become a body patients and practitioners can trust. In the first instance, in order for partnership with CQC and the new Chief Inspector to work, it was felt that **clinicians must be on board** and that for this to happen, the CQC and Chief Inspector should **engage with LMCs**.

"The main issues I see are increasing bureaucracy, micromanagement of practitioners from central government, needless reorganisations which are expensive and destabilising..."
[Primary care services, South West]

"We should as a CCG be able to point the CQC into what we want them to look at with our local knowledge."
[Commissioners of healthcare services / Primary care services, North West]

5.1.3　How do we stimulate new forms of patient involvement and insight, including introducing the Friends and Family Test in general practice?

There was general agreement that it was **important** to engage with patients and involve them in decision-making. In general GPs are keen to encourage **patient** participation, as long as additional **financial resources** are provided to enable this. Suggestions included engaging with:

- Carers – e.g. via Carers UK

- Children and young people

- Local Healthwatch to identify patient involvement groups

- **Patient Participation Groups (PPGs)**
    - All GP surgeries should support the set-up of a PPG
    - Provide PPGs with micro-sites to support collaboration and encourage engagement
    - Value the PPG and plan to do more with them
    - PPGs to support patients and the service especially re surveys

- RCPCH (Royal College of Paediatrics and Child Health) UK Youth Advisory Panel

- UK Parent and Carers Group

- Voluntary sector organisations – many have user involvement built into the way in which they work.

There was *little support* for the **Friends and Family test**, with many respondents arguing that it had little value, was too simplistic and lacked credibility. It was felt to be more relevant to secondary care than primary care and that in depth patient discussions about their experience would be more effective than the 'subjective and non-specific' Friends and Family test.

"Has the Friends and Family test been validated? It's a bit like asking your friends and family about buying a new car. Most people are not in a position to judge the quality of medical care."
[Primary Care Services, South West]

"The Friends and Family test is not fit for use in general practice. A patient GP relationship is a long term relationship based on mutual trust and respect…the test is too simplistic to have any true meaning in general practice."
[Other: Organisation, London]

"The Friends and Family Test has issues with credibility which are likely to become more marked in its application to a primary care setting - the provision of high quality evidence based care does not necessarily correlate with a high score in terms of patient satisfaction."
[Commissioners of healthcare services, East of England]

In general, the **GP Patient Survey** was more highly regarded than the Friends and Family test and was seen as a positive way of involving patients and obtaining their feedback. Respondents made some useful suggestions as to how this survey could be further improved, for example by **collecting the views of those under 18 years of age** and from **parents / carers** about the services provided for their children.

"Our practice has a patient group who are actively involved in projects in the community which we support and they are integral in the writing and delivery of our patient surveys."
[Patients and service users, South West]

"If we were to engage patients to try and get out the message to the public that they need to value the NHS and use it more carefully then that could be constructive."
[Primary Care Services, London]

5.1.4   How best do we roll out new models of patient choice?

A number of respondents queried how much patients really wanted choice, and instead argued that high quality locally-available care and improved access are of more importance to people. It was felt that instead, NHSE should **make money available to GPs** to enable them to make the required changes needed to improve the quality of patient experience – e.g. **through improvements to premises, websites, patient-booking systems** etc.

There were some comments that **choice increases costs** at a time of great financial constraint, as patients can request more specialised care pathways over which the CCG has no control. Therefore, **some services should be charged for** to prevent inappropriate use of NHS – as per Australia, Canada and New Zealand.

Other respondents stated that NHSE should not consider widening patient choice, but that it should instead look at how to **ways patient expectations could be managed, within the limits of existing resource**. Other respondents argued that 'patient choice' is an unfair and unequal policy as it favours the urban dweller, health literate, digitally competent and assertive. In addition, patient choice only works in areas where there *is* choice. NHSE therefore needs to give consistent messages out to both patients and GPs regarding this issue.

"…choice and enforcing competition are not what my patients want – they want a joined-up, needs led, accessible and efficient set of local services that work together to deliver good quality care."
[Primary care services, South West]

"The evidence from people with LTCs is that they want continuity, consistency and team work, not choice. Aspects of health provision that benefit from choice are limited and are more related to social factors than quality of care."
[Primary care services, West Midlands]

"Striving for a 24/7, instant access service may not be in patients' best interests and is not possible given current workforce capacity."
[London]

"I do not want choice. I want a local GP practice and hospital which provides all care."
[Patients and service users, London]

"We believe too much patient choice can also be detrimental. What is needed is good quality consistent & personal care that is easily accessible."
[Primary care services, West Midlands]

"It is not possible to please everyone when they have unrealistic expectations of what a public healthcare system can provide for free…the choice agenda is a deliberately distracting technique being used to avoid facing the only important issue, that is how we fund healthcare in the face of limited money and unsustainable demand.""
[South West]

"There is already choice in the system. If we introduce too much everyone get confused and patient experience reduces. Just need to reinforce what we already have."
[Primary care services, East Midlands]

"Patients don't want choice; they want local good quality care. Why is choice held up as the gold standard of achievement? We should be aiming for uniform high quality care in all localities. Choice in rural areas is an illusion anyway. Once again, this is a London-centric question that has no relevance to 95% of the population."
[Primary care services, East Midlands]

[London case study]

We currently manage the **Earls Court Health and Wellbeing Centre** and the Camden Health Improvement Practice - two primary care services in London, the latter specifically for homeless people. When designing the Earls Court service we deployed our model of community-led commissioning, **Connected Care**. The Centre brings together, under one roof, GPs, dentists, a sexual health service and wellbeing support. It is also a community resource for local groups to use. Connected Care was rolled out to train local people to be Community Researchers, to engage with their local communities on what is and is not working with current provision, what is missing and what would improve their experience. The results of this work informed the design and continue to influence delivery at the Centre, including the employment of Navigators instead of receptionists and the establishment of a successful Timebank. We believe something like this should be employed across primary care to make engagement more than a tick box exercise but instead an empowering process by which people inform the way their services are run. Further information on Connected Care can be found here: http://www.turning-point.co.uk/community-commissioning.aspx.

[Patients and service users, South West case study]

We work closely with the **South Devon and Torbay CCG**. It is forming **Ambassadors** i.e. Visually Impaired Ambassadors as a consultation group. Getting patients and ambassadors to be involved in the design of consultations ensures a greater understanding of their need. Most important of all is the training of patients in representation and feedback. In Torbay, Healthwatch Torbay VI Consultation are designing a survey to go out to their network to evaluate patient's view on receiving treatment either in the clinic or a community setting.

[London case study]

We publish comparative information at a Network level for sharing amongst Practices. This is used to prompt discussion and support peer review. In our engagement with Practices, we have heard that the sharing of this type of information should be done positively, focusing on the best performers and learning about how they are achieving good outcomes, rather than being used as a stick to beat the lower performers. Any developments in publically published information should be considered in this spirit. We believe that **working through Network arrangements**, there is real potential for geographically scaled up models of General Practice to become more engaged in their local communities, to create good and positive discussions about General Practice services, seeking meaningful feedback and through this providing education to local communities about self-care, self-management and preventative health services.

[Yorkshire and the Humber case study]

We have found the **Practice Champions Model** works really well. Asking the local community to volunteer to help in practices, where practices are open to different views, has led to real change in the way primary care is provided, with service users/public providing masses of support from the usual support groups to advice to GPs on how to run their clinic sessions for ethnic groups, to providing prevention programmes, to diversifying the GP business. The GPs need support in being able to 'hear' the ideas and views of their local volunteers. It shows there is a lot of capacity in the community to provide support.

[London case study]

The **RCPCH** is committed to the meaningful involvement of patients, families and the wider public in the NHS. The **RCPCH UK Youth Advisory panel** and **UK Parent and Carers Group** actively advise the RCPCH in its work to improve healthcare for children, young people and their families from a patient perspective and their views are incorporated into this response where appropriate.

[East of England case study]

We support the current initiative by the **Herts Valleys CCG** to involve patients in decision making, but our main concern is the poor communication between one's GP and the hospital consultant - electronic communication seems to be forbidden. Communication about a patient between hospital trusts also seems to be forbidden. Why?

5.2   Clinical leadership and innovation

This section consisted of four question areas concerning the issue of **clinical leadership and innovation**.

5.2.1 How can we best stimulate and create space for clinically-led innovation?

There were comments that there is already a great deal of innovation going on in primary care that is being recognised – for example through **GP Awards**. However, there are few forums where clinicians can share good practice or learn from others. There were calls for the need for better opportunities for sharing information – for example through **workshops, innovation events** etc.[3].

A suggestion was made that a nationwide '**ideas for innovation' database / repository of best practice** be created that all clinicians could access. **Outcomes** of any innovation could also be collated here.

There was agreement that any new clinical innovations needed to be **rigorously evaluated** to ascertain what **does and does not work**; for example by assessing the impact on patient experience and outcomes. Furthermore, innovations needed time to bed-in before their success or failure was evaluated / determined. A realistic timescale was deemed to be 2 to 3 years.

Suggestions as to **ways innovation could be stimulated** include:
- Providing every CCG with a dedicated budget for healthcare innovation
- Funding clinically-led innovations that have an evidence base and are being piloted and/or evaluated
- Investing in the dissemination of good practice
- Freeing up GP time – for example, by removing non-clinical targets; reducing the GP:patient ratio; funding GP locums
- Supporting local annual primary care awards for innovation
- Stopping the policy of changing the GP contract on an annual basis, which can prevent any forward planning and innovation
- Encouraging groups of practices to work together / network to push forward innovative ideas
- Practically and financially supporting / incentivising the development of groups of practices into **federations**
- Providing innovation-related CPD points
- Removing existing requirement for practices to report back to multiple agencies, which can therefore divert resources away from development and innovation
- Investing in estates and facilities to properly support and facilitate clinical innovation
- Simplifying the regulatory framework and relaxing the rules that stifle innovation – for example, by paring back QOF

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[3] One respondent stated that **Academic Health Sciences Networks** (AHSNs) can help ensure good practice is shared

- Establishing one complete pathway across primary and secondary care to help facilitate and support innovations in care
- Utilising the strength of localities (where they exist) e.g. Clinical Programme Groups that bring together all health and social partners around a single clinical programme area (e.g. older people)
- Creating an NHS Clinical Innovator Network
- By pooling health and social care budgets.

"We can best stimulate and create space for clinically led innovation by providing a stable financial environment for practices, which will then permit space for proper consideration of service developments."
[Primary care services, London]

"Involving GPs and other healthcare professionals in care pathway re-design, as is now happening through CCGs, is creating clinically-led innovation."
[Primary care services, South East Coast]

"Hurley Group GP talk, offering email response to patients with a guaranteed turnaround time of 24 hours, and hope within 5 years to offer within 4 hours 24 / 7 – but they do have 300 doctors, so maybe federation would work (or organised in an IPA (Independent Practice Association) model like in New Zealand). They further anticipate that within 10 years 80% of GP contacts by email, Skype or phone and the remainder would be for personal continuity of complex problems."
[East of England]

"We need to invest in primary care by offering relaxation of rules that stifle innovation."
[Primary care services, London]

5.2.2 How can we challenge and support local health communities, including CCGs and health and wellbeing boards, to develop more stretching ambitions for primary care?

Several comments were made that, considering the current economic climate, developing even more stretching ambitions for primary care was unrealistic and unwelcome. A number of respondents commented that **GPs need more time with patients** before they can consider more stretching ambitions for primary care. Furthermore, comments were made that there is ambiguity over the role of CCGs / NHS England / Health and Wellbeing Boards in primary care development. This either needs to be clearly defined to promote action, or a clear message given around the limited capacity of NHS England for primary care development, and therefore the need for other organisations to act. Moreover, NHSE needs to have a clearer vision about what challenge / support means and what its ambitions are for primary care.

Suggestions put forward as to how local health communities can be both **challenged and supported**, were as follows:

- Pay for the recruitment of more specialist trained GPs and nurses
- Double investment in GPs and community nursing teams
- Pay practices for improved quality of service
- Create an innovation fund (people and money) to help practices with good ideas
- Provide financial incentives for more joined up working
- Stop Payment by Results
- Incentivise secondary care to discharge patients into primary care
- Create a Coordinated Care Network Incentive Scheme
- Ensure primary care commissioning is linked to the health needs of a geographical area
- Second CCG clinicians to Area Teams
- Give CCGs the responsibility for primary care commissioning
- Buddy CCGs together
- CCGs to act as 'critical friends' to each other
- Share 'good news' and 'good practice' – e.g. via websites, webinars etc.
- CCGs to encourage primary care to improve communication via PPGs, Patient Liaison Groups, Healthwatch, local councils, residents associations etc.
- Continue and strengthen the role of multi-disciplinary teams – e.g. ensure patients, local voluntary and community sector, local authorities (especially housing and social care departments), frontline providers, and Allied Health Professionals (AHPs) are included in discussions about the provision of healthcare
- Reinstate integrated primary healthcare teams which are GP-led and based in health centres
- Ask each CCG and HWB to designate at least one more stretching ambition that they want to achieve. Collate and fund priorities in properly resourced and evaluated pilots
- Provide a linked email system and single IT system to help improve communication
- Develop robust links between Higher Education Institutes and primary care in all areas, in order that the training for new practitioners remains of the highest quality
- Benchmark with equivalent services in other countries with better outcomes
- Encourage greater coordination between guidance and monitoring bodies
- Provide local health communities with information on local needs etc. This will enable them to see what needs to be done and what the baseline is
- Small locality groups to share and discuss comparative data in order to help improve patient care
- Health and Wellbeing Boards (HWBs) to produce well conducted Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategy (JHWSs) to cover the needs of the whole population
- Review patient use of other healthcare providers (e.g. pharmacists).

"GP's practices and hospitals, PHE and NHS England should have a linked email system. At present it is not possible for hospitals to communicate by email with GP practices."
[Patients and service users, London]

"Fix the financial inequalities immediately in primary care funding. Similarly the PCT locally was so financially burdened by the local PFI that there was very limited investment in primary care estates. This needs sorting and is a clear inequality with neighbouring CCGs. HWB's will succeed in improving community based care if they are a true partnership of LA's and CCG's - not just a formal sub-committee of the local council. We are working hard to achieve this with our LA colleagues and both parties are showing commitment to working together. HWB's must be allowed to hold NHSE to account for under funding of primary care. We would like to move to CCG contracting for primary care in future."
[Primary care services, North West]

"Primary care does not need more stretching ambitions. It needs to be able to perform its core functions well."
[Primary care services, London]

"Just get the basics right first. Never mind 'stretching ambitions for primary care' unless by that you mean enough GPs to meet the needs of the community."
[Patients and service users, South Central]

"…shift funding away from secondary care and divert it into primary care where the vast majority of patient care happens. To do this you need to give the CCGs sufficient power and support to enable this to happen."
[Primary care services, South West]

5.2.3 How do we best support integration pioneers in testing new ways of commissioning and contracting for integrated primary care and community services?

