HSJ LOCAL briefing

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# STEADY PATH OF IMPROVEMENT IN GENERAL PRACTICE

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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## In brief

**Issue** There are calls for transformation of general practice, so it can play a full role in meeting pressures on the NHS – particularly from patients with co-morbidities. There is also pressure to address variation in care quality and value of providers.

**Context** Progress is being made but slowly and there are workforce and funding problems. The Department of Health is attempting to change the contract, and the NHS Commissioning Board will take over GP contracts from April. Clinical commissioning groups will also have an incentive to improve general practice.

**Outcome** Dramatic policy shifts are unlikely although there will be a single model for commissioning and a national primary care strategy. The local commissioning board teams and CCGs will need to work together to agree improvements cautiously. In some areas this may succeed in accelerating change.

## Context

General practice is critical to the operation and affordability of the NHS – and has always evolved – but there remains significant discussion in the NHS about the need for transformation and improvement in the sector.

The major changes to NHS services which are required to accommodate limited funding and growing demand and technology costs will apply as much, and in some ways more, to general practice as to the rest of the system. A huge and growing part of the health service's work will involve patients with multiple chronic conditions, implying a more prominent role for generalist care.

Change is sought so primary care can:

- Meet growing demand and unmet need – particularly in deprived communities
- Improve prevention of illness across a population
- Provide much extended and improved care for patients with long term conditions
- Prevent exacerbation with use of new technologies
- Co-ordinate more seamless care and treatment
- Form closer links with specialist and social care
- Provide more services traditionally provided in hospitals.

Much of this is endorsed by work for the Royal College of GPs.

One example of the kind of change sought comes from Lord Darzi's 2006 call for the introduction of "polyclinic" health centres across the country. His report on service reform in London said they would "offer access to antenatal and postnatal care, healthy living information and services, community mental health services, community care, social care and specialist advice all in one place".

It said: "They will provide the infrastructure (such as diagnostics and consulting rooms for outpatients) to allow a shift of services out of hospital settings. They will be where the majority of urgent care centres will be located. And they will provide the integrated, one-stop-shop care that we want for people with long-term conditions."

The King's Fund's inquiry into the quality of general practice, published last year, said the sector needed to move from a "cottage industry" approach to providing "post-industrial care".

The ageing population and growth of co-morbidities, it observed, required support for self-care; use of technology which "could transform the way patients interact with general practice [but that the sector] has been slow to adopt"; and to "become increasingly involved in, and responsible for, the health of local populations [including] those who are most in need of care but currently do not receive it".

Although many senior NHS figures recognise the value of primary care to the NHS, there is a strong perception of significant variation in:

- the quality of general practice
- GP practice income and individual GP partners' earnings
- the value and productivity of practices.

There is pressure in the service to address these issues, and tackling them is also important to achieve the transformation described above.

The state of the general practice workforce is also an important part of the context for services. There is widespread appreciation there are not enough GPs, and it is difficult to recruit, which is particularly exacerbating problems increasing access and service quality in deprived areas. There are moves to begin addressing the shortage. In addition, in recognition of some of the shifts described above, GP training is due to be extended to four years.

## Is progress being made?

The King's Fund report in 2011 said that that although "the role of general practice has changed significantly since the NHS was founded", there was much to do to modernise services.

Continuing failures to improve against some key indicators of NHS efficiency and effectiveness, which are particularly linked to the role of primary care, also demonstrate there is a long way to go. Examples include the rate of emergency admissions to hospitals for issues and conditions which could be managed in primary care, and a widespread perception of poor care co-ordination. A recent analysis showed the link between deprivation and poor access to primary care persists, and called for national action.

In order to meet the requirement for transformation and improvement, it is expected the size/scale of general practice in many areas needs to increase. The possible routes to this are mergers between practices; expansion of large groups, such as the Hurley Group, or more commercial operations such as Virgin Care; or individual practices creating close formal collaborations, known as federations. The Royal College of GPs has recognised the need for much closer working and has particularly advocated federation, publishing a paper on this approach in 2008.

