Developing new primary care contracts

Grafton Group members

The Kings Fund

Ideas that change health care

Introduction

There is now broad agreement that to be able to make the changes needed in the wider health system, primary care will also have to change. A nationally negotiated standard contract applied top down no longer seems to be an appropriate method for doing this. Area Teams appear to lack the capacity and in some cases the expertise to actively commission new approaches to primary care. There is a strong argument for CCGs taking an active role in the commissioning of primary care, albeit with safeguards and mechanisms to deal with the potential for conflict of interest. Without this, attempts to create more integrated care will often only be partially successful as the obstacles posed by the GMS contract, while they can be overcome, are significant.

The Grafton Group of CCGs have been meeting to look at the opportunities for redesigning primary care and specifying a new contract to be delivered locally. This paper sets out these ideas – it is intended for discussion and will be amended and adapted in the light of comments from the group. The intention is to provide a briefing document to inform the national debate and for local use in discussion with Area Teams.

The case for change in primary care is well understood and has been rehearsed elsewhere. Briefly there are a number of issues that need to be addressed including:

- Growing demand and expectations
- Increased complexity of patients' conditions
- Growing opportunities for primary care to offer a wider range of services, but with very great time constraints
- Significant variation in standards of care and the level of service offered
- A lack of integration with other health and social care services, in particular an increasing disconnection from community services, mental health and hospital specialists
- A view that the QOF and other aspects of the current contract may be obstructing change.

The rest of this paper is divided into four parts. Firstly, it briefly sets out some of the standards that CCGs would like to see built into contracts. Secondly, it looks at the models that could develop to deliver this. It then considers some of the steps that are required to move this forward. Finally, there is a list of issues which have not been considered here but need further attention.

Standards

There are a large number of existing standards for primary care and general practice produced by several different bodies. There is some work to do to rationalise these in order to avoid the danger of layers of potentially conflicting standards that are not prioritised and create a confusing burden. Group members had some clear views on additional standards they would wish to see commissioned as a priority, to build on existing standards. In a number of cases, providers across an area would be collectively required to meet these standards, rather than each individual practice being required to meet them individually.

The overall aim of the commissioning approach should be to develop primary care which has:

- Improved clinical management with more focus on anticipatory care and systematic case management
- Standardisation and consistency between providers
- Approaches which deploy larger teams including community health services, social care and mental health professionals, who signpost and have access to a range of community and social resources
- Much closer working with secondary care specialists
- More focus on managing population health
- Better access, including extended hours and days of operation, and access to online and telephone consultations and advice

Standards

Access

Urgent appointments should be available seven days a week. However "urgent" is hard to define and difficult to police, as it relates to many issues beyond the medical condition. Groups had different views about the core hours and those that should be required across an area – this varied from 8-6pm to 8-9pm. The solutions for this are explored below and will depend on the local context.

Practices should offer telephone consultation with rapid ring back (30 minutes – 2 hours) for urgent cases and email access with reply within one day.

There was some discussion about the use of GP or other senior decision-maker based triage – this is seen as a way of achieving other standards set out here rather than a requirement in its own right.

Practices should be able to determine the length of the appointment according to the patient's needs (sometimes it will not be possible to establish this until the GP has seen the patient).

Prevention

The prevention of ill-health should be a core function of general practice. Current standards should continue to apply, and further work is needed to develop additional robust standards around prevention, in areas where it is possible to meaningfully measure progress. This should include, for example, pregnancy smoking cessation services, proactive baby checks at 6-8 weeks, and the identification of unregistered children of registered mothers.

Practice responsibility for patients referred to specialist

Coordination sits with the GP. If patients are referred to an alternative provider, and the patient attends, the responsibility should shift to that provider. However, the practice should maintain an overview of where the patient is in the health and care system and should monitor progress (including chasing referrals when appropriate), and should be supported to do this by appropriate IT systems. On discharge, responsibility should revert to the GP who should act as the patient advocate, proactively target patients for follow up once a specialist letter is received, and ensure that the patient understands the outcome of any diagnostics or treatment.

There should be a system for peer review of letters and the reasons for referral.

Standards

Pastoral care

The practice team will be expected to provide appropriate pastoral care for the following:

- Miscarriage
- Worried well
- Ill-defined symptoms
- Frequent attenders
- Carers
- Family dynamics - substance misuse, alcohol, self-harm etc
- Adjustment reactions, eg loss of job, bereavement.