There were some queries as to what exactly 'integration pioneers' were. Others commented that significant barriers to integration exist that need to be removed, for example, commissioning services from lots of providers; the cutting of multi-disciplinary teams, market competition in the NHS, etc.

Suggestions provided as to how integration pioneers could be best supported included:

- Investing in them – for example by providing ring-fenced budgets
- Providing resources for the staffing of multi-disciplinary teams to deliver high quality integrated primary care in the community
- Relax commissioning rules. There were comments that the current commissioning and contracting structure is too complex
- Relaxing contracting / procurement rules would enable the development of integrated work
- Giving back practice-based district nurses, health visitors and social workers
- Incentivising frontline workers to encourage them to work across teams

- Breaking down the barriers between primary and secondary care – for example, by integrating systems
- Making integration possible by linking people / organisations in the healthcare process together locally
- Encouraging / facilitating the shadowing of roles across disciplines
- Using 'Enter and View' visits.

"In Tower Hamlets, we have had investment from our PCT and now CCG to support 8 networks of practices, which has resulted in substantial health improvements. This is part of a whole system of integrated care."
[Primary care services, London]

"Integration will come from better understanding of the whole – more shadowing of roles across disciplines."
[South West]

5.2.4 How can we best mobilise existing improvement resource (e.g. NHS IQ) and facilitate access to other potential external support for primary care transformation?

Many respondents struggled to understand this question, expressing their lack of clarity regarding what existing improvement resources there were. Therefore, few provided feedback. Of those that did provide feedback, many expressed concern about the term 'primary care transformation' and sought clarification as to what this entailed and when this was likely to happen.

As regards **mobilising existing improvement resource**, suggestions included:

- Linking electronic records
- Share success stories via networks
- Utilising JSNAs
- GPs working sessionally in secondary care and vice-versa
- Alliance contracting
- NHS IQ to investigate the features that make some practices successful and others fail
- NHS IQ needs to be proactive and contact organisations to offer support, help and advice
- The need for genuine local empowerment and the encouragement of local initiatives that work, rather than a national one-size fits all London-centric model.

[London case study]

As **National clinical director for mental health,** I have been visiting several services across England and am finding that clinical innovation is booming...but there is no place to share it. Examples include:

Living well after Stroke courses in a large health centre in Swindon, enabling practice patients to have an 8 session CBT group programme to assist their recovery from stroke and rehabilitate and return to work faster.

Living well with chronic pain: a group programme based on CBT and Mindfulness principles for 15 people with long term conditions and chronic pain, supporting them to lead higher quality lives and manage their disability well. This has reduced acute trusts A/E and outpatient attendances.

Physical and mental healthy life programme: based in primary care for people with obesity. This has enabled people to come off the waiting list for bariatric surgery.

Oxford: GP run with psychologist courses for people with asthma and panic attacks, reducing GP consultations as people manager their stress and asthma better.

[London case study]

Tower Hamlets CCG have set out an ambitious programme for primary care through the Achieving Excellence in General Practice programme. The aims of this project are to:

1) Keep up the momentum that Tower Hamlets has created for supporting primary care development.
2) Explore and agree the role of the CCG in supporting primary care development.
3) Address issues of equity in relation to access and outcomes from general practice services for the population of Tower Hamlets, ensuring high quality services and supporting quality improvement where needed.
4) Address the unprecedented levels of demand in general practice and support them in preparing for the future, in particular to be able to respond to the changes that integrated care will bring.
5) Promote and nurture a culture of innovation to respond to the challenges faced by General Practice.
In Tower Hamlets, this is both driven by ambitions for primary care, but also through recognition that not addressing the issues faced by primary care is not an option – both because of the demands on General Practice and the need to be able to deliver the out of hospital care agenda.

[London case study]

The Proactive Care: Long Term Conditions pilot project started in April 2012 in the **South Kent Coast CCG**. Here patients are supported by a multi-disciplinary team including a GP, community matron, health care assistant, physiotherapist, occupational therapist, pharmacist, health trainer, care manager and mental health professional. Patients are offered a 12 week package of support to improve the management and self-management of their condition. Evidence shows a 15 percent reduction in A&E attendance, 55 per cent reduction in non-elective admissions and 75 per cent report improvement in functional quality. In March 2013 savings stood at £225,938. (Kent Community Health NHS Trust, March 2013 The Human Touch, Transforming Community Services in Kent. Service in the spot light: Pro-Active Care: Long Term Conditions).

[Patients and service users, London case study]

"Clinically-led innovation" - I think that our new **Surbiton Health Centre** is going to be a great catalyst for that. The Polyclinic model is a good one, and I am already seeing the four different practices stimulate each other into innovation. Of course, the most important thing is that the NHS injected investment and faith into these practices.

[Primary care services, South West case study]

In **Northamptonshire** I personally set up with the CCG and local cardiologist an **Extended Role Cardiology service** which started as a 10 practice pilot 3 years Ago. It now has 26 practices with a GP cardiology lead who gateways all elective cardiology for the practice and is personally connected with their Consultant cardiology mentor. The GPs had 4 sessions of training and ongoing support. Elective referrals have been cut by 50% compared to non-involved practices.

[London case study]

The **LIFT investment model** sees NHS estates owned and managed independently. Clinicians and practice partners are therefore freed up from the numerous demands, pressures, and expenses of running a large public facility, and able to devote more time and resources to delivering innovative care services to their patients. An example of this would be investments made in solutions such as tele-health which allows patients to be treated in their own homes, reduces demands on frontline services, and therefore freeing up clinicians time to spend on those patients most in need of their care and attention.

5.3   Freeing up time and resources

This section consisted of six questions on key aspects relating to **freeing up time and resources**.

5.3.1   How might we develop QOF so that that we preserve its essential features but create more flexibility for practices and reduce the feel of a tick-box culture?

Although the Quality Outcomes Framework (QOF) initially started well with high evidenced based goals that helped improve the health of the nation, there were a number of comments that the purpose of QOF had changed over recent years and that since QOF became managed by NICE, it has become more of a heavy-handed micro-management of the doctor:patient consultation. Respondents commented that it is now too focused on measuring process, and is less useful for measuring outcomes – i.e. it currently rewards the 'doing' and not the actual result. In addition, the focus of QOF keeps changing, and some commented that it has been taken over by 'political whim'.

Several comments were made that it is currently too easy to score well on QOF, making it difficult to root out the particularly bad (and good) practices. Furthermore, it was felt that QOF had not sufficiently adapted to take account of the changing needs of patients and our ageing population, in that many people now suffer from multiple, complex conditions, yet QOF primarily focuses on single conditions. In addition, many argued that Payment by Results (PbR), of which QOF is a part, is a poor way of incentivising GPs and throws up perverse incentives that detract from patient care.

If QOF is to be developed, the general consensus is that it needs to become less onerous, and much leaner and smarter. Several respondents commented that QOF should be much less tick-box oriented and instead include free text options to enable clinicians to provide a better picture/contextualise what is happening. It is felt that too much patient consultation time is spent on QOF at the expense of the patient.

The following ideas for the **development of QOF** were proposed:

- QOF should be developed with public consultation included in decision-making
- Reasoning behind the QOF needs to be **clinically evidenced**
- QOF must be **clinically led**
- QOF must **incentivise good practice**
- QOF should be properly evidence-based, and should concentrate on proven, important indicators only
- QOF should focus more on holistic patient-centred care, rather than one or more conditions
- Whilst generic national measures of quality are needed for comparison purposes; however, QOF must be developed to allow general practices the autonomy to **set their own locally-relevant targets / initiatives** within a framework. These could be decided by local communities, councils and clinicians

- QOF should collect data on some or all of the following:
  - Outcomes
  - Patient satisfaction
  - Access
  - Quality
  - Value
  - Results / performance
  - The more commonly experienced conditions – e.g. hypertension, diabetes, stroke care, mental health, depression, epilepsy and COPD.

The overwhelming feeling was that, before any new version of QOF is released, it **must be sense checked** by a cohort of frontline GPs.

"We need another way. Not all things that can be measured are important, and not all things that are important can be measured."
[London]

"Local communities and councils should be able to determine what QOF targets apply to their local primary care services, according to their most pressing needs."
[London]

"QOF needs to be an essential feature in the background of the consultation, not competing with the patient for centre stage."
[Primary care services, South West]

"Perhaps there needs to be 5 QOF areas that are left open. Each practice / CCG could decide on their own targets and therefore try and meet them allowing for local tailoring of QOF."
[London]

"As the QOF framework was clinically agreed, it should be left in place as remaining valid for several years, which will allow staff to get used to working within its framework."
[Primary care services, South West]

5.3.2 How can we get best value from enhanced services and reduce process-oriented measures?

In general, respondents saw the benefit of enhanced services but felt they should be controlled by general practices and that the move to public health of some enhanced services was a mistake. Furthermore, some respondents felt that enhanced services are a postcode lottery, as practices have a choice as to whether to provide them or not.

For some respondents enhanced services compounded the problems of managing multiple income streams and providing them took up precious, limited time and staff resources. Therefore the administrative burden of providing these services needs to be reduced. In addition, it was argued that enhanced services should only be offered where they genuinely offer improved patient care. Some felt that there was great potential for enhanced services to re-introduce practical skills GPs used to have and tasks they can do – e.g. minor surgical procedures.

In order to get **best value** from Local Enhanced Services (LES), the following were suggested:

- Department of Health should stop dictating enhanced services. Instead they should be truly local and CCG-led

- The contracting of all enhanced services should be passed to CCGs as this will facilitate a greater chance of bringing additional services out of secondary care and into primary care

- They must be **output/outcome based** rather than input focused

- CCGs should be given budgets to spend on LES

- Where LES are provided, this should be built into the CPD for GPs and practice nurses

- Rewards CCGs or surgeries with Charter Marks or prestige awards for providing a wider range of services

- Measurements have to be equally simple/easy to understand / administer

- They should be rolled into GMS core work but this should be a driver to expand the contract not reduce cost

- They must be evidenced based and costed properly so practices do not make a loss if they take them on

- CCGs and Public Health need more flexibility to devise and contract for a much smaller number of enhanced services according to need.

"These are full of process measures, most of which are not unique or specific, and merely serve to indicate that processes have happened. Many processes, such as the holding of meetings and the writing of minutes, are not associated with a health gain even as a proxy. Collaboration that is effective is characterised by casual discussion, joint working, and sharing records, not big formal meetings."
[Primary Care Services, West Midlands]

"Enhanced services should be flexible enough to support practices and CCGs in their development whilst recognising the need to reflect local issues and resources."
[London]

"Key to high quality enhanced services is a robust development process with dedicated management time and clinical champions so that it's clinically driven, are based on best practice, and are based on local need."
[Commissioners of health care services, South West]

"Enhanced services allow secondary care work to be done in primary care and resourced, so increase rather than reduce…they are cheap by comparison."
[Primary Care Services, South West]

"To get the best value from enhanced services, the current system of small amounts of money for lots of small services, tied to increasing amounts of work and onerous/unnecessary training should be removed."
[London]

5.3.3 How should GP IT systems develop to support more efficient and integrated working?

The general consensus from respondents was that the *most important* IT development would be the creation of **one IT system** linking those in primary, secondary, community and social care, and mental health to facilitate the sharing of relevant information and ability to access all information relating to a patient. It was commonly agreed that, in general, primary care IT systems are more sophisticated than those used in secondary care. Therefore, the most popular IT system currently being used by most GPs should be the system rolled out across the healthcare sector[4].

It was urged that patients, clinicians and frontline staff be involved in the design of a suitable IT system, to ensure the resulting system is fit for purpose. It is essential that developers understand what is needed, rather than providing solutions for theoretical needs.

The new **IT system** should:

- Be used to integrate referral pathways from third sector partners
- Be joined up
- Be set up in such a way that data / information does **not need to be entered more than once[5]**
- Be designed to help improve patient outcomes
- Allow patients to access a copy of their personal health record
- Help reduce emergency call-out by having FaceTime or Skype set up on the system
- Have the latest versions of Windows etc. and a fast broadband width and Wi-Fi connection
- Allow for automatic data extracts as per GPES (General Practice Extraction Service).

"Many of the people we support are in contact with multiple agencies, yet have to repeat information multiple times because their GP cannot share information with the support worker or other care professional. This is unhelpful, frustrating and often leads to people falling through the gaps in provision."
[London]

"Data protection and IG issues are preventing staff from working effectively with important data and making it difficult to gain the right support from commissioners and IT support staff."
[South East Coast]

"IT needs to talk to each other, cut choice and mandate systems across an area. IT not working together stifles things and wastes time. We should also be using electronic / digital technology for consultations, e.g. Skype, especially improved access for younger people."
[East Midlands]

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[4] For example, Emis Web or SystemOne
[5] Duplicate data entry into different systems is currently a common, time-consuming and unwelcome practice

"If GP systems were compatible with CHS and secondary care so that letters, notes, results could be shared and clinical colleagues could message each other with ease it would make life so much easier."
[London]

5.3.4 How can we help improve the productivity of practice systems and processes, for example through the Productive General Practice programme?

Some respondents objected to the assumption that practices were currently unproductive.

Other respondents did not see the value of the Productive General Practice Programme (PGP) – for example stating that it is expensive and often time consuming for practices. It should not be imposed on general practices, but should instead be their own choice.

Where respondents did provide **suggestions as to how productivity could be improved**, these included:

- Appropriately valuing and rewarding productivity
- Giving time and money to general practice – this will help lead to innovation and improvement
- Facilitating the sharing of best practice so practices can learn from each other
- Documenting systems and processes being used that work most effectively
- Encouraging practices to work in federations or networks – for example by sharing managerial resources and expertise
- Reviewing the practice skills mix
- Examining international best practice
- Using patient self-referral more (e.g. to physiotherapy)
- Utilising the support of AHPs (incl. physiotherapists) in creating programmes, providing expertise and reducing burden on GPs
- Requiring practices to have systems that permit CCG-wide roll out of innovations / improvements
- Raising patient awareness that they do not always need to see the doctor
- Mentoring of practice managers
- Undertaking local needs assessments and locally-led bespoke programmes. Some felt that this, instead of PGP was more likely to deliver what is needed
- Providing additional training so that nurses could undertake chronic disease management or acute triage in primary care.