Figures indicate that over the previous decade this type of change has been happening in some areas but not others. The total number of GP practices fell by about 8 per cent between 1999 and 2009 to about 8,200. The number of practices with only one GP partner fell from 2,721 in 1999 to 1,838 in 2009. Workforce figures also reflect a gradual change over the past decade. New and more productive models and larger providers are likely to employ a larger proportion of salaried GPs – as opposed to partners in the contract – and also more nurses and healthcare assistants. The workforce has moved in this direction but the ratio of GPs to other staff has not changed dramatically.

The King's Fund report found there were "wide variations in performance and gaps in the quality of care" in general practice, and HSJ research last year found that,

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according to scorecards created by PCTs, about one in five practices had been rated red for performance on more than a third of indicators.

## The size of variation

HSJ analysis this week shows the huge variation in the rate of funding to practices. That is despite some PCTs initiating funding reviews – particularly of practices on primary medical services (PMS) contracts – in recent years.

The analysis also shows there is no visible significant link between GP practices' rate of income and measures such as the rate at which their patients are admitted to hospital for emergencies (including among patients with conditions which can often be managed in primary care); and patients' experience of care at the practice. Some strongly reject that these measures are a reflection of the quality or type of care provided.

Some GPs also argue that for many of the practices, additional funding rates are justified, as the payments are for additional services provided which represent good value.

There is a widely held view in the NHS that reform of service provision, particularly in general practice, has been delayed since summer 2010 because of the time required and confusion caused by the government's commissioning reforms. RCGP chair Clare Gerada – a supporter of practices federating– has made this pointto HSJ.

## What might drive change?

There are numerous factors and policies which may drive changes in the next few years, as well as the context demands outlined above. These include changes to GP contracting, the role of CCGs, the role of the NHS Commissioning Board, initiatives by the GP profession, funding, increased transparency and workforce.

## Plans to change the contract

The Department of Health last week announced its proposals for contract change covering 2013-14 and setting a framework for the next few years.

It wants to move to a standardised rate of funding for practices' "core" services over seven years, scrapping the minimum practice income guarantee. Governments have expressed an intention to scrap the MPIG for several years, and not made much progress. Therefore these changes, which have a very significant time lag, may not make a big difference quickly.

HSJ's analysis of income variation suggests that standardising the rate

**HSJ analysed details of the NHS income of more than a third of England's 8,300 GP practices for 2011-12. It is the biggest analysis of its kind and GP practices' income has previously rarely been published. It comes a week after the DH announced a fresh attempt to standardise part of GP income.**

**HSJ divided the total NHS income of 3,046 practices by the number of patients on their practice list, which had been weighted for needs using the method employed by the DH in calculating GP contracts, with factors such as age make-up and deprivation. Specialist GP practices and extreme outliers were removed.**

**It showed the income ranged from about £65 to £320 per head of needs-adjusted population.**

**HSJ calculated the difference between the income of practices which are paid above the average rate, and their income if they were paid the average rate per patient, taking account of need. The figure was extrapolated to estimate the potential effect if practices' income was standardised across England – with practices earning above the average rate reduced to the average rate. It showed the total reduction in income across all practices would be £566m each year – around 7 per cent of the total GP services budget.**

**Much of the variation is due to performance rewards under the quality and outcomes framework, and practices providing services beyond their core contract requirements. Although many specialist providers have been removed from the analysis, some variation could be explained by payments for different types of practices, such as health centres.**

**However, even if performance rewards and additional services – known as enhanced services – are excluded from calculations, there is huge variation, with income per needs-weighted patient ranging from about £30 to £300. If those practices receiving above the average rate, excluding QOF and enhanced services, was reduced to the average, it would save about £400m nationally.**

**Outside performance rewards and conventional extended services, practices receive payments for a long list of hugely varying reasons. They include payments which are national policy but not applied universally, for example the seniority of GPs, IT and premises maintenance.**

**They also include payment for generic schemes such as "practice innovation" and "transforming primary care"; practices' use of locums due to sickness or maternity; training; referral management; involvement in CCGs and other committees; medicines management schemes; and to fund items including mobile phones.**