The practice responsibility is to identify patients requiring pastoral care, signpost them and review achievement of goals. Identified patients should have a care plan in which the achievement of goals is checked after an appropriate review period. This will include a shared agreement of the problem, shared ideas of interventions, self care, escalation plan and signposting to directory of local services available. The plan should be available to both the patient and the practitioner electronically.

The practice should ensure that all members of the care team are informed of the death of registered patients.

Coordination & planning

There is an expectation that there will be proactive management of the population with risk profiling to identify vulnerable patients. Whether this is through predictive software or caseload reviews and sharing, is for local determination.

For patients with long-term conditions, including mental health conditions, there would be an expectation that they will have: an individual care plan; a named nurse, doctor and carer; and anticipatory management and prescribing.

There is an expectation that for patients being actively case managed, where decisions about admission to hospital need to be made, practices will enable contact to be made with suitably informed doctors for telephone advice.

Care plans should reflect a patient's goals and be based on a discussion of these. Plans should include escalation arrangements and advanced directives.

Standards & requirements

Enhanced services required

For some conditions there will be an expectation that the practice will have access to specialist expertise including from consultant specialists, practitioners with a special interest, and advanced care practices e.g. for mental health, dermatology (see full list to the right).

The provision of diagnostic services (in particular phlebotomy) which minimise the requirement for travel or return visits is essential.

As with the other requirements practices may provide these as part of a wider consortium.

- Insulin initiation
- Anticoagulation
- Injectable risperidone
- Joint injections
- Minor injuries
- Minor surgery, including vasectomy
- Tongue tie
- Fracture clinic
- Biopsy clinic
- Endometrial biopsies
- Leg ulcer
- Neonatal checks
- Near patient diagnostics
- Doppler pressure testing
- Pre and post-operative care
- Enhanced drug monitoring
- Complex drug regimes
- Eye, ENT, and microsuction
- Dermatology
- Immediate care and first response
- Family planning, and young people's sexual health
- Young people's clinics
- Substance misuse
- Homeless care
- Complementary therapy
- Extended geriatric care
- Complex care
- Nurse development

Standards & requirements

Other standards and requirements in specific areas of care

Frail older people / complex patients

- Multidisciplinary management
- Regular reviews
- Intervention when risk scores reach a predefined level
- Choice of appointment length
- Support to nursing and residential homes including 'ward rounds', medication reviews, care planning and support to staff, and a lead clinician for each home.

Maternal & child health

- See standards on prevention
- Doctors of both genders available in the practice
- Access to maternity care for all pregnant women through their GP practice, with midwives carrying out the majority of the activity and GPs maintaining an overview
- Registers of children at physical or psychological risk, eg children who are obese.

General requirements

- Open book accounting
- Information and data sharing with other services, as appropriate
- For sensitive issues, patient access to a GP or other professional who is not part of the normal practice team
- Feed back to patients regarding their use of A&E and other urgent care services
- Single information system or at the very least inter-operability and in real time - linking acute, GP, mental health, urgent care facilities; and the ability for other parts of the system to flag any intervention or discharge and transmit the information rapidly

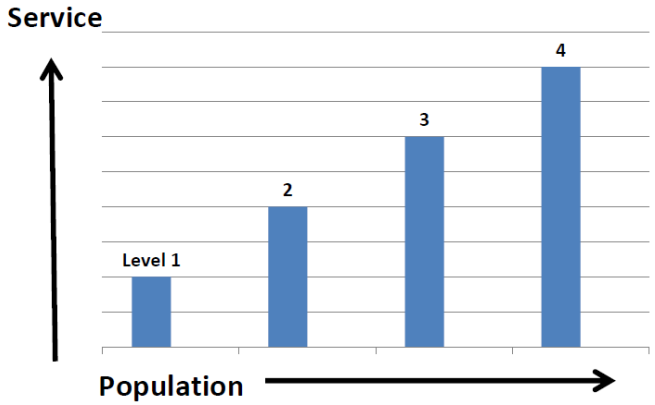
Standards & requirements

Developing Models

There was agreement that a 'stepped' approach to specifying primary care is needed, with different services and population sizes at different levels of service. The task is to define the services, population sizes, and contractual approaches at these different levels, recognising that these may vary between urban and rural areas, and depending on the proximity/access to hospital services.

We asked members to look at different types of area - rural, urban and mixed - to determine whether different models might emerge. In general there was a very high level of convergence between groups. The main differences related to population sizes covered and the local provision of some services in rural areas for reasons of access and travel times which are not required in more urban settings.