"The New Ways of Working audit tools used in mental health have been very useful to identify what could be done by others."
[London]

"…involve patients in the design of services. It is not rocket science to look at the best customer service in the outside world and apply those lessons across the NHS."
[Patients and service users, London]

"I think our practice were the only one to sign up for PGP, as we were previously for QPA…the NHS has an institutional approach to what is potentially very good. It is like a fisherman putting a net on the river bank and imploring the fish to jump out into the net. If practices were helped to use facilities that are relevant to them they would take it on. The problem with the NHS is it doesn't meet people where they are, but asks them to move to where the managers want them to be, at which point they might be helped. Practices don't usually produce development plans and I think they would be pleased to be helped. Maybe if they federate more, this is something that would come about through the federation having an overall plan in which the practices have a part."
[Primary Care Services, West Midlands]

5.3.5 How can we help ensure that practices are optimising their skill mix?

Some respondents objected to the suggestion that they were not currently utilising the skills of their staff. Others felt that this was the business of the practice and not of NHSE.

Some ideas were however provided as to how practices can ensure they are **optimising their skills mix**, and these included:

- Encouraging the use of Time-in-Motion studies
- Enhancing nurse-led services training
- Increasing Time-to-Learn sessions
- Tutoring primary care advanced nurse practitioners and other AHPs to be more autonomous and to manage some aspects of care and prescribing
- Training and developing nurses to best effect
- Removing some of the self-imposed boundaries. For example, at one time district nurses saw all age groups, as did practice nurses, but now they only see adults due to changes in training
- Providing additional funding to enable practices to develop their staffing and range of skills
- Encouraging shared use of staffing resources amongst practices
- Removing the requirement for nurses to work from PGDs, PSDs and other protocols
- Allowing Protected Learning Time for all practices and staff. This apparently used to happen.

"Our nurses and managers are run off their feet. I really don't understand how you imagine practices are not making good use of their staff."
[Primary care services, South Central]

"I think the idea that practices are not productive and not effectively using their staff is an insult. General practice/primary care in the UK is historically cost-effective and productive. The problem is that the targets for 'productivity' keep moving."
[Primary care services, South West]

5.3.6 How do we engage practice managers more effectively?

Some respondents stated that it was not clear what NHSE wants to engage practice managers in. They work for, and are paid for by GPs and GPs should be left to decide how they can best work.

Other respondents suggested that there should be practice managers across larger GP networks and that back office functions should be shared / federated. This would offer peer support and a wider range of expert skills and economy of time and effort.

A number of suggestions were provided as to how practice managers could be engaged more effectively. These included:

- Supporting and valuing them

- Funding managers properly

- Including them on CCG boards

- Providing leadership development and training where they can share ideas and learn from others

- Creating a practice managers' forum where they can discuss issues / concerns

- Providing funded meetings for practice managers at local and national level

- Offering them the opportunity to spend time with hospital managers and vice-versa

- Attending their forums

- Listening to them and avoiding a top down approach

- Producing relevant guidance for them

- Running focus groups with them

- Setting up practice manager groups supported by the CCG

- Allowing them the time to innovate and develop practices

- Reducing CQC

- Simplifying the SBS finance service

- Providing them with longer deadlines, at least 6 months warning for reports and returns

- Simplifying and enabling easier access of QOF, DES, LES and other small income streams. Practice managers would then have time to look at service development and staff training

- Restoring practice manager training, and also that for practice nurses.

"Our practice manager is fully engaged in primary care but feels deeply disenfranchised by the decision not to include PMs on the CCG board. Our PM is the vital conduit through which the endlessly imposed demands are translated into workable general practice."
[Primary care services, South Central]

"As a Practice Manager (or Business Manager) my day is filled with managing: the staff; the patients / customers; NHS England; the CCG; the LAT; the LMC; the finances; and recruitment etc. So what exactly do you want to engage me in? I currently feel engaged with a minimum of support from any of the organisations (plural) that replaced the PCT. So much for saving money and simplifying matters."
[Primary care services, East of England]

"As a Practice Manager I often feel dismissed as the email / document gate keeper rather than a professional manager who enables the GP's to spend time with their patients."
[Primary care services, North East]

[London case study]

Tower Hamlets have seen a range of schemes that have shown technology has the real potential to support demand management in General Practice. Areas that we are exploring further in Tower Hamlets include:
• Online consultation models: These are currently being piloted by practices in Tower Hamlets and offer an opportunity for patients to be directed to self-care resources, as well as completing an overview of their clinical condition for review by the GP and for advice and prescribing to be delivered without the need for a face-to-face consultation.
• Online patient portals for patients to access information from their patient record to support patient empowerment and self-care.

[London case study]

Key to freeing up time and resources in general practice and elsewhere in the health system is to make sure that people get the right level of input, from the right clinician, at the right time. The **Stepped Care Model** with appropriate risk stratification screening tools is one method that can help GPs and others decide what level of care is needed at different points. The 'Start Back' questionnaire for back pain is a good example of a screening tool that has been used in this way. This tool helps primary care clinicians (GPs, physiotherapists etc.) to group patients into categories of risk of poor outcome and target interventions for each sub-group. This was trialled and as well as achieving health benefits, it showed an average saving to health services of £35 per patient and societal savings of £697 per patient.

[London case study]

At the heart of physiotherapy is support for patient self-management of conditions, through advice, exercise, assessments of home and work environments. For example, the **Enabling Self-management and Coping for Arthritic Pain through Exercise (ESCAPE-pain**) programme developed at Physiotherapy Outpatient Department at Sevenoaks Hospital integrates patient education, coping strategies and a challenging exercise regime through group classes, the programme targeting patients who would normally likely to seek help from their GP. The programme has been commended by NICE and the Royal College of Physicians as an example of good practice. Developing programmes like these in primary care would free up considerable resources as well as empower patients.

[London case study]

The **National Mobile Health Worker** is a project where community-based health workers are given the technical resources to access and input to patients information systems while they were with patients in the community, removing the need to travel to and from the clinic to do this. Evaluation of the project has shown that this resulted in significant increases in both productivity and time spent with patients, and reduced costs in time and travel. Most importantly the report described patient confidence and engagement in the new system, which made it possible for example for them to see the availability of follow up appointments, and view patient information on screen e.g. choices of equipment.

[Primary care services, South West case study]

GP IT is a model of good computer use. It developed organically without rigid centrally directed planning and international procurement exercises. A simple set of core criteria of functionality was set and small local firms with dynamic interaction between programmers and GPs (sometimes the same person) led to systems that were useful to doctors and could be changed on a weekly basis with feedback from users. This is a total contrast to the top down and failing model of nationally procured rigid systems with cost billions, take years and are utterly rejected by disengaged hospital consultants.

[Primary care services, South West case study]

I was part of the ERDIP programme, a precursor of NPFIT. We spent a quarter of a million testing GP and community systems. We tried costly central systems with single suppliers twice and failed. We then used **integration software** (from Graphnet) and succeeded in a few weeks. This uses **XML machine language** to connect diverse front end systems effortlessly in the background, without needed GPs or nurses to change from familiar front end formats. This has been shown to work in the Hampshire shared record and also in Wales by Graphnet.

[Primary Care Services, West Midlands case study]

We (and four other practices) pioneered the concept of QOF through PMS+ right at the very start. The basis of our PMS was that practices should be accountable, and the measure of accountability would be outcome, not process. QOF adopted some process proxies for outcome, and process measures have proliferated ever since. Now QOF has very few actual outcomes, it is based on things that can be measured annually, and the value given to these and the selections themselves generally have a poor (or non-existent) evidence base in primary care. There is now an implicit assumption that more is better, with the targets moving according to achievement, rather than accepting a tolerance based on overall population need. Process measures in contracts always take the form of tick-boxes and this is what you must remove. The QP element focusses on activity levels that are too small to demonstrate significant change within a year. It fails to take account of chance, and it places a requirement to deliver change without an evidence base for the causes of behaviours it seeks to change or an evidence base for the activities that could be instituted. To be sure there is a lot of speculation, but the most frequently promulgated theories are not backed up by proof. Annual performance should be replaced by publication of trends and outcomes over years with very little annual reporting, the value of the QOF should be reduced considerably.

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[Primary Care Services, West Midlands case study]

I know our practice is the only one that has supported staff through university. We sent our current manager through CIPD too, as far as chartered fellow, which is the maximum qualification. We have sent nurses through masters courses to become nurse practitioners, and even the cleaners have been sent for training to help them understand their job. There is no support for this, you have to fight for any help, and the candidates may then leave to develop a career. We are the only local practice to fully operate Agenda for Change employment policy, and the only practice whose qualifications are accepted by the acute trust as equivalent training, and whose training is considered equal. There is only one university in the country that has a nurse training program based first in primary care, and that course is based uniquely on our practice. In short, nothing in the system is designed to help primary care offer jobs which are genuine career options, or to develop people to their full potential. Without proper HR training, practices are never going to maximise the human potential they employ. Maybe in a federation it would be possible to share a resource, as FCIPDs are not low cost staff. If you were able to support federation infrastructure costs, that would be by far the best way of ensuring that local resources are available to maximise primary care HR potential.

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5.4   Defining practice accountabilities

This section consisted of four questions regarding key aspects of **defining practice accountabilities**.

5.4.1 Should we seek to develop a joint concordat with key partners that re-affirms and refreshes the core features of general practice?

A number of respondents stated that they struggled to answer this question as there was a lack of information as to what the concordat would entail. One respondent stated that a concordat already existed in the form of the **NHS Constitution**. Some respondents felt that a joint concordat would be difficult to achieve when rival private companies (who bid for contracts that GPs don't have time or resource to do) are involved.

Other respondents who agreed with the principle of developing a joint concordat made recommendations as to the groups that should be involved as **key partners**. These included:

- Optical Confederation and wider optical sector
- Patients
- Patient group representatives – including those for children and young people
- CCGs
- Royal College of General Practitioners (RCGP)
- NHS Alliance
- National Association of Primary Care (NAPC)
- British Medical Association General Practitioners Committee (BMA GPC)

Those who agreed on the development of a **joint concordat** provided some useful **suggestions**, as follows:

- Provide funding for this to happen
- Must be meaningful and focused
- Lay out simple functions of the service and expected responses
- Include indicators around community engagement, joint working and improved access
- Ensure it does not increase the administrative burden
- Should include the following features: continuity of care, commitment to community, professional autonomy, lifelong learning.

> *"Yes, let's have a core standard for primary care agreed and supported by key partners."*
> **[Primary care services, South West]**

5.4.2 How can we put general practice at the heart of more integrated out-of-hospital services and give GPs and GP practices greater responsibility for coordinating care for patients?

Some concerns were expressed that GPs do not have the time or resources (or indeed the specialism in some instances) to coordinate care for patients. Instead, this role would be better performed by others, for example **community nurses**, **district nurses**, **social workers**, **community-based mental health teams**, and/or **CCGs**. GPs should be kept informed throughout their patients' hospital admission, and should be involved in their discharge. Discharge plans should be shared and agreed by a GP or community team, but this needs to be matched by a **shift in resources to primary care**.

If GPs *are* to take greater responsibility for coordinating out-of-hospital services, then they need to be at the heart of the NHS on appropriate contracts as per their provider colleagues. Integration means enabling individuals & organisations to negotiate and identify local co-operative solutions, this is currently hindered by management by contract.

In order to be able to put **general practice at the heart of integrated out-of-hospital services**, respondents suggested the following:

- Provide incentives – most notably funding and extra staffing resource
- Create funding mechanisms, i.e. community tariff
- Strengthen links between hospitals and GP practices
- Reinvest spend on acute A&E to support prevention and commissioning of crisis home treatment teams
- Put a primary care centre in every acute hospital, but not in A&E
- Return 24 hour care to the GP, rather than offered by a 3rd party
- Co-locate GPs and hospital out of hours services
- Integrate GP out of hours with mental health crisis home treatment teams and social care
- Integrate complementary and alternative medicines within the system
- Put social care at the heart of non-medical aspects of patient care
- Put practice nursing teams back into GP practices
- Get GPs working better with social services to help keep patients out of hospital care
- Establish practice-based teams with a full complement of allied health professionals
- Invest in modern, fit for purpose premises and facilities
- Ensure IT systems are linked up / one system is provided for all
- Empower patients to take responsibility for their own health.

"Part of the problem is that CCGs do not commission primary care, they cannot, due to conflict of interests. Before you can get integrated care you need to have integrated commissioning."
[Patient and service user, West Midlands]

"…the current multi-purpose facilities being provided by LIFTCos up and down the country are doing just that;, bringing many services out of hospitals and back into local community facilities."
[London]

"General practice has a very small proportion of the health budget. It needs a bigger slice of the cake. There is only so much a practice can offer within existing resources and in terrible premises."
[London]

"At present secondary care funding that depends on attracting more 'business' means they are not interested in helping support out of hospital care. Change the funding streams to make it explicit that they will not be rewarded for doing more even though it may be of negligible value to the patient."
[Primary care services, London]

5.4.3 How should we define high quality general practice and their responsibilities/ accountabilities, through the GP contract?

Some respondents queried the definition of '**high quality general practice**', stating that, if this relates to the standard of professional knowledge then this is currently done by the GMC and the RCP / RCGP. In addition, respondents argued that 'high quality' *cannot* be uniformly defined across the country, and that the GP contract is a **service document** not a quality document. Therefore, quality **cannot be defined** through the GP contract but can instead be rewarded through it.

A **high quality GP** was defined as: providing patient centred coordinated, holistic personal care of a safe and consistent high quality.

If high quality general practice *is* to be defined by a contract then GPs must be involved in developing it and helping to define high quality alongside NHSE. Furthermore, it is essential that specifying what patients can expect from good general practice *must be coupled* with what patient expectations are. Moreover, many respondents felt that contracts needed to be more specific rather than a 'cover all' in a similar way to other contracts. Concerns were expressed that a new contract will result in savings rather than benefitting patients.