**We also looked at whether there was a link between outcomes – including the rate of emergency bed days for patients with long term conditions among the practices' population – or patient experience – and the income rate of practices, to examine value. There was no clear link:**

| Practice funding per head of weighted population (HSJ research) | Number of emergency bed days for long term conditions, per 1,000 weighted population (NHS Information Centre) | Proportion of patients reporting experience of practice as good or very good (GP patient survey, weighted) | Proportion of patients who have seen GP in past six months (GP patient survey, weighted) |
|---|---|---|---|
| £62-£115 | 482 | 79.9% | 71.3% |
| £116-£170 | 459 | 82.1% | 72.2% |
| £171-£220 | 443 | 84.0% | 73.0% |
| £221-£270 | 504 | 85.3% | 71.1% |
| £271-£323 | 512 | 81.7% | 69.8% |

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of "core" income would mean a reduction of about £256m nationally, across half of practices, meaning an average fall of around £64,000, although it would not be spread evenly. For some practices it may mean a significant drop in income compared to what they would have otherwise received in future years.

However, the implications are significantly less than if the DH decided to also standardise income outside "core" payments, such as for enhanced services and various other categories.

The DH also last week set out to make significant changes to the quality and outcomes framework. If they are enforced, practices would have to provide a new set of enhanced services, directed by the DH and NHS Commissioning Board, to continue earning the same income. They would also be required to step up performance on QOF measures, many of which are focused on population health and prevention.

The department has not said what the new enhanced services would be but it is expected they would include:

A requirement to risk-stratify their population for likelihood of illness and deterioration, and provide support/attention to them

Improving services for those with chronic conditions and for older people

Promotion of patients' self care, including through access to their own records.

It is not yet clear how much of it will be implemented. It is likely the DH may compromise on some of the changes to the QOF if it means it can reach agreement with the British Medical Association GP committee.

The proposed contract changes would to some extent force a focus on some of the changes outlined above – prevention, chronic conditions care, and self-care.

However they would not directly bring about shifts such as a dramatic shift to larger practices and multi-disciplinary working. However, if enforced strongly, they could bring about a step-change tightening of the requirements on practices to provide this kind of care. If so, in order to earn income and remain viable, practices may be forced into mergers or joint-working arrangements with other providers, and into a more "post industrial" approach, at a faster pace.

Senior NHS and policy figures have also discussed and suggested more dramatic changes to GP contracting. An important suggestion is to include in the contract a much more specific definition of what a general practice should provide, for example about opening hours and the large range of services which some practices provide and others don't.

This would allow commissioners to more effectively require practices to meet standards, and also make it easier to agree fair payments for services. It has also been noted publicly that a more specific contract definition would make it much easier to develop the integrated provider models that are currently a major theme of national and local policy.

Proposals to develop integrated models of care also give rise to calls for more novel ways of contracting general practice – for example GP lists run by provider organisations, whether hospital trusts or independent organisations.

A forthcoming paper by the think tank Policy Exchange is expected to call for a relaxation of the purchaser provider split, allowing GP referrers and secondary care to come together in one organisation, with a single payment.

It is also highlighted in the DH's current piloting of a year-of-care tariff for integrated provision, which has had to exclude primary care, despite it being a key part of the types of care proposed, because of payment arrangements.

Another potential route is to change the contract to give clinical commissioning groups a more explicit role in managing and developing their member GP practices.

A likely option would be to make a larger part of practices' funding and accountability directly linked to the CCG. Such an approach is expected to be publicly supported by the National Association for Primary Care – which has always backed more local determination of contracts – this week.

## Clinical commissioning groups as a driver for change

Although CCGs will not hold GP contracts, many expect them to be a driver for change in general practice. Their ability to provide good care and balance a budget – for which they are directly accountable – gives them a strong incentive to try to improve the quality of primary care, and tackle members who are underperforming.

They also have a duty to help the NHS Commissioning Board (the direct commissioner of GPs) to improve quality. The commissioning board has described a role for CCGs in contributing to its commissioning of general practice.

CCGs also hold budgets for local enhanced services – about £270m for extended services based with GP practices – and for community services. A top priority for many CCGs will be to attempt to extend community services hosted by and wrapped around practices.

