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Fellowship Support Unit

Improving General Practice – Call to action Team
NHS England
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8 November 2013

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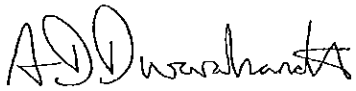
Dear Sir or Madam,

IMPROVING GENERAL PRACTICE – A CALL TO ACTION

I refer to NHS England's request for comments on the consultation on *Improving General Practice – a call to action.* I am pleased to enclose the comments of the Royal College of Physicians of Edinburgh.

Please note that these comments have already been sent to you by e-mail.

Yours sincerely



Dr A Deepak Dwarakanath FRCP Edin
Secretary

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Royal College *of* Physicians *of* Edinburgh

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Consultation response

The College promotes the highest standards of practice in internal medicine and related specialties wherever its Fellows, Collegiate Members and Members practise.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

IMPROVING GENERAL PRACTICE – A CALL TO ACTION

CALL FOR VIEWS BY NHS ENGLAND

The Royal College of Physicians of Edinburgh (the College) is pleased to respond to the call for views on Improving General Practice by NHS England.

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

The College notes that there has been a shift in the role of general practice over recent years and feels that this review of the future of general practice is therefore timely. There are a number of pressing factors, such as our changing demography, a desire to balance care between the community and acute sectors, and the substantial pressures currently faced by secondary care that should be addressed as part of this review.

The NHS England ambitions for primary care should include re-engagement with the out-of-hours processes and a focus on the integration of health services so that the best service and quality of care will be delivered to the patients.

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

The College feels there should be a greater emphasis on partnership working between primary and secondary care. This has to be manifest by the standards for healthcare delivery being shared jointly by primary and secondary care. Such standards could include, for example, responsibility for acute readmissions to hospital.

The development of standards for speed of patient access to general practice and levels of care would also be beneficial. The QOF standards themselves should remain but be refined to reduce the time spent on this routine element to facilitate a greater active focus on improving the delivery of service. The GP contract should include reference to provision of an out-of-hours service with, for example, telephone availability in the evening and the greater ability for patients to make same day appointments.

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?

It is regrettable that incentivisation is thought necessary as this indicates an extra financial element which should not be needed: practices should be required to provide specific services and to engage in meeting the local service requirements. It should be mandatory to engage in collaborative working with service users and other providers. This should include targets for demographically adjusted acute admissions with penalties for non-achievement and for delayed discharge. Currently, this is dealt with through section 5 costs to social services but could be added to GP responsibilities to ensure co-operation.

A system where GPs could develop interests in certain areas should be encouraged, for example in chronic conditions, where they could develop specialty clinics within primary care to provide direct care and advice to patients who may belong to their colleagues within the same practice or from other practices. These specialist services could be supported and supplemented by secondary care directly or indirectly through community clinics or e-consultations. The collaboration across primary and secondary care could include non-medically qualified colleagues, such as specialist nurses, who have a proven record of improving health care standards in certain areas.

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?

It should be a core part of the work of GPs to achieve specific clinically derived and driven targets within the NHS and therefore outcomes such as avoiding admissions, or even improving public health by acting to diminish the incidence of key illnesses, should be a part of GP responsibilities rather than something which is considered separately and specifically rewarded.

How can we support health investment analysis that allows for optimal balance of resources between acute and community services?

The College feels at present that there is an artificial division between acute and community services, which can lead to misunderstandings, duplication and potentially poorer overall patient care. Services that are truly integrated and collaborative should be promoted and rewarded. There are obvious specific areas such as increasing and improving early discharge from hospital that require greater investment in community care before such schemes are universally beneficial.

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?

The College feels this is a complex area. Areas which may be considered include an increase in both the duration of GP training and in the time spent training in secondary care with a specific focus on community aspects. This increase in time spent in secondary care training could help to reduce the pressure involved in the provision of acute care and allow greater involvement of GPs in the admission process.

New educational models for general practice (and indeed in secondary care) may be needed as the increase in less than full time working continues to rise. The focus however of this training has to reflect demographic changes, including the increasingly elderly population, but also an emphasis on long term conditions, including the acute exacerbations of these illnesses, and mobility issues.

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?

It is probable that a renegotiation of the GP contract will be needed so that it reflects a responsibility to provide an element of out-of-hours cover. This could include, for example, telephone availability of a GP in all practices in the evening and/or GP involvement in admission of patients in the evening e.g. the review of patients with an intention to self-admit.

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?

The College feels that the tendency to reduce investment in acute hospitals, without very significant investment in community services has simply exacerbated many of the recent problems, for example, unacceptable boarding rates and delayed discharges. Unless there is very firm evidence that the shift of resource to out-of-hospital care will result in an efficient healthcare service that promotes improved care in the community for many of the acute problems that result in hospital admission at present the College has to express severe concern about the implied reduction of hospital services.

An innovative approach is needed so that health care professionals in the community are empowered to deal with the wide range of issues which often prevent patients staying in, or returning to, their own home. Social services must be adequately resourced to develop efficient integrated working with acute and primary care and facilitate effective discharge.

Some patients with very complex needs are optimally cared for in a care setting and cannot

be adequately cared for at home. Whilst we should do all in our power to make it possible for people to be cared for at home, we must recognise that sometimes this is not possible or desirable. Recommendations should be based on the patient's needs and what will work best for them within the reality of financial constraints.

The continual pressure to deliver care closer to home may have laudable aims in terms of patient experience, however the College is concerned that quality of care, cost effectiveness and patient safety may suffer as a result and could also lead to significant inefficiencies of practice from the point of view of the health care professionals delivering the care. Large scale pilot programmes are necessary and must be proven to be successful before services are moved.

All College responses are published on the College website www.rcpe.ac.uk.

Further copies of this response are available from Lesley Lockhart (tel: 0131 225 7324 ext 608 or email: l.lockhart@rcpe.ac.uk)

8 November 2013