

Monitor

Making the health sector
work for patients

**Responses to Monitor's
call for evidence on the
general practice
services sector in
England (GP services):
clinical commissioning
groups**



This document contains non-confidential clinical commissioning groups' written responses to our [call for evidence on GP services in England](#). We have published these responses with permission, in full and unedited, except for limited circumstances where text has been removed as it was identified as being confidential, or identified individual GPs or GP practices.

Alongside this document we have published responses from patients, patient representative groups, providers, representative bodies, local medical committees and other respondents [here](#).

These published submissions form part of the information considered in our [discussion document](#) following Monitor's call for evidence on GP services, which sets out what we have heard and proposed further work.

Clinical commissioning groups (CCG)

Please click on names in this list to jump to the submission you require.

- [NHS Guildford and Waverley CCG](#)
- [NHS Leeds North CCG](#)
- [NHS Leeds South and East CCG](#)
- [NHS Northern, Eastern and Western Devon CCG](#)
- [NHS Tower Hamlets CCG](#)
Please note that this submission is a work in progress
- [Anonymous 1](#)
- [Anonymous 2](#)

Dr David Eyre-Brook (Chairman of Guildford and Waverley CCG)

As GP chair of Guildford and Waverley CCG we are starting to make changes to the new world of General Practice. Some of the thoughts driving this are stated below

General Practice bursting at the seams and becoming even more of a reactive service

QOF drives tick box mentality and has probably served its purpose

Boundaries between General Practice and District Nursing and Community Therapy teams not helpful and getting worse

Hospital Spend rising when we all know that frail elderly should be discharged as soon as medically fit which would result in better patient care and lower bills both for health and social services

What needs to happen.

Centrally

new contract both for General practice moving away from targets and encouraging joined up primary care both functionally and structurally when required (note CG Tax is a problem here) ? new contract to replace Pbr for hospitals which is less activity driven

Locally

GPs as providers need to step up to the plate and federate to manage patient care more effectively. This needs to be supported by a facilitative CCG and Area Team.

This may include

increase in GPsi services

management of District nursing moving to federated primary care management of community therapy teams moving to federated primary care Greater focus on Proactive management and care planning with active management of patient care when they go into hospital as emergency

The GP and his/her team must go back to feeling a responsibility for managing the care of his or her patient at all times whether in or out of hours and whether in their homes or in hospital

more integration with Social services.

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Leeds North Clinical Commissioning Group

1 August 2013

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Monitor's call for evidence on general practice services in England.

Monitor is to examine the commissioning and provision of GP services in England to see if there are barriers preventing patients from securing access to the best possible care.

In particular, requesting views on:-

- 1. Patients' ability to access GP services, including their ability to switch practices*
- 2. The ability for new or existing providers of GP services to develop the scope of the NHS services they offer, including in new locations*
- 3. New models of primary care that local health communities are planning or considering and the potential barriers to these being implemented*

Leeds North CCG Response to Monitor

Leeds North CCG is one of 3 CCGs in Leeds. It serves a population just over 200,000 living in North Leeds. It is a member led organisation. The members are providers of Primary Care (31 practices in total). We are responsible, along with the other 2 CCG's in Leeds for commissioning secondary care and community services. On behalf of the city each CCG has a lead role with regard to the contract with one of the major providers. Leeds North CCG leads on the Mental Health contract with Leeds and Yorkshire Partnership Foundation Trust.

Primary Care not only provides routine frontline services to patients, but also plays a vital role in helping patients make informed choices regarding their health and the need for referral to specialist services when necessary.

NHS England are responsible (not CCGs) for commissioning primary care.

In order to show value for money and best use of public money, the CCG needs to commission the best possible care for our patients. This care needs to be in the most appropriate setting, and able to serve the population of Leeds North. This is reflected in the LNCCG commissioning strategy, which was developed with our member practices and the population living in the CCG area. LNCCG along with the other CCGs in Leeds have worked closely with our providers and Leeds City Council to achieve a truly integrated health and social care model. This has been nationally recognised and Leeds is currently being

Chair: Dr Jason Broch Chief Officer: Nigel Gray

NHS Leeds North Clinical Commissioning Group is a smokefree organisation

Together 
we're better

considered for a pioneer bid which will help support accelerate and develop Leeds's Integrated Health and Social Care model and committing Leeds to sharing the good work we have already done and being a driver for change nationally. The pioneer bid if successful will allow Leeds to :

- innovate through supporting new solutions and approaches –uniform information governance models and quick route of access to sound out ideas,
- improve commissioning through new care and funding models – improve understanding of data, payment systems, pilot new person centred tariffs
- deliver by building on our existing successes –promoting good local practice across the system, shaping organisational design and communicating our vision to the people of Leeds and how we will improve quality of care.