It is envisaged that there would be tiered incentives to encourage the development of services into the higher levels.



Rural area

Level 1 (basic GMS) - minimum 6,000 population

- Telephone first appointment system
- Chronic disease care management, and support to multi-disciplinary team/ matron (community matron actively managing the highest risk patients - top 0.5%)
- Population health and some preventative public health
- Coordination functions
- Extended hours for: specific services - wellness, contraception; single episodes; specific population cohorts i.e. working population (this may require being part of a network that provides extended hours)
- Diagnostics, pre- and post-acute - work up, stitches, and risk management
- Budget for out-of-hours service (not including '111') and minor injuries. There is a 'make or buy' decision here - if practices are unable to provide the service then they have responsibility for buying from elsewhere

Level 1 Plus

- Nursing and residential home service: scheduled; linked; medication and ward rounds; advance planning and escalation

Level 2 - 30,000-80,000/100,000 population - this should be a natural geographical population rather than disparate practices that want to work together

- Post-discharge (i.e. services that are needed for timely discharge from hospital, delivered for a maximum of four weeks); step-up; intensive home-care support; community hospitals. Enhanced, longer-term home-care
- Chronic disease management packages of care (Level 1 chronic disease management is about coordination, whereas this is about hands-on provision eg medication, leg ulcer treatment, some specialist nursing etc.)
- Specialist practices as part of the network
- Home-care nursing, allied health professionals, social care teams with a pooled budget,
- Specialist nursing - tissue viability, end of life, midwifery (both a provider function, and the education of home-care nurses). Again, there is a 'make or buy' decision for primary care provider/ hospital.

Level 3 - 100,000-200,000 population

- Paediatrics and geriatric medicine and some other hospital specialists
- Mental health team including drug/ alcohol services - this could be provided in house to agreed standards or procured
- Out-of-hours

Mixed area

This approach is based on moving towards a concept of a geographically commissioned ACO, with each level specifying what patients can expect to receive from general practice.

Core - less than 20,000 population

- Current GMS (although there needs to be recognition of the disparity between what is currently provided in different practices)
- 8am - 6pm access
- Maternity
- Chronic disease management
- End of life care
- Minor surgery etc

New core (ambitions for what core should be) - 20,000-50,000 population

- 8am - 9pm access
- Core work in non-core hours - eg end of life care in out of hours
- Community specialists
- Complex care management
- Diagnostics

Core plus - 50,000-100,000 population

- Out of hours
- Specialist end of life support
- Complex maternity
- Diagnostics
- Response teams, children, mental health
- Wrap-around integrated care, and risk stratification
- Early discharge
- Intermediate care
- Urban community hospital
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Core 'squared' - capitation budget for all except specialist care

- Electives
- Rehabilitation
- Dialysis
- Chemotherapy

As with the rural version some of the services in the more advanced versions of the model would be subcontracted or purchased rather than being directly provided.

Urban area

This approach is very similar to the other models being proposed

Level 1 - GMS - anything currently offered on national basis by NHS England

Level 2 - enhanced services

Level 3 (20,000-50,000) - out of hospital care, GPs with Special Interest, and non-elective

Level 4 - community mental health; GPs with special interest working with consultant

Level 5 (150,000+) - fully accountable

Levels 3 and 4 require practices to federate. The organisational form should allow CCGs to hold a single contract for out of hospital care. At this point, practices have 'make or buy' decisions, can also become training practices, have an investment portfolio, and start to have conversations about how to encourage specialists to deliver services in primary care settings (governance can sit with the acute trust).

Discussion

It can be seen that there is a great deal of commonality between the three models. In each case the underlying concept is that groups of practices can be built organically into larger networks. These will be capable of delivering a more diverse range of services as well as acting as the purchaser for some more specialist care. At the point that the population size is large enough to allow stable actuarial predictions of spending it will be possible to allocate increasing elements of insurance risk via a capitation payment to the network for the overall care of its population. This will include some or all of its general services including community, most mental health, adult social care and a range of other services. Such a model would also be a gateway to a number of other services and resources that can help improve independence and health.

Consideration was given to the notion of 'carving out' services for particular patient groups who require a very specialist service, such as homeless people, where doing so may offer opportunities to improve the quality of care. However, it was agreed that there were significant risks of fragmented care, and that the guiding principle, as far as possible, should be of 'cradle to grave' primary care.