Where suggestions were made, these included:

- Need to **involve GPs in shaping this**
- Govt, NHSE etc need to be clear and realistic about what they want GPs to achieve. Need to reduce demand on services
- Resource the increase of GP consultations to a minimum of 20 minutes
- Provide well thought through incentives to drive the right behaviours
- Pay for what is outside the contract
- Clearly define the quantify standards expected of GPs and **pay them** if they meet those levels
- Consider changing the status of GPs from independent contractors to employed staff
- Develop a contract that pushes practices together

- Measures for patient satisfaction indicators of accessibility, outcomes for common diseases in local population
- Define quality by letting people know what should be offered
- Clearly define what is in the contract
- Focus on outcomes (e.g. disease outcomes) – which should not always be quantitative
- Define responsibilities and accountabilities through robust, clinical and Quality of Life measures and patient experience data. Adopt the same measures across all health and care services in the community
- Visit high quality practices to obtain insight
- Quality is best monitored on a peer review basis
- Share information / spread good practice
- Request Healthwatch to do Enter and View inspections
- Ask people who use the services.

"The key quality marker is 15 minute routine appointments. We have run these for 9+ years (and along with 'birthday reviews' and repeat dispensing which free up time to enable 15 minute appointments) are convinced these are the key quality markers in general practice."
[Primary care services, North West]

"The more that you define responsibilities and accountabilities through the GP contract, the less work you will get done and the narrower general practice will become."
[Primary care services, London]

"The core feature of the GP contract should concentrate on the evidence about quality, not politically driven ideas about quality or targets which are easy to measure rather than those that reflect quality. It is possible to measure quality in consultation skills, e.g. active listening skills, encouraging patients ideas and discussing their health beliefs, but this is expensive to assess, and so is not done. PSQ and MSF have considerable limitations on what they measure and yet are part of revalidation."
[Primary care services, North West]

"Using the contract for this is a bad idea as the nature of a contract is inevitably discrete components which are de facto tick-boxes. The contract should simply require compliance with external regimes (CQC, QPA, Reaccreditation), and these can operate at greater intervals than once a year. If you want to encourage quality improvement, put a small premium into attainment of a quality standard such as Investors in People, or QPA."
[Primary care services, West Midlands]

"Local services are better managed locally than through a national contract. You can put the tick boxes on a local body, such as a federation, and they can manage the quality improvements through direct engagement and facilitation rather than the rather crude device of policing through contract. Having tick boxes removed to a federation would be very attractive to practices, especially if they get the money for the federation's work. Personally, I would be very interested indeed in being part of a group developing a specification."
[Primary care services, West Midlands]

"You need to work cooperatively with the RCGP to improve quality form within using the RCGP criteria for good practices. This can be linked to funding and will encourage a drive to competitive good practice."
[Primary care services, South West]

5.4.4 How do we create synergy with the new system of CQC ratings and inspections to create a clearer sense of what patients can expect from good general practice?

There were some criticisms about the CQC ratings and the new system of inspections, with many stating that inspections should be supportive and developmental in order to create a culture of continuous improvement rather than being punitive. Some respondents stated that the system made them 'jump through hoops' and does not improve patient care. There were concerns that CQC was not 'fit for purpose' and that it needs to demonstrate that it is so. Furthermore, that GPs have five separate bodies to deal with patient complaints, therefore, what is the role of CQC?

Suggestions as to how **synergy** could be created with the new system of CQC ratings and inspections included:

- The core features of general practice should match what regulators are looking for
- Align QOF, decision support tools with CQC assessments
- Link to payments / penalties
- Use the press to get the message across
- Should be a single, regulatory process, rather than multiple ones
- Need to publish what practices are judged by
- Allow federated GP organisations to have one set of CQC and QOF policies and procedures, so we're not all re-inventing the wheel
- Place higher expectations on PPGs to partner strategies that improve ratings, similar to role of school governors following an OFSTED inspection.

"CQC must define better what part of quality it is responsible for so as not to supplicate individual practitioner revalidation and also GP conduct/performance issues."
[Commissioners of healthcare services, South Central]

"I do not believe very many patients have the foggiest about synergy with the CQC – which is just another bureaucratic body with no evidence of cost-effectiveness nor of improving patient care."
[Primary care services, South West]

[London case study]

Tower Hamlets CCG has identified, through an extensive engagement period with Practice team, partner agencies and patients, **11 components of an excellent General Practice service**. The components are:

1) **Continuity of care**: Continuity of care with a named GP or team of clinicians, to support, in particular, people with long term conditions

2) **Supportive infrastructure (workforce, IT and estates)**: Strong infrastructure to support General Practice services: having the workforce in place that is needed for the delivery of services, a strong and supporting IT infrastructure and premises that are fit for purpose.

3) **Access**: Patients are able to access the GP of their choice in a timely manner.

4) **Communication:** The delivery of excellent care through excellent communication between General Practitioners and patients

5) **Clinical quality**: Consistent high quality clinical services with good clinical outcomes for patients

6) **Innovation**: Having the time, space and opportunity to nurture innovation, enabling the continual improvement of General Practice

7) **Collaboration**: A general practice that collaborates well with their local community, other health and care services, the voluntary and community sector and Practices in their local area

8) **Teaching and training**: A strong focus on training and personal development, to ensure the delivery of high quality, safe and evidence based care and a teaching and training ethos within a Practice

9) **Synergy with wider health and social care system**: A system where all providers of services work together, are well functioning, reduce time consuming chasing and delays for patients. A system with shared goals which support each other in the delivery of services to improve outcomes for patients

10) **Caring, compassionate and holistic care**: A service which focuses on the whole person, delivers preventative care and takes into account their social context, as well as their presenting clinical issue

11) **Supportive work environment**: An environment where time with colleagues is valued, colleagues have opportunities for information discussions and feedback, both within and outside of the practice environment.

[Patients and service users, England-wide case study]

Carers UK's State of Caring survey of over 3,900 carers, asked a wide range of questions about their experiences of caring. 55% of survey respondents said that the person they care for has been admitted to emergency hospital services in the last three years. Many survey respondents attributed emergency admissions to a lack of support. Whilst 64% of survey respondents did not believe that the emergency admission of their loved one could have been prevented, significant percentages identified areas where additional support could have prevented admission:
•17% of respondents said more support from care services could have prevented emergency admission
•6% said replacement care (for when they, the carer, needs medical treatment)
•21% said higher quality care and support for the person they care for
•9% said adaptions in the home of the person they care for
•6% said telecare or telehealth (e.g. monitoring equipment, alarms and sensors) could have prevented the need to go into hospital.
This evidence shows that greater and higher quality support from community health and care services could have a significant impact on the number of emergency admissions to hospital.

[London case study]

In defining practice accountabilities, general practice needs to build upon the positive experiences of multi-disciplinary team working in the community. Sometimes such teams are GP led, but equally may be led by a physiotherapist, community matron, or another health professional. An example of this is the development of **'virtual wards' in a number of areas since 2006. Croydon is an award winning example** of this, where there are now 10 virtual wards with capacity to care for 1000 high risk patients. Their virtual wards are led by community matrons, and other staff including physiotherapists and occupational therapists and social workers. They used a Combined Predictive Model to identify patients with high risk of hospitalisation in the future who would benefit from multi-speciality case management. In Croydon the virtual ward team works closely with GPs in the area. In other areas that have developed virtual wards also using a predictive risk tool, GPs are part of the team, for example in Torbay and South Devon where virtual wards are hosted in GP surgeries**.**

[London case study]

The **LIFT Investment model** is focused around the provision of modern, fully integrated community health facilities which bring a range of services together in one location to the benefit of both patients and providers. LIFTCos work with local practices and other stakeholders to assess what facilities are needed locally and then strive to provide the building and technology to enable delivery of the unique integrated service package that has been identified in each locality.

> **[Commissioners of healthcare services, South West case study]**
>
> **Our CCG has 20 ICTs (Integrated (Health and Social Care) Community Teams)** (typically 1 team supporting 4 practices and 31,000 patients. The CCG is making additional investment to strengthen these teams with rapid response functionality, high intensity and 24/7 single point of access and additional skills development. Staff within the strengthened ICT, are aligned and have a prime relationship with one practice.

> **[Patients and service users, England-wide case study]**
>
> One model for involving carers and using their skills and experience is the **Supporting Carers in General Practice Programme**. This programme, funded by the Department of Health, was set up in October 2011 and includes three programme partners (Carers UK, Carers Trust and the Royal College of GPs). Carers UK supports around 20 GP Carer Ambassadors. These volunteers are making valuable contributions to their local communities across England by drawing on their caring, work and volunteering experience to complement and contribute to local activities aimed at improving services for other carers.

5.5 GP contract: incentives for outcomes

This section consisted of four questions on key aspects concerning the **GP contract: incentives for outcomes**.

5.5.1 How far should we create stronger incentives for both inter-practice collaboration and collaboration with other primary care providers, acute, community and social care services?

Respondents generally reported that the biggest incentive to inspire collaborative working is **money**. If NHSE fund it, practices will collaborate. Others argued that collaboration is the remit of CCGs, rather than NHSE, so it is up to CCGs who they incentivise collaboration. Therefore, genuine partnership working should be a critical success factor in CCG performance.

Other suggestions put forward included:

- Addressing barriers to collaboration. Learning from this should be shared and embedded within contracts or outcome measures linked to payments
- Promoting practices working in networks or federations – e.g. sharing managerial and support services (e.g. admin)
- Providing funding for the set-up costs of establishing federations
- Encouraging the sharing of back room functions, e.g. payroll, GP locums, nurse specialist bank
- Providing support to practices – e.g. facilitating them to work effectively together
- Recognising individual practice quality and performance
- Encouraging locality working to help cement inter-practice collaboration
- Allocating resources to networks or localities rather than individual practices
- Legislating to encourage and enable integrated working
- Providing joint funding for primary and secondary care
- Rewarding good practice and outcomes and removing barriers
- Coming up with a range of quality markers that practices can be awarded
- Rewarding good leadership across the agencies
- Publishing what good looks like – e.g. show casing federated models of care
- Updating and improving communications mechanisms between primary and secondary care
- Properly planning the medium and long term estate needs
- Encouraging GPs to use hospital estate where they can interact with and benefit from secondary care.

"The business model of small surgeries is simply out of date and very costly."
[Patients and service users, London]

"Integrated team working is essential with GPs leading other health professionals, but this needs funding."
[Commissioners of healthcare services, South Central]

"Primary care will collaborate and integrate if there are financial and organisational benefits. Allow authorised federations to combine for CQC, QOF, LES DES etc. so reducing primary care workload as well as NHS England contract management."
[Primary care services, East Midlands]

"Inter practice and inter service collaboration are valuable and useful and supported by many primary care clinicians but all take time and take away clinicians from actually delivering a service to patients. This has a detrimental effect on continuity of care, patient experience, patient satisfaction survey results and QOF attainment. There needs to be resource to free up clinicians to meet with colleagues outside practices and develop new services."
[Commissioners of healthcare, East of England]

"In my view collaboration works best when social workers and nurses are allocated to practices, maybe even employed by practices."
[Primary care services, North East]

"You need to go very far for this to work. If we locally could afford to move 5 practices onto our hospital site everyone would benefit and especially the patients, with one stop services. We just cannot afford to do it now our CCG budget has been cut and our UHMBT is under its second inquiry."
[North West]

5.5.2 How can we better stimulate and recognise/reward quality of care for people with co-morbidities and complex health and care problems?

Some respondents queried the need to reward or recognise quality of care as the **provision of good care** for all irrespective of their condition(s) or particular needs should be the **norm**. Others argued that it is not feasible to reward practices for long term outcomes such as reducing incidence of strokes and heart attacks. It was felt that NHSE needs to pour in resources and funding if it wants GPs to maintain existing service as those with complex LTCs is on the rise.

Those who *did* feel that quality of care be rewarded for more complex patients, made some useful suggestions as follows:

- **Fund the extension of appointment length** so GPs can adequately deal with complex cases
- Reward outreach to bring into care the most deprived with multiple conditions
- Help CCGs commission multi-disciplinary and multi-care teams and services
- Increase resources for growing demand for home visits
- Incentivise self-helping strategies
- Introduce subjective well-being/QOL measures
- Introduce QOFs for LTCs - weighting of QOF points to be worth more for those with complex needs
- Re-establish district nursing service. Include district nurse representative in GP practice management teams
- Focus on function not process. Shift the premise of reward to outcome
- Support / fund innovative schemes

- Reward and encourage continuity of care
- Facilitate the development of sharing care plans and information between the various caring agencies
- Encourage joint working between primary, secondary and community care by introducing a single contract.

"Is incentivising good care for people with complex needs and co-morbidities the right approach? Everyone has the right to good health. Incentivising this risks suggesting that healthcare staff are doing something over and above what is expected of them in meeting those needs."
[Patients and service users, London]

"Increased consultation times can only come with reduction of appointment numbers, more doctors, or less conditions dealt with by general practitioners. That reality will not go away and needs to be addressed head on."
[South West]

"The clinical work of a GP and a hospital doctor will now have to embrace complexity as never before. You will have to pour in resources and funding if you are going to maintain the existing service. There are no shortcuts and efficiencies that can deal with this immense problem which as you realise is the resultant success of the existing system to preserve and prolong life in our society."
[Primary care services, South West]

"I agree with outcome rewards but they will need very careful planning to recognise the different demographic challenges in various areas. The history of such markers in the NHS has not been good, yet we are saddled with non-evidence backed campaigns such as NHS health checks."
[Primary care services, Yorkshire and the Humber]

"Rewarding practices is not what I came into general practice for. Neighbouring practices have different populations of patients. We are in a deprived area and 3 miles up the road is not. Our patients have different medical problems to theirs so we should not be penalised."
[Primary care services, North East]

"The best solution would be to make community staff part of practices like our highly regarded, efficient and well used practice nurses. If only HVs, district nurses and social workers were as available, responsive, and practically useful, we could achieve much."
[Primary care services, West Midlands]

5.5.3 How far should we seek to reward practices for wider outcomes, such as enhancing quality of care for long term conditions and reducing avoidable emergency admissions, or reducing incidence of strokes and heart attacks, or improving patient experience of integrated care?

As with the previous question, a number of respondents stated that, considering the population and the growth in complex and long term conditions, the 'wider outcomes' are surely just 'business as usual' for many practices. Others argued that better collaboration should lead to increased outcomes, which should be reward enough.