1. *Patients' ability to access GP services, including their ability to switch practices.*

1.1. *Our local experience is that access to primary care is good. Results from the 2012/13 patient survey show that 92% of patients found the convenience of the appointment they were given very or fairly convenient, 94% were able to get an appointment when they wanted and 79% found it very or fairly easy to get through on the phone.*

1.2. *Across Leeds practices offer a combination of same day, open access and pre-bookable appointments. They also offer telephone appointments for those patients where it is appropriate and convenient.*

1.3. *There is inevitably a balance between quick access to primary care and the ability to see a named practitioner. However patients can exercise choice of a same day appointment with any practitioner for an urgent or acute problem against a routine appointment in a few days with a practitioner of their choice for a long term condition. There is evidence that patients with long term conditions value continuity of care. In the 2012/13 patient survey 49% of Leeds North patients have a preferred GP. This continuity of care is a strength of the current primary care model.*

1.4. *83% of Leeds North CCG practices offer extended hours in primary care to improve patients' ability to access GP services.*

1.5. *Leeds CCGs are undertaking a city wide review of urgent care service provision to include urgent services in primary care both in and out of hours. We are working with the area team who commission primary care so that there is co-ordination of service provision for patients. However there can be conflicts when different parts of the service are commissioned by different organisations.*

1.6. *Currently patients can change practices if they wish. However locally we see little demand for change, patients tell us that they value continuity of care. In the July – March 2012/13 patient survey only 9% of patients went to A&E or a walk in centre when they could not get a convenient appointment at the practice.*

1.7. *As commissioners, we see continuity of care as a vital part of general practice. It leads to better outcomes for patients and is essential if we are to help patients with long term conditions manage their health.*

1.8. *This is confirmed by the Kings Fund 2010 research paper "Continuity of care and the patient experience" which concludes that "the balance of evidence is that relationship*

continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes.”

- 1.9. *The Kings Fund paper recommends ensuring a better understanding of the importance of continuity of care and the need to prioritise or incentivise continuity of care alongside other developments in health care.*
2. *The ability for new or existing providers of GP services to develop the scope of the NHS services they offer, including in new locations*
 - 2.1. The main barrier to developing the scope of primary care is lack of investment in primary care. As a CCG we plan to shift care from secondary care to the community and primary care where this is safe and in patients' best interests. There are barriers to identifying costs of services and moving the funding.
 - 2.2. There is a lack of flexibility to move money around the system, particularly between health organisations and between health and the local authority.
 - 2.3. The degree of assurance required around spending relatively small amounts of money in new ways can stifle innovation. In any innovation some things will not work but the system is very risk averse and makes tolerating failure difficult.
 - 2.4. LNCCG are working with their member practices to look at what is needed within their localities, and look at how we can facilitate practices working together. Although CCG's are not responsible for contracting primary care, we are aware that need to work with NHS England to help develop a primary care strategy.
 - 2.5. However there are examples where this has worked well. In Leeds we have developed integrated health and social care teams, enhanced care for nursing home patients, dermatology, MSK, ENT and ophthalmology services closer to the patient's home. These have been successfully developed around existing services utilising and developing the existing workforce expertise and infrastructure.
 - 2.6. As more care moves closer to the patient's home, the blurring between secondary and primary care will be greater and the fact that these are commissioned separately will act as a barrier.
 - 2.7. Currently there are mechanisms through enhanced services for CCGs to commission work from primary care providers but this only allows for small scale changes. More fundamental change is needed if we are to meet the financial challenges of the future while maintaining safe, high quality services for patients.
 - 2.8. It is important to maintain integration of services so that education and training of the future NHS workforce is co-ordinated and of high quality, protecting the NHS of the future and ensuring the workforce is fit for purpose. Fragmentation of NHS services across many different providers will act as a barrier to this.
 - 2.9. As a CCG we want to develop primary care and expand its role in patient care, promoting self care for patients, signposting patients to appropriate secondary care and helping them make informed choices, but we do not have control of all the contracting levers to do this. The rhetoric from the NHS has been that the money follows the patient but this is still very difficult to achieve.

3. *New models of primary care that local health communities are planning or considering and the potential barriers to these being implemented*

- 3.1. We are conducting a review of primary care locally, engaging with our practices to discuss future models of primary care. We recognise that if we are to meet the challenges of providing high quality seamless care to our patients within current financial constraints we cannot just reform secondary care but need to review the whole system. It will examine ways practices can work more closely together to share services and develop new services. Currently this is a challenge for practices due to the complex procurement processes.
- 3.2. Leeds is undertaking a city wide review of urgent care service provision to include urgent services in primary care both in and out of hours. We are working with the area team who commission primary care so that there is co-ordination of service provision for patients. However there can be conflicts when different parts of the service are commissioned by different organisations.
- 3.3. We are building integrated health and social care teams to improve the experience of care for patients and introduce more efficient ways of working. This has required a lot of different agencies to change their ways of working and has been hampered by different pay and contracting mechanisms across different providers. We want to build on these integrated teams which serve a neighbourhood population to include other services such as mental health and the voluntary sector.
- 3.4. There are risks to fragmenting the health service with many different providers, which can give an illusion of choice but in fact restrict access to good quality safe care, to integrated services and make navigating the health service difficult for patients.

