Improving general practice – response from The Lesbian & Gay Foundation

Introduction

The Lesbian & Gay Foundation (www.lgf.org.uk) will respond to the consultation incorporating any likely impact upon itself and its lesbian, gay and bisexual (LGB) service users. The Lesbian & Gay Foundation is a vibrant charity committed to achieving more positive outcomes for LGB people, with a wide portfolio of well-established services and new initiatives. The LGF is also the lead organisation of the Department of Health funded National LGB&T Partnership.

The LGF is based in Manchester, and supports over 40,000 lesbian, gay and bisexual (LGB) people each year. In addition to a wide range of health and advocacy services, it also undertakes research, information provision and policy campaigning on a national scale. As a result, the LGF provides more direct services and resources to more LGB&T people than any other organisation of its kind in the UK. The LGF is reported by service users to be one of the first points of contact for them when they have been at a crisis point in their lives. We campaign for a fair and equal society where all lesbian, gay and bisexual people can achieve their full potential, and our mission is: 'Ending Homophobia, Empowering People'.

Consultation questions

Information, choice and control

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

Practices must publish equality data under the requirements of the Equality Act 2010, in order to demonstrate that they are working to meet the needs of the whole community. Best practice includes monitoring patient demographic data, including sexual orientation and gender identity, and analysing it against a range of measures including satisfaction to better understand where there are differences in patient access, experience and outcome. Sexual orientation and gender identity are not routinely monitored across the healthcare system, meaning that the specific needs of LGB&T communities are often not recognised or addressed. NHS England should encourage sexual orientation and gender identity monitoring, and encourage practices to use this data to improve services.

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

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

Patient engagement and involvement mechanisms must be representative of the local population, and be inclusive of LGB&T communities. The Friends and Family Test methodology has been criticised by research groups as it is unlikely to elicit reliable information about patient experience. It is also unable to offer comparison across patient groups as demographic information is not collected. We recommend forms of patient engagement which are fully inclusive, and recognise that patient access, experience and outcome will vary across groups.

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

See previous response.

Clinical leadership and innovation

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

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

NHS England should encourage co-production between communities and CCGs and health and wellbeing boards, etc. The voluntary and community sector (VCS) can facilitate such work as organisations can provide a direct link into communities, have valuable experience of working with those communities, and are often trusted by them above mainstream services. NHS England has a role to play in promoting good practice across the country; local areas can then roll out projects successful in other areas and achieve results. Pilot projects often generate positive responses and anecdotal evidence of success before evidence of impact has been formally collected, so the former should be considered rather than delaying implementation by waiting for formal evidence. The health community should be encouraged to work across local authority areas (e.g. pan-London) in order to increase efficiency and work to the strengths of an area. Local health communities provide opportunity to address ongoing issues, such as inclusion of LGB&T communities; again, the VCS has a role in supporting practices to provide a welcoming and inclusive service to LGB&T communities. Truly integrated care which considers the patient holistically should included prevention and early intervention; innovative care models which utilise the VCS as a key delivery partner will be able deliver this care.

- How do we best support integration pioneers in testing new ways of commissioning and contracting for integrated primary care and community services for people with physical and mental health conditions?

See previous answer. In addition, the Francis enquiry found that GPs were disempowered by lack of information shared by secondary care with primary; this is essential for properly integrated care and efforts should be made to improve the sharing of information between services.

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

Freeing up time and resources

- How should general practice IT systems develop to support more efficient and integrated working?

As mentioned previously, sexual orientation and gender identity are not routinely monitored across the healthcare system, meaning LGB&T people's needs are often not recognised or addressed. We have found that the majority of practices use national IT systems which do not allow for this information to be recorded, and therefore poses a barrier to effective implementation of monitoring. National IT systems should be developed to support monitoring.

Defining practice accountabilities for high quality

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

Yes. Public consultation should take place on this concordat.

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

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

High quality care must include a commitment to equality and diversity; an understanding of the specific needs of and issues faced by groups with protected characteristics, for example LGB&T communities; and a commitment to address these in general practice, for example by implementing monitoring of patient sexual orientation and gender identity.

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

A clear understanding of expectations for patients is vital. Healthcare bodies should work together to ensure a streamlined and effective shared system of ratings in order to achieve this.

GP contract: incentives for outcomes

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

Collaboration should be encouraged and if necessary, incentivised.