There was a general consensus that the barriers between hospital and primary care should be broken down and that there was a need to work towards 'whole care pathways'.

There were some concerns that other factors would influence emergency admissions which are outside the control of primary care – for example incidence of stroke and heart attacks. Therefore, NHSE needed to be careful about rewarding GPs for outcome measures not under their control.

Several comments were made about the term 'reducing avoidable admissions', as avoidable admissions are not caused by primary care. The best way to reduce unnecessary admissions is through better district nurse and health visiting services some emergency admissions are unavoidable due to cuts in community and social care, e.g. nursing homes, sheltered accommodation, social support for the isolated and vulnerable elderly and chronically sick. The greatest 'reward' NHSE could provide practices is **additional funding.** This could then be used for example to provide appropriate nursing care in the community to promote earlier discharge from secondary care.

> *"…so many people have long-term conditions and it's only going to increase as the longevity increases. This should be a core expectation of general practice not an add on."*
> **[London]**

> *"These are divisive issues that should be administered above practice level. Any form of pressure to encourage GPs to keep people at home who should be in hospital is a disgrace."*
> **[South West]**

> *"Be very careful not to penalise by default those working in environments where the culture/deprivation/demography make this harder-you will widen the care gap even more."*
> **[Primary care services, East Midlands]**

> *"I'd like to point out that we can't cope with the existing workload with our current resources, so no way to get us doing any more. There is no such thing as an avoidable emergency admission. If it was avoidable, it wouldn't be an admission. With an aging population and more co-morbidity, admissions will increase whatever we do."*
> **[Primary care services, East Midlands]**

> *"You should incentivise care homes for reducing hospital admissions. Having one or two GPs looking after a care home can reduce admissions."*
> **[Primary care services, North East]**

5.5.4 What is the potential future role for PMS and APMS contracts in stimulating innovative approaches or helping address particular local challenges?

There was not a great deal of response to this question.

Of those who did provide feedback, few were positive about the value of PMS and APMS contracts. Some argued that it should be the role of the CCGs to innovate and address local challenges. Others that there should just be one GP contract that should allow for the development of new services. In their opinion, having one central GP contract made sense as it meant time and resources could be put into providing services than into negotiations with PMS and APMS, as each negotiation takes a significant amount of time and there was nothing innovative about PPMS. A number of respondents stated that short term contracts such as APMS are short term fixes without the long term incentives of local investment in population health. PMS / APMS are seen as divisive and illogical and there is little/no evidence they have improved much. In addition, other respondents felt that APMS contracts are counterproductive in destabilising local services and secondary care as many work in isolation from a wider local service provision perspective.

"PMS was good, but we could not develop new services once it was in place as no new "growth money" was available to practices once the service started."
[Primary care services, London]

"APMS is a management tool to threaten and control general practice. It is a surgeon's knife in an unskilled hand."
[Primary care services, South West]

[London case study]

Publish 'what good looks like', showcasing federated models of care e.g.:
- NW London federation of 8 CCGs reengineering acute and unplanned care for all of NWL
- East London has 3 CCGs developing shared federations of children's services for mental illness, and joining forces to apply successfully for Big Lottery funds to change the face of Children's services, etc.

[London case study]

Tower Hamlets has seen significant clinical improvements in diabetes care, by a combination of financial and organisational investment into networks of general practices, and using incentive payments alongside educational facilitation with specialist input. There was strong engagement of primary and secondary care clinicians in the planning, implementation and governance of the process, and in contributing to educational support through multidisciplinary team (MDT) meetings.

[Primary care services, London case study]

A good example of inter-agency co-operation, facilitated by the LIFT programme is provided by the **Sparkbrook Centre in Birmingham** which, as well as housing three GP practices, also provides accommodation for a range of service providers, including:
– **Health services** such as dental services, physiotherapy clinics, district nursing and health visiting
– **Local authority services** including a City Council Customer Service Centre, benefits and council tax advice and information, homelessness services, housing repair reporting facilities, adult education services and a library including free IT access
– **Third sector and private providers** including a legal advice service (immigration), a domestic violence agency, a drugs and alcohol misuse charity and an optician.

[Primary care services, South West case study]

Shared budgets and pooled budgets at a GP locality level are key. This has been shown to work in **Torquay**. It can be undermined and sabotaged by rigidly imposed marketisation models that prevent cooperation and force decisive competitive behaviours. We want to cooperate and collaborate to integrate care. We have the buildings, we know the nurses, social workers, mental health workers and paramedics who would be part of this joined up team. We meet monthly and have agreed at the grassroots level that we would like to work this way. The shambolic re-disorganisations of the NHS and fragmentation into provider quasi-independent units and imposed cherry picking of services by private contractor's works against this cooperative ethos.

[Primary care services, Yorkshire and the Humber case study]

The relations between MH and primary care locally are much better where practices have embedded primary care MH workers (not IAPT - they are too isolated from the referrer to change things - and are totally overwhelmed). The GPs feel supported, there is a service for those who can present numerous problems to the GP but who don't fulfil secondary care criteria. The quality of referrals has improved and there is a real value to the GPs from having this service.

[Primary care services, East of England case study]

There should be incentives for inter-practice collaboration. We already have this in place. Practices hold multi-disciplinary team meetings on a regular basis for our patients with complex health needs.

[Patients and service users, West Midlands case study]

As a patient with a long term condition, I am scared of the day I will be forced to have a personal budget. Why? Because you will be shifting the responsibility of procuring services on to me. I am not good at procuring NHS services, I am not a procurement manager, indeed, I have never done it before. What happens when I get it wrong, whose fault will that be? Mine. You will also be fragmenting my care between a myriad of providers. As a patient I just want to feel well, and when I fall ill, I want to get better as soon as possible. That is *all* I want. I am not a healthcare consumer. When I am a consumer - for example, buying a new TV - I make careful informed choices. But as a patient, if I am feeling ill, how will I be able to make a careful, informed choice? Instead, I want the decision to be made by someone who I trust - my GP would be a good choice. I use a range of services. I want these clinicians to be working together. If I am expected to "buy" the services I need from a collection of providers the result will be that they will be only concerned with just the service I have purchased from them. Every other issue will be someone else's problem, because that particular provider will not have been paid to address that issue. This will fragment my care. I am a whole patient, not a collection of parts. How will you be able to performance manage multiple providers treating a single patient?...The frightening concern is that you - NHS England - will not assume the performance monitoring, because you are not purchasing the service. I will be, and it will be my "fault" if the care fails. For long term conditions the best action is to move towards a single provider with a single budget for the patient.

[Primary care services, North East case study]

Finance is one factor of an incentive but the reality is it is not always the best. Practices need to have adequate funding which allows for unforeseen situations which can then be absorbed without the need to worry over whom has responsibility and contract. This was the situation in **Northumberland** with the commencement of a PMS contract which led to the pooling of resources to allow 14 GP Practices to employ additional staff that could then be allocated to Practice with high demands or staffing shortages it was for the benefit of all. The funding had previously been considered for contacts with other organisations which also allowed for new ways of working and in 1998 this Practice had on sight – Podiatry, Dietician, Mobile Retinal Screening Unit, Urologist Consultant, CPN, Nurse Practitioner, Pharmacist not to mention the integration of Practice and Community Nurses and Health Visitors all which worked extremely well. Having had all this stripped away over the years it now appears that it is a desired to have some type of reinstatement, but not funded the same which enable the benefits to be provided. Trust is required that funding will be utilised appropriately – it seems that historical myths have been used to bring about a time and motion ethos which requires evidence (tick boxes) on how you have spent your time and demonstrate value for money.

5.6   Safe, controlled investment

This section consisted of five questions regarding **safe, controlled investment**.

5.6.1   How can CCGs, local authorities and NHS England best collaborate to develop integrated commissioning plans for out-of-hospital services?

Effective **coordination**, **pooled budgets** and **clearly defined responsibilities** were generally seen as key to successful collaboration between CCGs, local authorities and NHSE. It was recommended that **clinicians with the relevant clinical experience** be involved to help create a clear vision and shared purpose across health and social care. There were also suggestions that the NHSE should request greater input from **secondary care doctors** on CCG Boards, that the tariff in secondary care be suspended and the resources allocated to fund redesigned **pathways in primary care**. **Care pathway profiling** was suggested as a useful approach to take as it shows need, access, outcomes, and return on investment (ROI).

Some respondents felt that **one body** should be responsible for **commissioning** and that **CCGs were best placed** for this role with NHSE working alongside them on a clear vision and set of objectives.

"First of all we need to work out how to disinvest money from secondary care without destabilising the hospitals we need."
[London]

"Recent trends in the NHS have meant that experienced clinicians have been more and more excluded from these groups, and representation of the service has often been undertaken by managers with no clinical background and often therefore, with no capacity to represent appropriately the clinical and commissioning issues that need to be addressed."
[Mental health services, London]

"How can CCGs deliver an integrated health experience when we only commission one part of healthcare? We should be commissioning primary care too."
[Primary care services, Yorkshire and the Humber]

"Nationally, a disproportional level of investment is going into secondary care, but primary care capacity and capability needs to be expanded if a left shift is to be achieved and secondary care bed-base downsized. We must see a shift in resources from acute to out-of-hospital care."
[East Midlands]

"CCGs and local authorities are already collaborating re provision of out of hospital services. This requires investment of time by CCG managers and clinicians who already have a large workload and clinicians have clinical responsibilities. In order to make this work it requires information and easily accessible evidence based information to prevent duplication of effort. If NHS England has experience from other areas and expertise it can share with clinicians and CCG managers then it would be helpful
[Commissioners of healthcare services, East of England]

5.6.2 How can we support health investment analysis that allows for optimal balance of resources between acute and community services?

It was felt that, for successful health investment analysis to be undertaken, all relevant parties needed to **bring their data together** to share good practice / look for common issues etc. Respondents stressed that investment and analysis *must* be about **patients and their outcomes**, not just about commissioning and where the money is going, and that budgets must follow patients.

Others commented that the optimal balance of resources will only be achieved when the **market is taken out of healthcare**, which encourages primary and secondary care to compete against each other and undermines collaboration.

Suggestions as to how health investment analysis can best be supported included: **setting up monitoring programmes** that collate and slot the cost of clinical and non-clinical interventions with long term health outcomes; and reviewing ***actual workload*** (number of patients seen, number of unnecessary reviews , readmissions ,accuracy of SUS/HES data/coding etc.).

"All parties clearly need to bring all their data together, including their analyses of problems they experience. Perhaps mapping how they interact, information flows etc. This might be very revealing of problems, duplications etc."
[Primary care services, South West]

"Analysis would be helpful and should be supported but leaves the persisting problem of extracting finances from secondary care providers which to date has proved very difficult."
[Commissioners of healthcare services, East of England]

5.6.3 Where commissioning plans envisage additional investment in services provided by general practice, how can CCGs and NHS England best provide assurance that any perceived conflicts of interest have been properly managed?

It was felt that, to a certain extent, the new Health Bill had by its nature introduced conflicts of interest, with primary care being both provider and a commissioner of services through its role on the CCG.

In the main, respondents felt that the best way of *minimising* any possible conflicts of interest was by **working in an open and transparent way** - for example, by recording how any additional incentives have been spent and how they have benefitted the local population / community. All **decisions** must be public, transparent and **monitored** by someone **independent**. Lay members of the governing board of CCGs should have scrutiny and powers to act on any perceived conflict of interests.

Conflict of interest with primary care investment must be realised in the context of **what is best for patients** in terms of localism, care closer to home, continuity of care and a holistic approach without fragmentation of care. It should not be judged simply on the criteria of competitiveness and any willing provider status.

In addition, **quality of outcomes** and **personal investment** information regarding local services, in which GPs and local hospital staff have personal or family interest and /

or income should be published – i.e. declarations of pecuniary interests (as school governors etc. have to do).

> *"Being open and transparent about potential conflicts of interest but allowing us to proceed nevertheless has to be the way forward. The biggest problem is that we are attempting to have a free market for health which means that only well established and resourced companies can easily compete. We need to make it easier for community interest groups and social enterprises and create a market where social value is recognised and counted over and above shareholder profitability."*
> **[London]**

> *"By working to national community tariffs there is no conflict of interest. If a group of practices want to partner with a surgeon to do carpal tunnels at the community rate of £500 in a one-stop shop with all diagnostics and avoid the costs of OP referral, nerve conduction diagnostics, and HRG procedure costs there is no conflict. NHS England saves money, patient gets a better local service, and GPs/consultants share tariff funds. By taking on the local health budget in an incentivised contract they are also incentivised to only do the ops on those with genuine need."*
> **[Primary care services, East Midlands]**

> *"Perception of conflicts of interest will exist where you have commissioners commissioning themselves to provide services. Ensuring that all decision making is transparent and involves patients / members of the public ensuring neutrality would help."*
> **[South Central]**

5.6.4 How do we track value from investment and adjust investment plans to reflect evidence of outcomes?

Respondents stated that tracking value was about **having people in place to do the work**. It also involves undertaking audits, capturing and publishing patient-reported outcome measures and being **honest about the results**. It was recommended that NHSE talk to the Royal College of General Practitioners (RCGPs) and/or the Kings Fund regarding the tracking of value from investment.

NHSE needs to be specific about **what good outcomes are,** how they should be measured, and how much time should elapse before the outcomes are evaluated, as there is currently a lack of clarity around this.

> *"Build in the analysis from the start informed by Public Health and statisticians as to what can be accurately measured in what timeframe and attributed to the investment."*
> **[Primary care services, South West]**

> *"Cost benefit analysis is well established. DALYs provide a metric for comparison. Savings from investment may not accrue to the spending organisation e.g. reduction in road casualties from traffic interventions. These resource flows must all be captured and future savings even long term must be factored back into current calculations."*
> **[Patients and service users, East of England]**

5.6.5 How can NHS England and CCGs work together to make more effective use of existing community estates and, where necessary, allow investment in new or expanded premises?

Concern around the quality of community practice estates was cited by many respondents as a **factor preventing effective collaborative working**, which was impacting on the quality of patient care they were able to deliver. Focusing on the development of estates should be a prime task for CCG boards with support and funding from NHSE.

Respondents argued that estates **must be at the heart** of discussions regarding future GP care provision. **Strategic Partnering Boards** developed under the LIFT programme was cited by a number of respondents as an example of all agencies working together to develop service strategies linked to commissioning plans.

It was suggested that local strategic estates forums (or strategic partnering boards) should be reinvigorated in order to bring together public sector partners, commissioners and property professionals.