Yours sincerely



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Leeds North CCG

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Leeds South and East Clinical Commissioning Group

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18th July 2013

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Monitor's call for evidence on general practice services in England.

Monitor is to examine the commissioning and provision of GP services in England to see if there are barriers preventing patients from securing access to the best possible care.

In particular, requesting views on:-

- 1. Patients' ability to access GP services, including their ability to switch practices*
- 2. The ability for new or existing providers of GP services to develop the scope of the NHS services they offer, including in new locations*
- 3. New models of primary care that local health communities are planning or considering and the potential barriers to these being implemented*

Leeds South and East CCG's Response to Monitor

Leeds South and East Clinical Commissioning Group (CCG) are a membership organisation consisting of primary care providers and have a responsibility for commissioning secondary and community health care services for our population.

GPs not only deliver frontline services to patients, but also have an important role in referring those who need more specialist care, helping people to make informed choices about their health care. General practice therefore has a significant impact on the wider health sector.

We are not currently responsible for commissioning primary care.

We have responsibility with the area team of NHS England for quality in primary care.

Our 2013/14 commissioning strategy was developed in consultation with and gained the support of our population and our member practices.

Our strategy demonstrates that in order to commission the best possible care for our patients with the best use of public money there has to be a shift of care from hospital into community and primary care. There also has to be more integrated working across primary and secondary care and across health and social care.

The city of Leeds is a national leader in joint working across all sectors. We are building integrated health and social care teams to improve the experience of care for patients and introduce more efficient ways of working.

1. *Patients' ability to access GP services, including their ability to switch practices.*

- 1.1. Our local experience is that access to primary care is good. Results from the 2012/13 patient survey show that 92% of patients found the convenience of the appointment they were given very or fairly convenient, 83% were able to get an appointment when they wanted and 73% found it very or fairly easy to get through on the phone.
- 1.2. Across Leeds practices offer a combination of same day, open access and pre-bookable appointments. They also offer telephone appointments for those patients where it is appropriate and convenient.
- 1.3. There is inevitably a balance between quick access to primary care and the ability to see a named practitioner. However patients can exercise choice of a same day appointment with any practitioner for an urgent or acute problem against a routine appointment in a few days with a practitioner of their choice for a long term condition. There is evidence that patients with long term conditions value continuity of care. In the 2012/13 patient survey 43% of Leeds South and East patients have a preferred GP. This continuity of care is a strength of the current primary care model.
- 1.4. 30 out of 43 practices in Leeds South and East offer extended hours in primary care to improve patients' ability to access GP services.
- 1.5. Leeds CCGs are undertaking a city wide review of urgent care service provision to include urgent services in primary care both in and out of hours. We are working with the area team who commission primary care so that there is co-ordination of service provision for patients. However there can be conflicts when different parts of the service are commissioned by different organisations.
- 1.6. Currently patients can change practices if they wish. However locally we see little demand for change, patients tell us that they value continuity of care. In the 2012/13 patient survey only 6% of patients went to A&E or a walk in centre when they could not get a convenient appointment at the practice.
- 1.7. As commissioners, we see continuity of care as a vital part of general practice. It leads to better outcomes for patients and is essential if we are to help patients with long term conditions manage their health.
- 1.8. This is confirmed by the Kings Fund 2010 research paper "Continuity of care and the patient experience" which concludes that "the balance of evidence is that relationship continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes."
- 1.9. The Kings Fund paper recommends ensuring a better understanding of the importance of continuity of care and the need to prioritise or incentivise continuity of care alongside other developments in health care.

2. *The ability for new or existing providers of GP services to develop the scope of the NHS services they offer, including in new locations*