Next steps

Refining the model

There was strong support for the 'stepped' approach illustrated above. There is now a need to refine the 'steps' of population to match the different levels of service and to feed this vision of care into commissioning, clinical networks and health and wellbeing boards. There are some further questions that need consideration:

- How much risk for the use of other services should providers carry?
- Could hospitals act as the core for some of the larger and more scaled versions of these models?
- Should there be a more specialist primary care service aimed at the care home sector or frailty?

CCG Leadership

CCGs must assume responsibility and take on the commissioning of primary care and the associated risks even though they do not hold the contract. There are barriers to change but these are not insurmountable. Safeguards to protect against conflicts of interest can be constructed and concern over this may be hampering the development of new models unnecessarily.

The approach to change

Change will need to be evolutionary/ step-wise, rather than through the design of a finished product; there is no definite end-point but rather a range of possible options, a general direction of travel, and the principles for how the new system will work.

It follows from this that a one-size-fits-all national contract is likely to be unhelpful and national bodies should focus on developing a range of flexible tools that can be used and adapted locally. Defining basic national standards, the evidence base for different models of delivery and creating outcome measures, methodologies for contracting, incentive design and other mechanisms to support local initiatives would also be useful.

The new GP contract and consultant contracts should reflect the vision for primary care - for example, the consultant contract should change incentives around the location of work and model of delivery.

The focus should be on making federated models attractive ('pull'), rather than mandating these models ('push'). As above, incentives could include:

- GP trainees to be allocated exclusively to practices that are at the higher levels in the models
- New standards/ targets that are only achievable if working on a larger scale
- Triggering of additional payments as more capitation risk or services are taken on
- Preferentially supporting the development of higher levels of practice models through the provision of investment funding and other support; making additional resources available to practices that offer extended hours.

Next steps

Supporting change

Experience suggests that these approaches are most likely to work when they are led bottom-up. The leaders of this change will require support in a number of areas including organisational development and the difficult practice issues of business cases, legal arrangements, etc.

CCGs will also need help in developing and testing different contracting mechanisms and in the piloting and evaluating new models.

Transforming the use of the estate is important as a number of current services are locked in by their current model. There are a number of options to deal with this including area teams taking responsibility for estates and premises plans, and more radically, the creation of a property fund to change the use of/ unlock secondary care. Transforming the estate is vital to enabling larger extended practices and networks.

Fair funding of primary care will need to be implemented locally to allow a common approach to be developed. A key lesson drawn from the work in Liverpool is the importance of starting with a much fairer distribution of funding and services across practices. Liverpool have decided to level up to the top end of the distribution of spending per head and to tie this to clear deliverables.

Some of the models discussed will require a pooled budget for health and adult social care.

Commissioners will need to give thought to a number of other areas to create the basis for further change:

- Re-commissioning out of hours/ extended hours and 111 (and perhaps some QOF/ES), and de/re-commissioning community services to create the wrap around services described above
- Stocktake and standardisation of enhanced services
- Fair and robust approaches to dealing with poor practices by local area teams.

Hospital specialists

Some secondary care specialists (particularly those already doing private practice, specialists in chronic disease or care and others where new models are already emerging) may be attracted by the greater flexibilities that can come from working in primary care. Once a critical mass of involvement has been established it is likely that others would follow too. The advantages of involving specialists in supporting primary care can include improved clinical management, reduced prescribing costs, and more up-to-date treatment. It has also been found that GPWSIs that are not part of a network with specialists have difficulties in providing a service that is coordinated with care provided by specialists, and in maintaining their skills.

Next steps

Workforce

There is a need for closer or joint commissioning with the local authority and Local Education and Training Board (LETB) which could be used to drive multi-disciplinary working.

New types of workforce will be required to support the changes proposed here, including staff that can support people with health and social care needs. The creation of a more multiskilled workforce, for example with more blurred lines between specialist nurses, practice nurses and community nurses, will be an important part of this new model.

There will also be a need to develop additional expertise within networked practices to fill skill gaps in areas such as paediatrics, frailty, gynaecology, rheumatology, dermatology, ENT and other high referring areas.

Issues for further consideration

The role of pharmacists was not considered as part of this work. There are, however, important opportunities to involve pharmacists more closely in service delivery and as members of the multidisciplinary team – particularly in terms of medicines reconciliation.

The implications of competition and procurement rules for these proposals needs further testing.