It was recommended that an urgent review of existing premises be undertaken, as the proposed shift to out of hospital care requires a substantial increase in premises in the community in forward planning. It was felt that extra resource is needed for CCGs to undertake this work as current management allowance will not support this.

"The much vaunted movement of care into the community will be difficult to achieve without significant investment in community estate."
[Primary care services, Yorkshire and the Humber]

"NHS England and CCGs have to work together to decide to plan premises based on future requirements in terms of size of population and how services are to be commissioned."
[Primary care services, South East Coast]

"NHSE and CCGs need to work on a common currency for the value invested in and delivered through existing and planned 'community estates' so that their contribution to the impact and outcomes of local services can be assessed, compared and accounted for."
[Patients and service users, East of England]

"We are concerned that there appears to be a complete moratorium on development of modern estate for the provision of general practice. Many of the existing general practice premises will not allow expansion of services which will be needed to see an actual transfer of services from secondary to primary care."
[Primary care services, West Midlands]

[Primary care services, London case study]

Local Eye Health Networks provide the ideal local vehicles for bringing all parties together to achieve the optimal balance of resources across the community with full transparency, declarations of interest and clear decision-making, ensuring that any perceived conflicts of interest are properly managed.

[Patients and service users, South West case study]

I am on secondment to the CCG from the UK Vision Strategy and have just completed an eye Health Needs assessment of the CCG area. It reflected the local need and made recommendations that are being taken forward by leaders in Health Social Care and Voluntary Sector. By bringing all the information into one document to be included in the JSNA and raising issues that arise in part of the local eyecare pathway and an integrated approach to savings and inequalities due to service delivery can be shared. Discharge and rehab services were key to preventing depression and reducing falls.

[Primary care services, London case study]

Community Health Partnerships recently published research that tracked the value of investment generated through the LIFT programme over the past ten years. The research specifically explored the socio-economic impact of the LIFT Programme during both its construction and operational phases. The research, undertaken between January and April 2013 by AMION Consulting, found that one of the most important outcomes of the LIFT programme has been the increased access to health and social care services for people in underprivileged communities; nearly 9 in every 10 projects are in areas with above average health needs and 40% of all LIFT investment (over £790m) has been in the 10% of most deprived areas across England.
Read more on our website: www.communityhealthpartnerships.co.uk/article/report-outlines-the-impact-of-the-lift-programme-over-the-past-ten-years. The learning from this work has now been taken forward to incorporate into future scheme business cases.

[London case study]

The **RCPCH** has been working with partners at the RCGP and RCN to identify what commissioning a good child health service looks like. This document provides guidance for Clinical Commissioning Groups and GPs on the particular consideration required for the 22% of the population that are children and young people, and describes how services can be designed and delivered to meet their needs. It stresses the role of the multidisciplinary team, the importance of high quality information, and the GP practice as gatekeeper and referral centre for the system. It outlines the relationships that CCGs will need to develop with the Local Area Teams of the NHS Commissioning Boards, Local Authorities, Health and Wellbeing Boards and the importance of CCGs' engagement with areas Joint Strategic Needs Assessments.

5.7 Market management

This section consisted of four questions regarding **market management**.

5.7.1 How do we ensure a consistent and disciplined approach to identifying and remedying poor performance, including effective partnership with the CQC?

Many respondents stated that in order to successfully identify 'poor' performance they needed a clear understanding from NHSE as to the **core features of good practice**.

Suggestions as to how **poor performance** could be identified included:

- Patients to undertake a 'mystery shopping' exercise
- By proper targeted patient feedback
- Keep data on interactions between acute and primary care (e.g. referrals) updated
- Local groups of GPs to discuss and analyse comparative data
- Set standards and apply them and audit the maintaining of standards
- Have a robust performance management system in place with effective reporting of outcomes
- Utilise the appraisal process to highlight performance issues
- Through peer review and remedy
- Put systems in place to support and encourage practitioners before performance becomes an issue.

In order to **remedy poor performance**, the following were suggested:

- Develop an 'after action' review approach to rapid resolution of patient complaint
- Practices to design services together
- Negotiate outcome standards **with GPs**
- Use external facilitators who are part of CQC – a quality payment can be made to CCGs if a % of practices achieve CQC standards and may incentivise CCGs to play a part in CQC achievement
- Invest in education and continuing professional development
- Provide support for those in difficulty – i.e. get away from the 'blame and shame' mentality
- Utilise the skills of 'change managers' to help poorly performing practices.

"They should send in a 'change manager' to sort out the issues and then work with the practices to make the necessary improvements. I have done this work myself and can testify that it works."
[Primary care services, South West]

"The contract needs to have both national and locally agreed aspects that reflect quality of care provided and to which the provider can be held to account. Experienced clinicians involved in the process, making use of all available data and soft intelligence with a requirement for absolute transparency and openness on senior management would identify areas of poor performance. CCGs are membership organisations with the ability to make use of clinicians "on the ground" to be their eyes and ears and to flag up areas of concern and of good practice."
[Commissioners of healthcare services, East of England]

"Better training and robust appraisal - as a locality tutor I know how hard it is to take positive action with failing juniors - I suspect even harder with established colleagues - whether individually or as a practice which is not managing."
[Mental health services, Yorkshire and the Humber]

5.7.2 How do we develop a more consistent and effective approach to new market entry, e.g. how far this should be targeted at areas of greater deprivation and/or lower capacity and/or limited patient choice?

A number of respondents did not support to idea of new market entry and called for it to be discouraged. They argued that **we cannot have both an NHS where market entry is driven by market factors**, and **one that is highly regulated**. Therefore, NHSE needs to decide which is more important. Some concerns were expressed that 'access' is being used as an **excuse to introduce private provision of care**. Other respondents felt that new market entry should only be used as and when necessary, rather than as the default, as it has the **ability to increase costs**, increase the burden of monitoring for CCGs, decrease effective integration and can lead to the fragmentation of care pathways.

If new market entry *is* to be encouraged, then respondents made the following suggestions:

- Understand the **barriers that exist to inclusion of new providers** and explore how these can be addressed

- Reduce economic and regulatory barriers and simplify the tendering process, in order to encourage competition from small, specialist providers

- Work with social enterprises (such as Turning Point, Camden) who bring expertise in supporting people with complex needs

- Additional need should be met by additional resources

- Target new market entry at deprived areas where morbidity is greatest

- Review how community optical practices operate

- Get people who understand how markets work into responsible positions

- Work on collaborative agreements about outcomes and standards with partner agencies.

"The tender process can be a huge barrier, the requirement of capital resource or even extra pressures around regulation costs can hinder smaller, specialist services from entering the market."
[London]

"There are multiple references to deprivation being an indicator of an area ripe for the introduction of new providers. This is illogical, naïve and absolutely not the case. What is needed is a funding approach that recognised deprivation, disease burden, age and care home patients."
[Primary care services, East Midlands]

"Empowerment within local areas so that each area can address own needs and shortcomings within existing system."
[Patients and service users, London]

"In my opinion, the very use of the word "market" betrays the general attitude of looking at the NHS as a business, with money considered first and patients and staff second."
[South East Coast]

"In my experience new market entries tend to happen where there is an easy picking to be had, not where there is deprivation or poor choice."
[Primary care services, East Midlands]

5.7.3 How might we stimulate new, innovative provider models that offer both greater quality for patients and satisfying careers for those working in general practice and primary care?

A number of useful suggestions were made regarding the stimulation new provider models, as follows:

- Provide **adequate resources and support** to enable this
- Release resources from secondary care into primary care
- Fund innovation and small projects
- Through PCP contracts as they have the potential to drive change
- Facilitate **collaboration** between a range of primary care providers
- Encourage the creation of **GP federations**. This will enable the spread of skills and the ability to develop infrastructure
- Stimulate new partnerships with local communities to provide core services
- Look at good practice internationally
- Provide ongoing training and development to help CPD
- Survey younger medical and nursing staff and other AHP workers in primary and secondary care. Ask them what would make their job more satisfactory.

"…federations of current GP partnerships under a limited company allowing them to retain individual GP contracts but collaborate in integrated care. The latter is a model we are looking at here but getting the funds to deliver the services is difficult due to AQP regulations. These organisations will require practices to work to common policies and single clinical systems so they will promote best-practice within themselves. CQC and NHS England can monitor this."
[Primary care services, East Midlands]

"Satisfying careers for those working in general practice will stem from adequate support and resources to enable a platform in which the opinions and needs of GPs are collated, heard and acted upon. Opportunities for ongoing training and development to ensure continuing professional development should be readily available."
[Primary care services, London]

5.7.4 What are the potential opportunities for 'primary care plus' contracts, built on co-commissioning between NHS England, CCGs and local authorities?

In general, there was a **good deal of support** for Primary Care Plus (PCP) contracts as long as **long term sustainable funding** is provided alongside clear quality objectives. Respondents felt that the opportunities for PCP contracts were significant, with proper joined up working, as **combined commissioning** allows for a broader remit to encompass the full range of socio-economic determinants of health.

For PCP to succeed there must be recognisable benefits for all parties, and **budgets should be held jointly** between hospitals, primary care (including Allied Health Professions), and community providers. There were calls for PCP contracts to be for longer than five years, to facilitate long term service planning.

"Potential opportunities for primary care plus contracts could see primary care, community services and social services co-located ad working in a truly integrated way. This can only benefit the patient but will be a huge cultural shift!"
[Primary care services, South East Coast]

"I wish we could have had a primary care plus contract instead of going for AQP. Not sure what the difference might be other than the badge between that and PMS+. In 1982-85 we had such an organisation, social services and all, delivered from our general practice. Successive central strategies for community nursing, social services, 'advanced access' and other micromanaged changes completely destroyed every vestige of integrated working."
[Primary care services, West Midlands]

[Primary care services, West Midlands case study]

Our experience is that patients prefer the model where the doctor providing the care is also responsible for the quality of the provision of care by that organisation. This model also improves retention of medical staff thereby enhancing continuity of care, which is well recognised as providing the highest quality and most cost effective provision of care.

[London case study]

We support new approaches to commissioning; particularly primary care services which look at bringing together a wider range of organisations to either manage, or be partners within primary care provision. By doing this, barriers around access of certain groups can be addressed as well as the economic costs of people who have multiple needs but do not know where to turn for the best support.

5.8   Workforce development

This section consisted of four questions on key aspects of **workforce development.**

5.8.1   How can we and our national and local partners best support improvements in recruitment, retention and return to practice?

The main comment from respondents was that, in order to **recruit** to the **primary care** sector, more **investment** was needed in order to attract the best quality doctors and nurses. It was suggested that the profile of GPs be increased in undergraduate and foundation training, and that the time spent in GP practice during the GP registrar year be increased from 1 to 2 years.

Suggestions as to how to **retain** practice staff included:

- Allowing GPs to provide **longer appointment slots** – i.e. 15-20 minutes
- Encouraging practices to **work in local groups** as this can be very supportive – for example, they can facilitate more flexible working and they can share good practice. It may also provide **better job opportunities** leading to increased satisfaction
- Allowing GPs to control their working environment as **partners**
- Trusting the profession more and **reducing** the level of **monitoring**
- Removing Payment by Results (PbR)
- Providing better, modern, **fit for purpose buildings** and facilities
- Investing in wider primary care and community healthcare teams
- Supporting local nurse training in general practice
- Supporting newly trained practitioners in the early years of clinical practice
- Employing a pool of GPs within CCG's to get varied experience working in practices and help with succession planning
- Involving staff in designing new ways of working
- Designing better, more workable solutions so that staff and patients have ownership
- Providing more ongoing support programmes for nurses and HCSs in primary care
- Introducing apprentice programmes for HCAs and nurses
- Valuing and making the best use of the opinions of healthcare workers
- Working with government and the media to arrest the blame culture against GPs
- Developing the role of GPs with specialist interest to work as an interface between primary and secondary care
- Providing incentives for GPs to work in unpopular areas, as happens in other countries e.g. Australia
- Offering returner routes and induction for those able to work in the UK but who have no recent NHS primary care experience/orientation.

"General practice needs once again to be an attractive career choice for young doctors and NHSE has a large role to play in this."
[Primary care services, South West]

"As an ex-healthcare professional, a large factor in people leaving the health service is the lack of pay and low staff to patient ratio."
[South East Coast]

"When GPs are seen as appropriately funded without unnecessary burdens of patient demand and bureaucracy and key-players in the management of the local health economy, there will be no problems with recruitment as it will be a rewarding job working in partnership, not conflict, with specialist colleagues each recognising the others' abilities."
[Primary care services, East Midlands]

"Stop the briefing against GPs in press - very demoralising and makes GP unattractive to medical students."
[Primary care services, East Midlands]

"The pension situation and revalidation and demography is going to see a relatively sharp fall in the workforce over the next 2-3 years and there are not enough trainees coming through to fill the gap."
[Commissioners of healthcare services / Primary care services, East of England]

"Until this constant GP bashing by the media and the politicians stops, you will find recruitment and retention will worsen year on year."
[Primary care services, North West]

"NHS workforce planning has been poor at predicting workforce needs."
[Primary care services, West Midlands]

5.8.2 What are the strategic priorities for improvements in education and training to reflect the evolving role of general practice, the changing profile of the GP workforce and the challenges facing the health service in the next ten years?

There was general agreement that there is a need for ongoing training for practice staff. However it was argued that their **time off work** to train or refresh their skills must be **protected,** and that training and continuing professional development needs to be adequately **resourced**. Respondents stated that training opportunities should be as varied as possible to enable staff to access it – for example, online, day release, block courses, mentoring, shadowing etc. It was recommended that general practice staff be trained *alongside* secondary care and public health staff in order to motivate multi-disciplinary working.

A number of recommendations were made as to the **training needed** in general practice, including:

- Paediatric care – e.g. shared opportunities between paediatric and GP trainees will encourage better working together

- Supporting those with long term conditions (LTCs)

- Care of the ageing population – including dementia care

- Mental health care – including for children and young people

- Maternal health care

- Early diagnosis of cancer

- Supporting the needs of those with learning disabilities – for example, ensuring they understand information and their care plan

- Supporting patients in the self-management of their care

- Business understanding – including commissioning, governance, business management and budget holding.