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

Systems should be put in place to better integrate the care of people with complex needs.

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

These should be core outcomes rather than “wider” outcomes.

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

Additional comment:
Evidence shows that there is a greater likelihood of poor outcomes in single-handed GP practices than in full GP practices. We assume that organisations such as Monitor would not monitor such small organisations, and would therefore like confirmation on who is responsible for quality assurance of single-handed GP practices. Such practices tend to be in areas where there is no other choice of practice, and therefore this issue is extremely important in terms of meeting the needs and providing a good service to all parts of the community.

Safe, controlled investment

- How can CCGs, local authorities and NHS England best collaborate to develop integrated commissioning plans for out-of-hospital services?
- How can we support health investment analysis that allows for optimal balance of resources between acute and community services?
- Where commissioning plans envisage additional investment in services provided by general practice, how can CCGs and NHS England best provide assurance that any perceived conflicts of interest have been properly managed?
- How do we track value from investment and adjust investment plans to reflect evidence of outcomes?
- How can NHS England and CCGs work together to make more effective use of existing community estates and, where necessary, allow investment in new or expanded premises?

Market management

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

- How do we develop a more consistent and effective approach to new market entry, e.g. how far this should be targeted at areas of greater deprivation and/or lower capacity and/or limited patient choice?
- How might we stimulate new, innovative provider models that offer both greater quality for patients and satisfying careers for those working in general practice and primary care?
- What are the potential opportunities for 'primary care plus' contracts, built on co-commissioning between NHS England, CCGs and local authorities?

Workforce development

- How can we and our national and local partners best support improvements in recruitment, retention and return to practice?
- What are the strategic priorities for improvements in education and training to reflect the evolving role of general practice, the changing profile of the general practice workforce and the challenges facing the health service in the next ten years?

A greater awareness and understanding of minority groups, for example, lesbian, gay, bisexual and trans communities and an understanding of the health inequalities experienced by them in relation to sexual orientation and gender identity should be a priority. Evidence shows that some LGB&T people experience poor care from health professionals linked to discrimination and homo-, bi- and transphobia and many are unwilling to disclose their sexual orientation or gender identity for fear of discrimination or a lack of understanding from a the healthcare professional. Adequate training undertaken by all health professionals would be one way to address this.

- What developments would help provide more structured careers for GPs, practice nurses and other primary care practitioners?
- What factors are likely to promote and support good employment practice, e.g. practices providing training and development opportunities for practice nurses and practice managers?

Specific issues and questions

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

People with complex health and care needs should be supported as much as possible to coordinate their care, including having a named clinician. Information necessary to coordination of care should include knowledge of their support networks, including friends and partner(s) as well as family and individual preferences (for example, an older LGB&T person may prefer to access services from a specific support group for older LGB&T people rather than a mainstream

organisation). Care plans should be sensitive to an individual's needs and preferences where possible.

- How can we strengthen general practice accountability for the quality of out-of-hours services provided to patients and ensure that OOH services are more integrated both with daytime general practice and with wider urgent care services?
- How do we stimulate more convenient routine access to general practice services, including ease of making appointments, speed of contact for urgent problems (whether telephone or face-to-face), ability to book less urgent appointments in advance, ability to communicate electronically (e.g. online consultations) and, particularly for working-age adults, availability of evening/weekend slots?

- How do we stimulate general practice responsiveness to access preferences of their populations?

Better use of data within practices will help to stimulate responsiveness to practice population preferences. Patient demographic data, including sexual orientation and gender identity, should be monitored and analysed against a range of measures including satisfaction to better understand where there are differences in patient access, experience and outcome. Sexual orientation and gender identity are not routinely monitored across the healthcare system, meaning that the specific needs of LGB&T communities are often not recognised or addressed. Patient engagement and involvement mechanisms must also be representative of the local population, and be inclusive of LGB&T communities. The Voluntary Sector Strategic Partners programme supported by NHS England is a key way to engage with community groups across the country through their representative partnerships.

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

Additional comment:
We are concerned to see that there is no mention of equalities or the protected characteristics in the consultation and supporting documents, and no recognition that inequalities more than geographic. Evidence shows that LGB&T people report lower satisfaction with their GP that the wider population (Stonewall, 2013 and NHS England GP Patient Survey 2012) which should be recognised and addressed in an proposal to improve general practice.