

# NHS Next Stage Review

*Our vision for primary and community care:  
What it means for GPs and practice staff.*

## Key Points

"We are delighted that the document reaffirms the central role of the General Practitioner and primary care team."

*Professor Steve Field, Chairman,  
Royal College of General Practitioners*

- > Our overarching purpose is achieving and rewarding ever improving quality of care
- > New opportunities for GPs to have a more prominent role in leading the service design by reinvigorating **practice based commissioning**, making sure that PBC groups are entitled to the necessary information and resources
- > Allowing innovative clinicians to test new ways to achieve better care and better health outcomes by **piloting integrated collaborations** across primary, community and secondary care
- > **Better rewards** for GPs who provide responsive, accessible and high quality services, and attract more patients, making it **easier for patients to choose their GP practice**, and developing a fairer funding system for GP practices
- > Embedding a patient-centred approach, by ensuring the 15 million people with long-term conditions have been offered **personalised care plans** by 2010, benefitting both patients and practices alike
- > Asking NICE to work with professional and patient groups in overseeing an independent and transparent process for developing and **reviewing the QOF indicators**, and discussing with the BMA and others how to refocus QOF more on health promotion, clinical quality and health outcomes
- > Working with the Royal College of General Practitioners to develop a voluntary **accreditation** system for GP practices, to be rolled out by 2010, and working with the new Care Quality Commission on a **registration process** to ensure that local services meet national minimum requirements for safety and quality
- > More **responsive** services, driven by an expanded GP patient survey that will measure the aspects of care that patients value the most from their GPs and rewards for GPs that become more responsive

# How we developed our ideas

Our vision for primary and community care has been developed through intensive debate and discussion with GPs, patients and the public as well as other primary care clinicians, under the guidance of an advisory board drawn from leading primary care and community clinicians and national stakeholder groups.

We found considerable agreement about the key characteristics of high-quality primary and community care services – services that treat people fairly, delivered by staff with the power to improve care and make decisions locally.

“There has not been a better time to be in primary care and operate across organisational boundaries for over 10 years.”  
*Dr James Kingsland, GP and senior partner, St Hilary Brow Group Practice, Wallasey and Chair of the National Association of Primary Care*

## Building on solid foundations

General practice is the lynchpin of a high-performing health service. We need to build on the strengths of our current system, whilst reducing variations in quality of care, ensuring services are better connected, and preparing for the challenges of the next 10 years.

Strengths	Challenges
Personal continuity of care, strong ties to local communities and a population focus for promoting health	Services that could be more connected, with more involvement for individuals in their health and care
Professional ethos and high levels of patient trust	An ageing population and increasing prevalence of lifestyle diseases
QOF has led to improvements in quality of care, particularly for those with long-term conditions	Unwarranted variations in quality of care, with scope for more focus on health and treatment outcomes
Progress with partnership working, across primary, community, secondary and social care	Clinical leaders to be liberated to design services for the benefit of their patients, and then held to account

# Our vision for primary and community care

Primary care services should be shaped around individuals and listen to and respond to their needs. The system should feel connected and work for them. They should have convenient access to a growing range of health services in GP surgeries, in a range of other community settings and in their own homes. They can make more choices, including choosing their GP practice. People can take greater control over how they manage their care, particularly those with long-term conditions.

Primary and community care services play a central role in helping people live healthy lives. Health promotion is embedded in the millions of daily contacts with family doctors, community nurses, pharmacists and other community-based staff. We can do more to promote health at all stages of life and more systematically identify and support those individuals most at risk of ill-health. There should be increasing access to services that help people maintain and improve their health and wellbeing. Primary and community clinicians can enhance their role in promoting equality of opportunity and equality of health outcomes.

"The strategy sets out our vision for a continuously improving service, where essential services are guaranteed and excellence is rewarded."

*David Colin-Thomé, National Clinical Director for Primary Care*

Around the country, there are countless examples of excellent, high-quality services and innovative practice making a huge difference to the lives of their patients, delivered with compassion and respect by dedicated staff. The challenge for all of us is to make these examples the norm.

We see greater clinical freedom and stronger commissioning as two sides of the same coin. The best commissioners will be those who create an environment in which clinical leadership and innovation flourish, in which health professionals can work more collaboratively across traditional boundaries to provide more integrated care, and in which there is a reorientation of commissioning intentions towards health and well-being, preventing the onset of long-term conditions.