"The RCGP is on the money as far as training, education and workforce issues are involved and NHS England would be well advised to pay more respect to their views."
[Primary care services, South West]

"Incredibly a practice nurse year-long training course for those new to practice nursing in our area did not include any training in long term conditions. Why would GPs release their nurses to go on it?"
[East Midlands]

"Training needs to reflect that GPs are now the general physicians of the past and no longer supported by easy access to general physicians in secondary care as a result of increasing sub specialisation. There is a need for increased experience in medical specialties / care of the elderly medicine to reflect the changing case mix seen in general practice. Given the expectation that GPs will also manage more of the other specialty work previously referred to secondary care in the future, there may be a need for GPs to develop areas of interest to provide the services out of hospital previously provided by secondary care. It is only feasible to encompass all of this by increasing the time to train GPs."
[Commissioners of healthcare services, East of England]

"Perversely from the workforce viewpoint, the GP contract needs to include a session per week for education and training, just like the consultant contract does now. This might be education within a CCG, within a practice, or whatever is relevant to needs. Given resources, we can develop programmes of education in joint working, new ways of working, extended roles, developing the workforce as long as the funding is there."
[Commissioners of healthcare services / Primary care services, East of England]

"Part of GP training could be to shadow other community workers and roles to see how other health services/social care services work in practice."
[West Midlands]

5.8.3 What developments would help provide more structured careers for GPs, practice nurses and other primary care practitioners?

Some respondents queried the assumption that primary care staff were leading unstructured careers.

Others provided some useful suggestions as to developments that would help provide more structured careers for primary care practitioners. These included:

- Development of an appraiser role to provide individualised and tailored career support
- Giving staff the opportunity to rotate between different environments in primary and secondary care
- Developing a career structure that values progressions and development of professional skills
- Rewarding innovation
- Promoting development of integrated GP/community/other primary care facilities
- Retaining opportunities for split jobs with one or more sessions in acute care or mental health - or opportunities for staff (including nurses and practice managers) to have swaps or sabbaticals in other surgeries or clinical areas
- Facilitating a more federated approach to the provision of primary care services. This may then allow GPs /other clinical staff to develop careers in which they could pursue an area of interest
- A career structure in commissioning and medical leadership for primary care.

"More specialist practices to reflect local need would provide a good opportunity to build specialist as well as generalist skills and skills of evaluation."
[London]

"There has been an explosion in the % of salaried doctors in the workforce and I wonder if as partners retire, we will see more unforeseen consequences of this approach with fewer GPs running partnerships. This may be an opportunity to develop a career structure for GPs."
[London]

"Not necessarily practices on their own, but I do think CCGs can have a major role in training for all these groups. That is one of the focuses of the CCG education strategy that I am writing at the moment."
[Commissioners of healthcare services / Primary care services, East of England]

5.8.4 What factors are likely to promote and support good employment practice, e.g. GP practices providing training and development opportunities for practice nurses and practice managers?

Few responses were provided to this question. Those who *did* provide a response suggested the following factors as likely to promote and support good employment practice:

- Learning organisational models

- Reliance on high trust contracts with a stable financial environment

- Recognising the importance of training and the cost of good training

- Creating local groups / forums where staff can learn and share good practice

- Encouraging the pooling / federation of back office / HR functions

- Increasing training standards (and regulation of them) for practice nurses and managers

- Making available local, high quality, appropriate training at no or low cost

- Supporting the development of a career structure that enables the retention of senior nurses in clinical roles

- Supporting the training of nurses financially

- Supporting the development of new roles as integrated care and federated structures develop

- Funding practice nurse / HCA training programme / practice accreditation for nurse training / invest to create more training practices

- Reducing the over-burdening of practices to provide appropriate training atmosphere.

"Time and resource – we can only enthuse and train others if we have protected resourced time to do it. Any such input takes us away from the day job."
[Primary care services, South West]

[Primary care services, East Midlands case study]

In these organisations, GPs can remain doing what they do now but others will become clinical directors etc. and practice nurses can be involved in basic treatment room duties or get involved in specialist clinics e.g. we have a practice nurse who specialises in diabetes. Her role is currently limited to QOF diabetes reviews but under new integrated structures she could support consultant-led community clinics, so giving her a more interesting role. Allowing GP / consultant partnerships to participate in foundation doctor, GP, SHO, registrar, practice nurse and specialist nurse training under the LETBs will promote and support good employment practice and training.

[Primary care services, East Midlands case study]

Make it easier to return to practice after a career break. It's impossible at present as no-one can afford to work full time and have to pay for the privilege, which is the current situation. No-one wants to train as a GP now as the hours are punitive (an 8am-6.30pm day is in reality an 8am-8pm day and days off are used catching up on paperwork). As a part time GP I work about 45 hours a week. Talk from politicians of increasing opening until 8pm would make a 14-15 hour day. Talk of weekend working makes it a family unfriendly option. I don't have childcare at the weekend, so if I have a contract that includes weekends I'll be leaving the profession. I suspect many others will too. GPs often have children later in life and so don't have young fit grandparents to pick up the slack. We also often have to train geographically distantly from extended family. We are a different species to nurses who tend to live near their families, train locally and have their children in their 20s. Weekend and evening working is not possible without family backup. Child-minders and nurseries aren't available at 8pm or on a Sunday afternoon, so there goes my career. It's not all about money. It's about work-life balance and being able to work safely, with safe hours and adequate time off. There are not enough GPs to provide that service at the moment. Pension changes mean anyone who can will be leaving in the next 2-3 years.

[Primary care services, North East case study]

When I studied medicine in Germany, I earned half of my university fees by working as an auxiliary nurse in hospital. I wiped quite a few bottoms clean, and that was good for appreciating the work of nurses. I saw some patients die at night as a night sitter. These practical experiences do not seem valued enough at the moment.

[Primary care services, North West case study]

In Mersey I enabled one young GP who had been off work for 2 years to return to work thanks to very generous funding from her insurance company. She is now making a very worthwhile contribution again. But there is no general funding for others, and I despair that GPs struggle enormously to return to work after prolonged sickness absence.

[Primary care services, North West case study]

I have been a mentor for the Specialist Nurse Degree for PN's but have had no students for the last 5 years as there is no protected finance for this course. All the CCG's monies are distributed to GP's. With better trained nurses and particularly the employment of NP's Primary Care Costs could be better managed by redistributing work appropriately to nurses who would be better trained to deal with these problems. It is a false economy to keep employing more GP's whereas the equivalent cost /or even less could employ 2 nurses to provide the appropriate service required. I have continually banged on to my CCG that the PN workforce is reducing due to an ageing workforce; also the PN's of today in some practices are under trained and therefore do not offer the appropriate care to patients. It may also be useful to shift some of the hospital trained nurses to primary by offering a preliminary training experience, to give them insight into PN's with the facility of then being offered a specific course. The students I have trained as PN's have succeeded in leading other nurses in other practices and have been well received by GP's for their experienced and knowledgeable input in their practices.

[Type and region unknown case study]

We are advertising for a new partner due to retirement and have had one applicant. Old doctors are working out their exit strategies and new doctors don't want to be partners. The hours are longer and longer, we are earning less, stress levels are higher, patients are more demanding. The job is wonderful and I love it, but providing an excellent service is at the expense of any life outside work. Change is needed - a debate on what is GOOD about general practice, stop the constant negative press, value your GPs or there won't be enough to keep primary care going. If you really want quality I would slash practice lists so GPs have longer with their patients. But I assume that is too expensive, so I would look at maximising GP time with patients and do everything possible to relieve GPs of all the admin that wastes our time. It's increasingly difficult to find time to study. I'm not home until 9pm, and go to bed at 10pm ready to work again the following day. Study is squeezed into the weekend along with seeing the children, housework, chores etc.

5.9   Other comments made

Consultation responders were asked to provide their proposals/feedback/insight on key issues around **other key areas**. We address each area in turn.

5.9.1 How do we ensure that people with more complex health and care needs have a named clinician with responsibility for coordinating their care? Should people with more complex needs have a named GP with responsibility for overseeing their care?

A range of differing opinions emerged on this point. Some contended that the current model does not allow for this, whilst others stated that this is already very much happening or that this is not really a necessity. Some questioned the feasibility of the named approach due to a number of factors, including part-time working and the lack of time, i.e. 10 minutes being insufficient. Mostly however, there were a number of suggestions of who could provide such support for those with complex needs:

- Option is for nurse practitioner to be named clinician with GP advising
- Up-skill nurse practitioners to junior doctor level
- Improve role of Community Matron / Nominate an individual to coordinate care, not necessarily a GP, perhaps a Community Matron
- GPs working with a practice team
- Community nurses need to be more integrated within GPs
- We need to be thinking about a primary care based multi-disciplinary teams
- Locally Complex Care Coordinator – probably need one for mental health
- Some geriatricians should be community based and not hospital based
- Each practice needs the support of a named general physician or geriatrician, perhaps with a monthly meeting to discuss more complex patients

"…people cannot expect me to be their 24h GP, a CCG leader, provide instant access for emergencies and also be bookable and do online consults - unless I am only looking after a realistically small number of people. Adequate numbers of workers, team working, good IT and telephony will solve this, but at the end of the day it's a volume thing."
[Primary care services, East of England]

"There was once a provision for all patients to be registered with a named GP. With PMS and then GMS this disappeared and patients register with a practice. However patients do not really understand this and still talk about 'their GP' and wonder with whom they are actually registered. Maybe some return to the tried and tested way of registering would give responsibility to the GP who actually cares for the particular patient might work. However this might run counter to patient choice. Some patients like to see one GP for one thing and another for a different thing. Urgent and unscheduled care needs also get in the way of this sort of continuity of care."
[Primary care, Yorkshire and the Humber]

5.9.2 How can we strengthen GP practice accountability for the quality of out-of-hours services provided to patients and ensure that OOH services are more integrated both with daytime general practice and with wider urgent care services?

Opinions around these points focused on either the need for resources, financial and human, or in respect of OOH services. The need for resources also included reference to the need for integrated IT services, a theme explored in previous sections. It was felt that GP opinion on OOH service development should be canvassed, however as there is currently no accountability for GPs relating to OOH, this is going to be difficult. A number of suggestions were made with regard to how OOH should be organised / resourced / monitored as follows:

- OOH to be provided by a cooperative of GPs

- Encourage primary and secondary care to jointly develop OOH services

- Allow CCGs to quality control / commission OOH services

- Combine 111 and OOH, see Derbyshire model

- Directing patients back to primary care where appropriate rather than being seen by OOHs

- Integrate it with out of hours mental health and social care

- Improve referral process back from OOH to primary care (the whole not just GP)

- Enable referral from primary care to OOHs for continuity and preventing A&E attendance or admission

- The community hospital would offer a much extended opening time, with the GP's committing to shifts and split days.

5.9.3 How do we stimulate more convenient <u>routine</u> access to general practice services, including ease of making appointments, speed of contact for urgent problems (whether telephone or face-to-face), ability to book less urgent appointments in advance, ability to communicate electronically (e.g. online consultations) and, particularly for working-age adults, availability of evening/weekend slots?

Issues raised on this theme included legal / specification issues around consulting online and definitions of what access means. There was concern around the lack of access for those that worked full-time and support for extended opening hours, e.g. 7am-8pm weekdays and 9am-6pm weekends, including an ability to management appointments online. Alternatively a rota system could be developed to provide access at one of GP, acute or walk-in centres. Overwhelmingly, there was support for triage / consultation by means other than face-to-face, such as by telephone or virtually, e.g. Skype.

Various comments referred to the need for public responsibility not to abuse the system or an ability of the public to self-manage, whilst others suggested that patients should pay for services like they do in Sweden.

"There should be more education for the public to be able to self-manage minor conditions without the need to see their GP, e.g. warts, verrucae, head lice, minor muscle aches, colds, minor episodes of gastroenteritis."
[Primary care services, North West]

"If people want a 7 day a week general practice service with evening and weekend appointments this will cost a lot more money. It is not possible with the existing workforce."
[Patients and service users, London]

"Re ability to communicate with email, which patients do you deal with first, the housebound patient, the one in the surgery, the one on the phone or the one via email? It should be done in terms of the most ill, the most in need, it too cannot be measured simply, we are not a call centre with all calls being of equal importance as they are about the same thing, a call about chest pain needs dealing with much more rapidly than one about a verruca. Do not try to measure the un-measurable, all this does is basis towards the quick and easy ones like the verruca call rather than the complex home visit that actually is more important clinically."
[Yorkshire and the Humber]

5.9.4 How do we stimulate GP practice responsiveness to access preferences of their populations?

Coordination and liaison were the key themes emerging from the notion of stimulating responsiveness. However, further comment was made alluding to the need to address needs rather than wants, as well as reducing the GP:patient ratio. Furthermore, in this respect, the ability to monitor the number of whole time equivalent GPs, not just number of qualified GPs, may prove beneficial. Other suggestions / comments included:

- Develop a nationwide mystery shopper model

- Continue incentivising current access initiatives until they become mainstream.

"We recently listened to our patient survey saying they want to have more on the day appointments and changed our whole appointment system on that basis, only to be met by a raft of complaints about the new system they asked for!"
[Yorkshire and the Humber]

5.9.5 How far should there be a shift of resources from acute to out-of-hospital care? How far should this flow into general practice and how far into wider community services?

A number of comments emerged regarding this shift. Suggestions ranged from revision of GP contract to assist this process, to not being seen as pre-determining which part of the community market "gets the business" that results from such a shift. Others commented as follows:

- Joint targets with Acute Trusts to reduce attendances for both

- Significant shift of resources to primary care

- Incentivise outcomes, not process (at CCG level)

- Community services to be managed by both primary and secondary care

- Major shift in funding to enable this as there has been in mental health services i.e. community teams, clinics in primary care etc. Ideal is where GP services and MH are co-located with social care

- Hospital should always be seen as last resort

- If you shift resources too quickly from secondary to primary care, the whole system will implode

- We are increasingly using the narrative hospital based services than acute, recognising that acute services can be provided in the community

- If practices get the business model right they will be well placed to compete and win that business

- If we return to the ICO type of organisation then it can be directed to whichever providers we want

- The service should be provided by whoever can deliver it best closest to home. Locality commissioning of community and general practice services is one option.