- 2.1. The main barrier to developing the scope of primary care is lack of investment in primary care. As a CCG we plan to shift care from secondary care to the community and primary care where this is safe and in patients' best interests. There are barriers to identifying costs of services and moving the funding.
- 2.2. There is a lack of flexibility to move money around the system, particularly between health organisations and between health and the local authority.
- 2.3. The degree of assurance required around spending relatively small amounts of money in new ways can stifle innovation. In any innovation some things will not work but the system is very risk averse and makes tolerating failure difficult.
- 2.4. However there are examples where this has worked well. In Leeds we have developed integrated health and social care teams, enhanced care for nursing home patients, dermatology, ENT and ophthalmology services closer to the patient's home. These have been successfully developed around existing services utilising and developing the existing workforce expertise and infrastructure.
- 2.5. As more care moves closer to the patient's home, the blurring between secondary and primary care will be greater and the fact that these are commissioned separately will act as a barrier.
- 2.6. Currently there are mechanisms through enhanced services for CCGs to commission work from primary care providers but this only allows for small scale changes. More fundamental change is needed if we are to meet the financial challenges of the future while maintaining safe, high quality services for patients.
- 2.7. It is important to maintain integration of services so that education and training of the future NHS workforce is co-ordinated and of high quality, protecting the NHS of the future and ensuring the workforce is fit for purpose. Fragmentation of NHS services across many different providers will act as a barrier to this.
- 2.8. As a CCG we want to develop primary care and expand its role in patient care, promoting self care for patients, signposting patients to appropriate secondary care and helping them make informed choices, but we do not have control of all the contracting levers to do this. The rhetoric from the NHS has been that the money follows the patient but this is still very difficult to achieve.

3. *New models of primary care that local health communities are planning or considering and the potential barriers to these being implemented*

- 3.1. We are conducting a review of primary care locally, engaging with our practices to discuss future models of primary care. We recognise that if we are to meet the challenges of providing high quality seamless care to our patients within current financial constraints we cannot just reform secondary care but need to review the whole system. This work is being done now and will be concluded in the autumn. It will examine ways practices can work more closely together to share services and

develop new services. Currently this is a challenge for practices due to the complex procurement processes.

- 3.2. Leeds is undertaking a city wide review of urgent care service provision to include urgent services in primary care both in and out of hours. We are working with the area team who commission primary care so that there is co-ordination of service provision for patients. However there can be conflicts when different parts of the service are commissioned by different organisations.
- 3.3. We are building integrated health and social care teams to improve the experience of care for patients and introduce more efficient ways of working. This has required a lot of different agencies to change their ways of working and has been hampered by different pay and contracting mechanisms across different providers. We want to build on these integrated teams which serve a neighbourhood population to include other services such as mental health and the voluntary sector.
- 3.4. There are risks to fragmenting the health service with many different providers, which can give an illusion of choice but in fact restrict access to good quality safe care, to integrated services and make navigating the health service difficult for patients.

Dr Jackie Campbell
Director of Clinical Engagement
On behalf of Leeds South and East Clinical Commissioning Group

NHS Clinical Commissioners Connect Senior Policy Manager, Julie Das office@nhsc.org

NHS Northern, Eastern and Western Devon Clinical Commissioning Group

Please find below the response from NHS NEW Devon Clinical Commissioning Group to Monitor's review of general practice.

NHS Devon CCG welcomes the opportunity to contribute views on the vital role of general practice in the overall system of healthcare. The contribution below is brief and based on a collection of views of senior leaders within the CCG.

Patients' ability to access GP services, including their ability to switch practices

Patients' ability to access GP service is generally good but not without exception. We believe this to be true from historic patient surveys (e.g. the General Practice Patient Survey) and the fact that few complaints have been received on this. GP practices are most definitely operating with little, if any, spare capacity. Some practices have invested significant time and resource in completely reviewing and revising the way that patients can access care and advice, for example the 'Patient Access' system which is associated with significantly reduced ED attendance. Other practices have moved to, for example, increasing the availability of access to clinicians by telephone and email. Locally we are asking GP practices to review why their patients who visited the Emergency Department with presentations that were suitable for the primary care environment did so, asking whether any issues of access to primary care services played a part in any, with hindsight, unnecessary ED visits. Practices are still heard to quote, "We only have 10 minutes per patient" or words to that effect – this is an example of current features of primary care which could be affecting the wider healthcare system, as well as a cause of some dissatisfaction for some patients. The upside is that general practice is a very efficient and valuable resource.

A review of access would be welcomed but it should not be considered in anything but a sensitive and comprehensive fashion. It might be productive to examine in closer detail:

- how perceived and real access varies between various population cohorts (further to the insight into this that the GP Practice Survey gave us – though with minority groups being underrepresented). This could focus particularly on the vulnerable, those living further away from their general practice, children, those with communication difficulties of varying sorts and so on – and how new technologies or systems might improve access particularly for those in particular need.
- how practices assure themselves that they are meeting all reasonable demand and need of their populations in line with (and over and above) their contractual responsibilities – and how NHS England intends doing this.
- what the future looks like if the current status quo is maintained (e.g. with a particular factors such as workforce (locally around 50% of practice nurses are aged

50 or over with limited training and career planning available), premises (a very mixed bag), patient expectations and inequalities in health).

- what effect requiring practices to be open for more than their currently contracted hours would have on all stakeholders.