## More detail on the key areas

### Practice based commissioning

(from paragraph 8.9)\*

PBC puts clinical engagement at the heart of PCT commissioning and strategic planning, allowing groups of GPs and community clinicians to transform services for their local communities. PBC is central to our ambition for health improvement and high-quality care, but we need to strengthen and reinvigorate it. To do this, PCTs will be held to account for the quality of information and management support for PBC groups and will provide management allowances for PBC groups. Successful PBC groups will benefit from increased earned autonomy – as groups mature, with more multi-professional engagement and a greater focus on upstream interventions they will be entitled to increased freedom in managing resources and designing services.

### Integrated care (from paragraph 8.14)\*

We will test and evaluate new ways in which PCTs can commission more integrated care from innovative groups of clinicians, across primary, community and secondary care. Studies have shown integrated delivery systems can increase the focus on the prevention and treatment of long-term conditions, realising the expected benefits of coherence across care pathways and aligned incentives across professions. We will invite proposals for pilots that involve clinicians working on a collaborative basis to achieve more personal, responsive care and better health outcomes for a local population (based on the registered patient lists for groups of GP practices).

These pilots will test a range of approaches including working with local government and testing ways of PCTs commissioning 'integrated care organisations' – multi-professional groups based around groups of GP practices – to manage the health care resources for their local populations.

"The advent of integrated care organisations will be seen as a ground-breaking initiative that can enable specialists and generalists to work together to deliver clinical excellence."

*Professor Mayur Lakhani, GP from Leicestershire and Medical Director, NHS East Midlands*

### Choice (from paragraph 5.14)\*

People can already choose which GP practice to register with, but this is sometimes difficult for patients because of a lack of practices in some deprived areas, closed lists, narrow practice boundaries and a lack of information. We will make it easier for patients to make an informed choice, because we believe this will lead to higher quality services. We will continue to develop the NHS Choices website so that it includes more comparative information and a simpler way of registering electronically with a GP practice.

### Fairer funding (paragraph 5.17)\*

To deliver more responsive, high-quality services by expanding patient choice means developing

\* References in brackets are to the main document

fairer rewards for practices that attract more patients. We will work with GP representatives to remove the historic income guarantee (MPIG) which perpetuates inequities in funding. Instead, we want resources to be channelled into fair payments based on the numbers of patients registered with each practice, their level of need and quality of care.

## Care plans

Care planning helps ensure that people with more complex and long-term care needs receive the best, most appropriately tailored packages of care to meet their individual requirements and wishes. This involves individuals working with carers and with professionals such as GPs and nurses, linked to social care teams to agree what their goals are, which services they choose to receive and how and where they want to access them. Evidence from existing work demonstrates the benefits to patients and practices alike.

By 2010 all people (of all ages) with a long-term condition, including people with mental health problems, should be offered their own personalised care plan. Over the next year, we will be supporting the NHS and social care in delivering this commitment.

## Quality & Outcomes Framework (paragraph 7.13)\*

We will work with professional and patient groups to develop a fresh strategy for developing the QOF. This will include working with stakeholders and with NICE to create an independent and transparent process for

developing and reviewing indicators. We will also discuss with the profession how to reduce the number of organisational or process indicators so that we can focus resources on new or enhanced indicators to promote health and greater clinical quality. And as GPs are best placed to understand the priority needs of their population, we will explore how to give greater flexibility to the local NHS to work with local GP practices to select quality indicators (potentially from a national menu) that reflect local health improvement priorities. Finally, we will explore the use of patient reported outcome measures (PROMs) to enhance overall indicators of quality.

## Regulation & accreditation (from paragraph 7.19)\*

We are promoting the use of accreditation schemes to drive quality improvement. We are currently supporting the Royal College of General Practitioners to develop a voluntary accreditation scheme for GP practices, which will be rolled out nationally by 2010. This scheme will involve a rigorous assessment of the systems used by GP practices to ensure safety and quality of practice. As well as assessing compliance with minimum criteria, it will pinpoint areas where practices have most scope to improve quality, thus acting as a spur for continuous improvements.