"Hospital care needs to be more holistic as hospital consultants have become so specialised they do not deal with the bigger picture, e.g. a patient of mine with MS was admitted to hospital with sepsis following a UTI and LRTI and these problems were treated with antibiotics however blood tests at the time revealed several abnormalities such as anaemia, low protein levels, very high inflammatory markers, raised alkaline phosphatase none of which seem to have been addressed and no follow up arrangements seem to have been planned and so as a GP I am left to pick up the pieces. Every week we all have several patients to sort out who have been inadequately managed in secondary care or discharged too early and without a care package in place."
[Primary care, Yorkshire and the Humber]

[Primary care services, West Midlands case study]

There are limits to what you can do if you have to provide appointments accessible in different ways and at different times. The average full time GP in our practice only works 62 hours a week, of which about 38 hours are consultations. Some 57% of demand is for same day, so this is protected. About half the remainder is booked more than a week in advance, and the difference is for same week advance booking. 8% is made available for telephone access, 12% for visits, 8% of the same day appointments are also made available for advance online booking. There are about 50 telephone consultation daily on top of this. Working age demand is low, the numbers of people who would like it is fairly high, but their use of appointments is very low, so beyond the hours we currently offer there would only be one person every three hours for whom the further extension is most appropriate. You cannot extend availability to meet such a small demand. In fact early morning appointments (between 06:00 and 08:00) are by far the most popular, not evenings and weekends. Even so, the waiting time for a routine appointment is currently a week. The excess demand is almost all created by reviews relating to DESs and QOF activities. We know this from analysing the consultation purpose. Our ratio of GPs to patients is above average, not below.

[Primary care services, West Midlands case study]

Regarding speed of contact, this has also deteriorated with the increase in calls. For a population of 11,000 our maximum call rate is 1,800 a day on Mondays, reaching a peak of 1 call every 8 seconds at 10:00. That is a 500% increase since 2008. The average call rate throughout the week is one call every 20 seconds. In 17 months we had 448,588 action contacts from 20,091 patients ~ 1000 per working day. Half are consultations with receptionists such as ordering scripts and does not include contacts to book appointments. Overall 1 action every 20 seconds of the working week. We made 127,004 appointments. 28 of our patients with a risk score >60 are from care homes. These had 843 appointments and this does not include those who died. This is an average of 30.1 each over 17 months and for the duration of actual registration is 3.04 appointments per month each. In addition to actual appointments these patients resulted in 4,688 contacts with the surgery, which is 167.4 each, in 68 weeks. This includes correspondence and results and is nearly 3 a week. Of contacts where there was direct or indirect contact relating to immediate care, there were 1,842 all for these 28 patients. Just over 1% were unscheduled care. The remaining 60 patients on the risk list made 2,476 appointments which is an average of 41.3 each, or 2.6 per month. In addition to the appointments, these patients resulted in 9,628 contacts with the surgery which is 160.5 each. The same as care home residents. I would welcome anybody from NHSE tell us how to contain the demand, it isn't a matter of stimulating better provision, the doctors are all working every hour that god sends, every telephone is in constant use, but we cannot improve flexibility as there aren't any more hours to be flexible into with the current resources.

[Unstated type and region case study]

We are working hard to support patients who wish to die at home - but good end of life care is very time consuming and there has been no shift of resources. If this doesn't happen, the quality of the service will have to fall. Today I spent 3 hours with a palliative care patient, and the district nurse another 2-3 hours, this on a Saturday. It is time consuming and emotionally draining, and has to be fitted in around the day job.

[Community based care, London case study]

People with complex conditions should absolutely have a named GP and another clinician who is the care coordinator. The virtual ward model pioneered in Croydon is a clear example of how well this approach can work for the most complex patients

6. DEVELOPMENT OF NHS ENGLAND'S ANALYTICAL PACK

Respondents were asked if they had any **suggestions for the development of the analytical pack**.

A significant number were unable to identify what was meant by the 'analytical pack' and may well have confused this with other information already out there; in some cases perhaps even the survey itself. Some respondents provided advice around what the constituent parts of the pack should include. Suggestions included: an executive summary; local flavour; intelligence; a core of consistent information; focus on key issues / needs; a narrative explaining outliers; and inclusion of questions which can differentiate between good and bad practice. Others contended that there is no evidence to support the changes proposed, or that the contents are largely unintelligible to the initiated, or queried the purpose of the pack. Specifically related to the pack, others focussed on issues such as length, tightening up the presentation, age of metrics, difficulty in identifying data by CCG, and the lack of reference to those with MSK conditions, who take up a significant proportion of GP time. However, from a positive perspective, a number agreed that the pack is good and that it supports change.

Some supported the notion of a more collective approach, i.e. that there was a need to work with CCGs for local indicators of quality care and performance. This included linking into other information sources, such as data from GP EHR (Electronic Health Records) systems. Some suggested that the data should be clearly defined by NHS England area team and by CCG, and could also be drilled down into practice and individuals within a practice; and that it also needed to reflect the changed footprints - CCG and PCT footprints aren't necessarily the same. But mostly a common thread was that clinicians should have input into what is produced.

There were also suggestions with regard to promotion of the pack, including:

- Make it comprehensive / understandable to the general public, e.g. no dogma, jargon, acronyms or complex arguments
- Wider circulation
- Identifying the appropriate target groups
- Promote through local workshops
- Make one side of A4 to show key messages only
- Shift focus from problem identification to solution provider
- Include different needs to different groups
- Extensively pilot the pack before any fundamental changes are made
- It should include clarification of what primary care should be doing, including the GP role, and what part the public have to play in terms of responsibility for their own health
- Ensuring it remains kept up-to-date.

Furthermore, there were a myriad of suggestions for improvement / amendments / additional information needed. Examples, some of which were very specific, included:

- Include performance indicators – to be managed by HWBs, Health Select Committees, CCGs for out of hours providers

- More up-to-date data on GP consultations, ask practices to record them in a consistent format

- Information on high risk groups – for early intervention

- Mapping of primary care

- MSKs deserve an integrated and strategic response to ensure services are delivered across a variety of health and social care professionals. This involves shared decision making, self-management and patient involvement

- Developing general practice and setting priorities for general practice that will have largest impact on health outcomes **must** include improving services for those with MSK conditions

- In reference to the different types of A&E department; suggest that the Type 3 descriptor should include the multi-professional nature of clinical teams, including the role of physiotherapists and other AHPs located within A&E, and the community who play significant role in supporting early discharge and preventing readmissions

- Include information on how many GPs are doing online consultations

- Data from predictive risk modelling (Kings Fund) on potential reduction in emergency admissions from proactive case management

- Community nursing caseload and acuity data

- Analyse social care predictive data (especially regarding needs of frail elderly)

- Include number of patients of different age groups

- Deprivation statistics / social class areas locally

- Disease prevalence / prevalence of chronic diseases

- Proportion of housebound patients

- Include GP estate or primary care estate information

- Average waiting times – to measure access / peak demand hours

- Number and opening hours of GPs and other services like walk-in centres

- Appointment availability

- A&E attendances / admissions

- Other performance areas like cervical cytology, immunisations, smoking prevalence etc. all that will lead to possible hidden or neglected areas locally

- Perhaps include more health specific outcomes such as mental health and learning difficulties

- Include a mixture of patients and healthcare and social care professional questions and answers, so you can compare data on these groups and their thoughts

- Set benchmarks for General Practice based on best practice

- Correlation of outcomes and value with list of practice size would help support larger groupings.

Likewise, there appears to be a demand for release of non-statistical information such as:

- Need idea of NHSE's strategy and their ideas of practical and achievable measures
- Describe how telehealth and telecare can be used to manage patients in their own homes
- Describe how many common conditions can be diagnosed without the need for a face to face meeting
- Show how many infections can be exchanged in GP waiting rooms
- Mental health data on impact of depression and isolation on long term condition management
- Consider carers' wellbeing and support needs
- Provide good practice examples – e.g. PPG involvement in governance
- Include the IT systems that GP use and whether they are compatible with systems in hospitals, community services etc.
- Set standards of care with the GP and patient at the centre
- Grade outcomes based on inventiveness, community collaboration and social deprivation of the population
- Care of staff - their development, multiskilling, not exploiting Nurse Practitioner.

"In mental health, we would like to show you our analytical packs which provide each CCG with its: prevalence, high risk groups for early intervention, top 10% who consume 50-60% spend methodology, how to map primary care, CCG commissioned tier…etc."
[Other: NHS England National clinical director - mental health, London]

"MSK conditions…are the fourth largest area of NHS spending in England…"
[Patients and service users, London]

"…educating patients has to be a key element in all of this. How to look after themselves; how to avoid getting ill in the first place; the dangers of a poor lifestyle…how to access health services appropriately…what the NHS/primary care/hospital/GP is actually to be used for."
[Primary care services, South West]

"Stop breaking down primary medical care into score of certain conditions that earn practices 'extra points'."
[South West]

"Sources need to be stated. I know that the figures on GP manpower are inaccurate"
[Commissioners of healthcare services / Primary care services, East of England]

"There are too many assertions and not enough support for those assertions: if the object is to inform decisions there needs to be better information - or links to information"
[Other: Retired GP, East of England]

"Does not include any analysis of sessional GPs - locum and salaried - a real omission as 40-60% of the GP workforce"
[East of England]

"I would like to join a working group to support this programme"
[Commissioners of healthcare services / primary care services, North West]

"We note the evidence pack demonstrates the success rate of general practice with satisfaction outcomes that any industry would be delighted with. We believe that the pack should refer to the 'Seventh Workload Study' which concluded that general practice has the worst morale at present than ever recorded. We also believe that it would have been helpful to have included recognition of the reduction of the percentage of healthcare budget which is spent within general practice"
[Primary care services, West Midlands]

"This is not at all a new idea. In the book "A General Practitioners Progress to The Black Country" such public discussions occurred regularly in The Black Country before the NHS was started when the Clubs funded the GP service"
[Primary care services, West Midlands]

This seems heavy on data (some of which is very out of date) and very light on insightful analysis
[Patients and service users, Yorkshire and the Humber]

"Detailed data should be available to care data to look for patterns of successful care outcomes and suspicious data recording, e.g. many people being recorded with the same health issues and treatment rather than a natural variation of conditions recorded. Use of structured assessments relevant to the health issue should avoid Boolean tick box responses but enable rapid information recording of more useful clinical information to enable outcome measure impacts of particular care approaches to be more accurately appraised"
[Patients and service users, Yorkshire and the Humber]

APPENDIX A: RESPONDENT PROFILING INFORMATION

Using the postcodes to map response by Strategic Health Authority

In order to assign postcodes to the Strategic Health Authority (SHA), for each postcode district, e.g. PO10, we first calculated a centroid point consisting of a northing (y-coordinate) and an easting (x-coordinate). To do this we imported some 1,691,639 postcodes into SPSS and executed an aggregate function that calculated the average value for the x-coordinate and y-coordinate for each postcode district. This resulted in a file containing some 2,961 records across England, Scotland, Wales and Northern Ireland. We then extracted from the respondent's postcode the district element, e.g. PO10. Note that in some cases the respondent only provided information at this level rather than a full postcode. We then attributed to each record the relevant centroid point, so for PO10 this was 475430 (easting) and 106353 (northing). We then plotted each of these references on a map and overlaid the SHA boundary file.

	Count
Unavailable	**37**
East Midlands	33
East of England	43
London	93
North East	20
North West	46
South Central	35
South East Coast	38
South West	84
West Midlands	44
Yorkshire and the Humber	48
Total	521

Ethnic Group

	Count
Unanswered	**33**
African	1
Any Other Asian Background	7
Any Other Black Background	2
Any Other Ethnic Group	5
Any Other Mixed Background	3
Any Other White Background	7
Bangladeshi	1
Caribbean	1
Do not wish to disclose	33
Indian	14
Pakistani	3
White	62
White and Asian	1
White and Black African	1
White British	338
White Irish	9
Total	521

Gender

	Count
Do not wish to disclose	25
Female	219
Male	255
Not Answered	22
Total	521

Type of respondent

	Count
Individual	428
Organisation	93
Total	521

Area of healthcare representing

	Individual / Organisation	
	Individual	**Organisations**
	Count	**Count**
Commissioners of healthcare services	49	13
Acute services	18	5
Mental health services	43	4
Primary care services	238	47
Community based care	20	9
Patients and service users	156	22
Other	19	25

Whether believe current system of primary care in England needs to change and improve

	Count
No	82
Yes	439
Total	521

APPENDIX B: STATISTICAL VALIDITY

A number of tests need to be undertaken if we are to measure the extent to which the conclusions are statistically valid. We would normally advocate undertaking a minimum of two tests, as follows:

- The extent to which our sample, in this case 521 respondents and the results for their responses for any given question, fall within specified parameters given a pre-determined level of confidence
- The extent to which the respondents match the profile of respondents on a given number of variables or traits.

It is typical, for market / social research purposes, to set a level of confidence at 95%. Typically higher values are used, such as 99%, when the need for reliability is higher, but we do not believe this applies in this case. It is also possible to reduce the confidence level to say 90%, but for the purposes of this exercise we will use the default of 95%. Given this level of confidence we can express the possible levels of error for any given response. The level of error is highest where an equal split occurs and lowest where it is unequal. To perform the calculation we require two figures, in this case the size of the population and the size of our sample. We do not have a reliable figure for our population, so we will use by default the total number of GPs in England. According to the GMC there are 259,675 doctors registered on List of Registered Medical Practitioners (LRMP). Taking this as our base, albeit that this excludes responses from other classes of respondents, and our sample of 521, we can provide the following:

Proportion:	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%
Likely error:	1.9%	2.6%	3.1%	3.5%	3.7%	4.0%	4.1%	4.2%	4.3%	4.3%

[In the case of a 50 / 50 split the error is largest, at 4.3%. Where the split is largest, e.g. 5 / 95, the error is smallest, at 1.9%]

However, this only looks at response in total. If we were to evaluate response to a particular question, such as the SHA they fall within, then the results, for London, would look like this:

Proportion:	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%
Likely error:	4.4%	6.1%	7.3%	8.1%	8.8%	9.3%	9.7%	10.0%	10.1%	10.2%

Consequently at the headline level we can state that our results fall within reasonable parameters, i.e. the likely error remains bellows 5%. However evaluating results based on other responses means that there is a greater chance that our estimates (results) are subject to potential distortion.

Ideally, we would like to be able to evaluate the extent to which our results are truly representative. That is, to what extent does our sample mirror that of our population(s), or does non-response have a material impact on our results? Unfortunately we cannot evaluate this properly, as we have no reliable way of evaluating the population(s) invited to participate in the survey, or examining if everyone to whom the survey was directed had an equal chance of being selected.