- how the current squeeze on resources versus costs of providing care is affecting access for patients being cognisant of the contractual requirements on GP practices ("meeting the reasonable needs") and the cause, effect and associated impact into the future of potential further disinvestment (relatively or really speaking) into primary care proportionate to the role that we need primary care to fulfill.

This is of course a complex matter with many factors seeming simple at first glance but usually much more complex when considering the varying needs, contexts and system effects. It might be that in order to improve access even further, practices could focus on different models of care rather than any suggestion that they need to spread their already very limited and stretched resources even further.

Locally, choice of GP practice is very good in urban areas but very much more limited in rural areas. Whether patients' ability to switch practices is good or not is largely unknown although we know there is some movement of patients between practices. Any benefit of moving to a different practice through choice must be balanced with the benefits of continuity of care. Transfer of notes (electronically and in paper form) from one practice to another must be made more efficient in order to protect clinical governance of care. Most if not all practice lists are currently open to new registrations locally. Anecdotally the frequency of practices considering their need to close their lists is perhaps more frequent than it used to be, with workforce difficulties often the underpinning reason for a practice asking to close.

In Devon the biggest issue is our population structure and it is vital that we stress that whilst it is a privilege to look after so many people who are elderly frail the complexity of this group are insufficiently resourced resulting in increasing difficulties in providing them with the time they need in primary care which is part of "access".

The ability for new or existing providers of GP services to develop the scope of the NHS services they offer, including in new locations

The difficulties of releasing funding from larger providers e.g. acute trusts is probably the most prevalent factor in providers and commissioners' minds when asked about shifting resources, particularly in these times of very little new investment being available. Locally, we intend proactively encouraging further potential shifts in workforce rather than funding, for example moving secondary care consultants into the primary care team for regular patient facing sessions and to increase skills and expertise in general practice in prioritised clinical areas.

Other very real limiting factors include premises and workforce. It is arguably not clear who now holds responsibility and resource for proactively assuring GP practice

premises are fit for purpose in order to host an increased range of services (albeit that a move to extending, properly, the opening hours of practices should and could occur without any particular premises resourcing issue). It may well be the case that the larger, corporate providers of general practice are much more able to invest in larger, new premises. The impact of this should be investigated.

That said, most GP practices are very willing to expand the scope of their services and they respond swiftly to do so. In order to improve continuity of care, limit the number of handoffs in care which do lead to breakdown in communication and make care as accessible as possible, expanding the primary care offer may become a priority.

New models of primary care that local health communities are planning or considering and the potential barriers to these being implemented

We have an example locally of an area in need of better access to primary medical services. We are in the early stages of currently informal discussions with NHS England about developing and trying a new way of providing access to primary medical services, potentially through a community pharmacy. It is a little too early to say precisely what the barriers are but funding in order to fast-track this is likely to be one.

We are also scoping the potential system-effects of creating much larger than currently average GP practices. This may have such far-reaching system-wide benefits that we deem such moves would be worth some kind of initial investment from the CCG.

We trust these views will be useful.



WELC
Care Collaborative

Response to Monitor Call for Evidence on General Practice Services

WELC Care Collaborative: Evidence to Monitor on General Practice Services as Part of an Integrated Care Program

Introduction

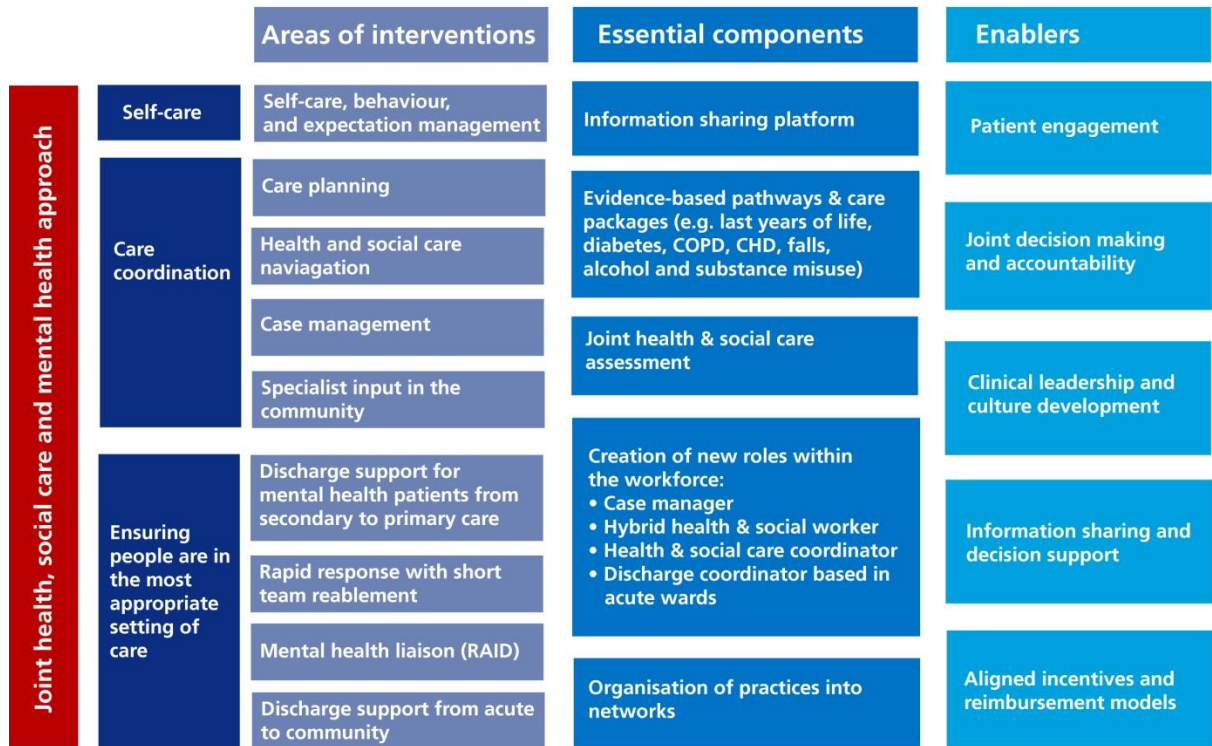
WELC or Waltham Forest East London and City comprise the boroughs of Newham, Tower Hamlets and Waltham Forest which are some of the most deprived in London. Health and local government partners in these boroughs have come together to form a collaborative and build a model of integrated care that looks at the whole person.