However, there are also some powerful barriers to CCGs acting as a driver for change in primary care. Some CCG leaders are very wary of the attempt to tackle primary care quality. Particularly where GPs are not enthusiastic about the CCG, GPs turning on their colleagues could seriously damage relationships. In addition, the system of close co-operation which will be required between the commissioning board local area teams and CCGs is untested.

A further barrier is limited ability to fund improvements and expansion in general practice and community care. Although there is widespread acknowledgement that the NHS should invest in these areas, it has been difficult to find the money as demand for expensive acute care continues to rise.

There is little sign of it becoming easier and for some CCGs – as novices in a new system attempting to manage large acute trusts – it could get harder. If the DH's planned contract changes are pushed through successfully, they will release some funds to invest in practices which have so far been underfunded, and those which can meet the new national requirements.

## NHS Commissioning Board and transparency

From April, there will be the extremely novel arrangement of having a single commissioner, the commissioning board, responsible for contracting general practice, albeit with much of its operation taking place through semi-autonomous local area teams. Senior board staff have attempted to describe how this will give it the ability to force improvement and standardisation of good practice more quickly, although they have not said much about how this will be done.

In relation to general practice, commissioning board chief executive Sir David Nicholson told the Commons public accounts committee in June: "The commissioning of primary care will not be the responsibility of local organisations,

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but the responsibility of the NHS Commissioning Board. So that direct accountability is very sharp...

"That gives us an ability to be more consistent across the country in the way that we treat outliers and the way in which the primary care services are developed."

It suggests a contrast with primary care trusts, many of which are perceived to have failed to tackle underperforming general practice.

It is understood the commissioning board is due to publish a single operating model for commissioning primary care in coming weeks. It is expected to include a national quality/performance dashboard, drawing on measures in the quality and outcomes framework, and other measures included in the NHS London GP outcome standards and framework.

It will be used to highlight underperforming practices. It is suggested that, in collaboration with CCGs, these could be addressed and improved more effectively than they have been by PCTs.

The commissioning board is also promoting much greater transparency of measures of quality and outcomes as a method to improve standards, including in primary care. Significant amounts of data on practices has been published in the past year, and may drive change at various levels as it brings additional scrutiny.

Meanwhile, the promotion of patient choice of general practice – although a government policy – is moving very slowly, and its likely effects are unknown.

The commissioning board is developing, working with CCGs, a national primary care strategy, which is expected to be published during 2013-14. It will be the first strategy by a single national commissioner of general practice.

It is likely to set out the future role of general practice (as well as the other elements of primary care) in a modern NHS, as the commissioning board sees it. This will include many of the changes described above as part of the shift to a "post-industrial" approach. It may give weight to commissioning board and CCG efforts to require certain standards from practices, and potentially begin a move to further contract changes.

The strategy is expected to be tied into a major consultation and exercise led by the commissioning board from next spring on the future shape of NHS services.

## Likely way forward

The model of provision of general practice will come under greater pressure to change significantly, as part of a step-change in the whole NHS system, of which it will be an increasingly important part.

CCGs and the commissioning board have an incentive to try to increase the scale and productivity of general practice and to focus it on illness prevention and on the groups driving demand on resources: Those with long-term conditions and frail older people. The commissioning board will elaborate on this in its primary care strategy next year.

However, for both CCGs and the commissioning board there are significant barriers to achieving the shift. Even if the DH and board manage to push through their proposed contract changes, GP practices are independent providers, and some will resist change to their behaviour and model.

In addition, there is recognition by some senior figures in the board of the value already provided by general practice, and the likely pitfalls and difficulties of making dramatic changes which could upset the sector. This probably means dramatic moves, such as major changes to contracting, or introducing new GP providers, are ruled out for the foreseeable future.

The practical and political imperative for GPs to be involved in CCGs may also act as a deterrent to these types of unpopular moves.

Therefore improvements to general practice will rely on the ability of CCGs and the local commissioning board teams, with general practice, to cautiously press for and agree change. In some areas, CCGs' basis in general practice, and their combined might with the board, may be able to succeed where many PCTs have not, and may also help release the necessary funds from secondary care.

However, this commissioning system is untested and in some ways radically new. There is serious concern at senior levels in the NHS about whether it will function well, and be able to transform services. There is therefore a risk that improvements will again be slow and very patchy.