We have recently consulted on proposals<sup>1</sup> that the new health and social care regulator, the Care Quality Commission, should in time regulate safety and quality for all GP and dental practices. This would mean that, for the first time, any organisation providing primary

\* References in brackets are to the main document

<sup>1</sup> The future regulation of health and adult social care in England: a consultation on the framework for the registration of health and adult social care providers. Department of Health, 25 March 2008

medical or dental care will be subject to a consistent set of minimum quality standards. The approach must be light-touch, risk-based and proportionate. The Care Quality Commission will work with a broad range of stakeholders to determine where best to deploy its regulatory focus. In doing so, the Commission will want to take account of professionally-led accreditation schemes and work closely with the professional regulatory bodies that are responsible for ensuring that individual practitioners (such as GPs, dentists and nurses) are fit to practise.

### **More responsive services**

(from paragraph 5.1)\*

The national GP patient survey last year asked five million people about access to their GP practice – and gave everyone the opportunity to compare how their local GP practice scores on indicators of patient satisfaction with any other practice in the country. But access targets are only part of the picture, and so from 2009, the survey will ask a much broader range of questions about the quality of services.

#### **Federated GP practices in Lambeth and Southwark**

*“We are able to offer more to our patients and be confident that our colleagues across each of the practices know the patient's specific requirements.”*

*Dr Clare Gerada, The Hurley Group, London*

Patients with specific needs in some of London's more disadvantaged communities were finding it hard to get access to specialist GP services in their area and were being referred instead to hospitals for treatment.

In response, five GP practices across Southwark and Lambeth joined together in a new kind of partnership or “federation”. The individual practices retain their independence and patients register at a single GP practice in the usual way. However, patients across the five practices now have much easier access to a range of local services, brought about by the five practices pooling resources and expertise.

The federation provides a broad range of specialist services, including a musculoskeletal clinic and gynaecological services, which means patients don't have to go to hospital as often. By using shared services and harmonising back office functions, the federation is also able to invest more in patient care. The doctors, nurses and other practice staff also receive more professional development and have more opportunities to share knowledge and experience with colleagues.

\* References in brackets are to the main document

This will make it easier to see whether, for instance, patients find it simple to make an appointment, whether they have the option of telephone consultations, whether they can expect to be treated by helpful and courteous staff, and whether the GP or practice nurse listens to and understands their problems. This in turn will help recognise and reward those practices that respond best to patients' views. Our aim is to stimulate innovation in service provision and to ensure that practices respond to patient views, including those who find it most difficult to use current services.

### **What we mean by registration and health centres (paragraph 5.18)\***

The system of registration with general practice is central to the future of primary care, as the basis for personalised services, with a stronger focus on prevention. However, a single general practice clearly cannot always be there to provide routine care for everybody all the time (such as parents juggling childcare responsibilities or manual workers who struggle to get time off work). Alongside the personal continuity of care that comes from GP registration, we want people to have flexible access to a range of primary care services.

For this reason, we invested part of our £250 million access fund for the NHS to develop over 150 GP-led health centres that offer walk-in services and bookable appointments from 8am-8pm every day. Patients won't have to register to be seen, meaning they can retain their registration with their 'base' practice. They will provide convenient access to routine GP services for those who are away from home or who

would like access to services when their own practice is not open. The balance of the £250m has gone to providing over 100 new practices in the areas with fewest clinicians, aimed at improving health and care in the most deprived areas.

"This document is a big thumbs up for general practice. The principles and values upon which it is based, such as the registered list, quality and personal care and continuity, are those that matter most to good GPs. Furthermore, it supports and extends our ability to improve the health of our patients and the services available to them. As a charter for renewed and refreshed general practice, the next challenge will be for us GPs to provide innovation and leadership that will enable the strategy to make a real difference for our patients."

*Michael Dixon, GP from Devon and Chair of NHS Alliance*

## **Next steps**

To read the full version of the primary and community care strategy, visit [www.dh.gov.uk](http://www.dh.gov.uk)

PCTs and SHAs will now work together with NHS staff, patient groups and local government, third sector and independent sector partners to develop local strategies for primary and community care that secure improved health and enhanced healthcare. For more information on this local work, please contact your local PCT.

\* References in brackets are to the main document



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