The details of how we deliver integrated care in each of the boroughs are evolving but the programme partners have agreed a common set of principles:

- Systematic, regular risk stratification of the whole population to support case finding for those most at risk of hospitalisation.
- Care that is centred on an individual's needs to enable individuals to live independently and remain socially active.
- Care that is evidence based and cost-effective.
- Preventing admission to hospital wherever possible by supporting care at home or in the community.
- Avoiding duplicated effort in situations where a patient has many people involved in their care.
- Actively developing local providers and supporting collaboration in the way we contract.
- Evaluating what we do as we do it and revising our approach as we learn about what we are achieving.
- Learning from each other, learning from national and international integration programmes and sharing our learning outside the programme.

We have adapted international best practice and evidence to WELC demographics to develop the model of care. The result is a suite of standard interventions that broadly cover supported discharge, care planning and coordination, and mental health liaison and Rapid, Assessment, Interface and Discharge (RAID). These interventions will be supported by system changes like routine information sharing and primary care networks, and enablers like patient systematic engagement, clinical leadership and IT.

WELC will provide nine key interventions for its population underpinned by five components and enablers



The contracting model for integrated care services is being developed in a dedicated reimbursement working group. The group has agreed a road map towards an eventual capitation model in 2016/17 with an interim integrated 'fee-for-service' model in 2014/15. The interim model will promote integration of services by CCGs contracting with a 'provider consortia' for all the interventions. The programme is very aware that bringing together provider consortiums to respond to an integrated care specification will pose significant challenges and will require specific provider organisational development.

Integrated Care and General Practice

GPs will be a major provider of integrated care services in the WELC model. All 3 of the boroughs have plans to develop or enhance existing network or consortia of GPs in order to underpin the care co-ordination services. We are working with local GPs to commission risk stratification and case management based on outcomes rather than process.

Developing GPs into networks of providers requires a significant amount of investment in terms of provider development; encouraging practice to think outside their own business, share information with neighbouring practices, manage joint finances, share staff and performance manage each other to achieve shared outcomes. It is challenging to find flexibility within existing GP contract arrangements to support this way of working. The aPMS vehicle has been used locally to cover services across a whole borough.

Where these GP networks have been maturing for a number of years it may be possible to use them as a basis on which to build a wider provider collaborative. This will involve as a minimum

community health services (CHS) and specialist input from the acute trust. Providers, in the first year, will contribute to care co-ordination through the GP network as part of their own NHS standard contract obligations. It is likely that these voluntary structures will need a “lead” provider who owns and manages the integration of all other providers who contribute in order to achieve the principles outlined above. We are unsure yet whether one provider will emerge as the lead for all the services or whether the lead for “integration” will be different between care co-ordination, mental health services and acute discharge support. Providers will be expected to develop ways to performance manage each other under these arrangements in order to achieve shared improved outcomes for patients.

The WELC Integrated Care programme has a provider development workstream and local providers have been meeting together regularly to discuss their response to integrated care locally. The group have identified that there are conflicts of interest which have to be resolved, particularly when GPs are taking part. A clear division is needed between CCG board member GPs and those who support provider development in order to help manage this.

Contributing to service provision in a larger and diverse group of providers is a much bigger challenge for GPs than they currently experience in their own networks. We are exploring how to support them to do this collectively in order to influence the larger acute and mental health providers. It is a huge challenge to ask a small group of GPs to represent agree implement and manage local strategy with providers on behalf of all GPs ironing out existing variability in independent clinical practice. The programme will rely on local provider ability and willingness to work together very closely and take responsibility for the performance of theirs and of others services where care is transferred across the interface.

A small proportion of the services provided as part of Integrated Care will be considered GP core duties under their GMS contract (achievement of QoF points for long term conditions is an example). Integrated care services that are in addition to core GMS will need to be adopted uniformly and considered a “core” part of local services by GPs in order for the programme to be successful. The job of integrating care for CCGs is harder than it was for PCTs who were the contract holders for all parties. CCGs will have to make use of a combination of limited contract leavers and a local role in improving the quality of primary care.

Information sharing is a particular challenge both technically and in terms of information governance (IG). The GP record is usually the most complete and up to date of the electronic records available. Linking other providers data to the GP record for risk stratification and to follow patients across a whole pathway is critical to the success of the Integrated Care program. We find that this is relatively straightforward in IG terms for clinical information sharing. However, for GPs and other providers to use identifiable linked patient data so they are able to track internally individual patient costs and activity in the target group is virtually impossible given the current IG restrictions. This position needs to change quickly in order to support engagement and planning for local GPs and all other providers in the programme.

Where a provider other than general practice takes the lead as an “integrator” their interaction will be limited to the patients they see (not a registered population) which means they are still dependent on the GP for risk stratification and referral into their service.

Intuitively it makes sense for the GP practice to be the lead “integrator” for care-co-ordination services. Their list will form the basis of case finding (using risk stratification techniques), except in an emergency they are usually the first port of call and the gatekeeper for healthcare and patients generally expect the GP to be able to navigate the healthcare system on their behalf. In the WELC model this could also make them accountable for achievement of shared outcomes and subsequent payment to participating services. It will require dedicated management and GP time, recruitment of additional staff and redirection of practice resources. There are clinical quality and safety challenges for practices around 24/7 care integration as a lead provider. All of this will require local GPs to think radically differently about how their services are organised locally if they are to become an integration lead. Without repositioning it could prove too big a financial risk for individual practices or even practice networks within their existing contractual arrangements. This will be complicated further by the fact that local CCGs do not manage general practice contracts and have limited flexibility to change that structure.

[X] Clinical Commissioning Group

These are just some brief comments;

Patients still perceive they will be discriminated against if they change practice. This isn't true. I believe most patients choose their nearest GP surgery.

There is a tension on access to primary care in that every time more supply is offered demand builds up until there is a tension in the system which then chokes the demand. Apart from the aging population the rest aren't getting any sicker. The solution is not obvious but telling the public that they can see their GP anytime is raising unreasonable expectations. The tax payer cannot afford that number of contacts with GPs/Practice nurses – hence 111 service etc

There is a significant cost to the NHS if there is over supply and I suspect that this will be true for new general practices. The current impression is that to provide a good service you should also be of a reasonable size. In a cash strapped economy, despite government rhetoric you do not have the luxury of choice.

Allowing new players into the market or to take over failing Practices should be done by having a Practice contract that demands good outcomes and has a review date that allows the NHS to cease buying the service from a poor provider.

Estates issues make expansion of successful practices or creation of new practices difficult and I do not think the new system has any idea how to tackle this especially in places like central London. Planners don't usually help either.

The current array of GP provider contracts makes it very difficult to manage GPs. To ask a GP who is being given half of what his/her neighbour is being given to do the same job is manifestly unfair and unachievable without reducing "take home pay"

(Conflict of interest with GPs and CCGs)

As the practice holds the patient record, at the moment, it would seem to serve the patient well if those items that are best supplied by seeing the patient in the round are supplied by general practice – anticoagulation is a good example where you have the patient in front of you, the result obtained from a finger prick and the medical records with a prescription all in a face to face setting. It can be done in a separate clinic but it is less safe. I believe that services that are "entire patient record sensitive" and/or require "continuity of care from a small team" should be commissioned from general practice.

Expanding the service that Practices offer is dependent on knowing that the income stream is for longer than 1 year as you cannot employ staff etc. Often with primary care the concept of a profit margin seems to be a dirty word.

A capitated budget that include social/community and primary care would be helpful. I am not quite so sure about it including care that can only be provided from hospital

overnight bed. Should this care be led by social or medical? I think that as the medical is likely to be the key driver of costs the service would be better left in the health system.

[X] Medical Director of a Clinical Commissioning Group

I am a Medical Director at [X] CCG and write to express personal views in note form. They do not necessarily reflect the views of CCG members.

MONITOR CALL FOR EVIDENCE ON PRIMARY CARE

Ability for new or existing providers to expand the scope of NHS services they offer particularly the factors that may influence CCGs or LA in deciding whether to commission services from GPs?

Pros of commissioning services from GPs

Should not increase fragmentation of care and should continue to ensure a holistic approach

List base of traditional practices may give the ability to get better metrics on need, uptake and outcomes

Practices ideally placed to be co ordinations or navigators of care

Known quantity (could work either way)

Cons of commissioning services from GPs

Perceived conflict of interest

CCGs need GPs to form homogenous groups to be able to demonstrate attainment of core standards in terms quality assurance, training on safeguarding etc.

Would want uniform coverage for population and unlikely to get full uptake from GPs and/ agreement on other practices taking on the work for reluctant practices, and those reluctant practices sharing patient information

GPs lack of capability to engage in detailed and costly tender process

Workforce issues in primary care- ageing workforce, barely coping with current work load.

Poor recruitment currently and changing demography presents a change to current model, which could be an opportunity, but few recognise this almost universal resistance to more change.

Lack of credible education and training resources available to skill up the workforce required

Any new forms of primary care or integrated care that local health communities are planning and any potential enablers or barriers that should be considered?

New forms of primary care

1. Primary care focused (and possibly provided). Urgent care service to replace OOH's current services, but would be 24/7. This would enable rapid assessment of urgent cases and hopefully lead to less people reverting to A and E as a default because of perceived lack of reactivity during office hours.
2. The urgent care would provide an in hours visiting service amongst other things, and would link into community based emergency multidisciplinary units. This system [X] focuses on holistic approaches to the multi morbid presentations frequently associated with frail older people who are currently admitted to the acute sector sometimes inappropriately. We anticipate the need for the development of interface medicine clinicians, who would be an amalgam of specialist generalists, and more general specialist in predominantly medicine for the elderly. If this models has a positive evaluation, it is likely that it would be replicated across the county, with a knock on effect on primary care
3. Primary care "practice" as front door of A&E. There is a mismatch between how primary care services are provided and how an increasing proportion of people wish to access it. For on-going issues and "cold" problems, most people, but not all, would seem to want to visit the GP with whom they have built up a trusting relationship. Alternatively, for acute issues, those people who are time constrained wish to see a doctor, but don't really mind if they have not met them before.

A significant number of these people arrive at A&E inappropriately. Others include visitors who do haven't registered with a GP, those who want a quick second opinion, those who are unable to attend in hours appointments, and those who lead chaotic lives.

The differing approaches to risk exhibited by primary and secondary care clinicians are widely recognised. An appealing approach to reduction in A&E attendances would be to have primary care units physically attached to the front door of A&E departments, and for primary care clinicians to triage all people wishing to attend A&E, even those brought by ambulance.

This is not a new approach, and this has been variably implemented across the country with varying success. It would be important for the primary care units to be independently commissioned separately from the acute trust to which they are attached.

In order to be successful, they need to be staffed by senior staff who are confident in making decisions in complex situations. In this way it is hoped to reach a consistent replicable, sustainable and high quality model of primary care.

4. Personally, given the changing aspirations and demographic of the workforce, I would question the sustainability of the traditional independent contractor status of General Practices.

Younger GPs tend to be more mobile, have a healthier attitude to work life balance, and have a subsequent reluctance to commit to buying into an equity share of a practice. The role of practice managers is becoming more sophisticated and more professional. There is a similar age profile of community nurses to GPs (28% of GPs are over 55) and this is likely to lead to a staffing crisis.

Recent reports from the Kings Fund and RCGP indicate that the optimum size of practice population is likely to be 20-30k population. It seems likely that the more traditional, equity partnership is replaced by larger practices with salaried GPs with either a GP director or practice manager running the business.

In my area we have little experience of alternative providers of primary care. We have one practice run by [X], which had a wobbly start, but now seem to be at least holding their own amongst their peers.

Our county's Darzi centre is run by a company formed by GP shareholders who co-promise approximately 60% of the county's practices.

5. [X]CCG is working towards outcome based commissioning in the areas of Maternity, Mental Health and Older People. It is anticipated that there will be a lead provider in all these areas, and that they will co-ordinate work by themselves and other providers, including GPs, involved in the care of these groups.

It is most likely that care for these patients in the community will be above and beyond what is currently thought to be within the core GP contract (though this can never be defined). [X]CCG is likely to need to be at the forefront in trying to forge a way ahead, which is fair, and transparent.

In order to achieve any of these models we need to have:

- A credible workforce plan for primary and community care
- A sustainable, simple and fair method of incentivisation and remuneration for those involved
- A realistic, evidence-based, user-friendly approach to education and training which is consistent and integrated across the county and between providers. This would also need to take into account cross-border issues
- A simplified non-bureaucratic approach to tendering for services.
- An integrated interoperable IT system which allows secure, real time accurate data flows and communication.



Making the health sector
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