RESPONSE TO NHS ENGLAND CONSULTATION - IMPROVING GENERAL PRACTICE - A CALL TO ACTION

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services. We speak for the whole of the NHS on the issues that matter to all those involved in healthcare. We also reflect the diverse views of the different parts of the healthcare system.

The NHS Confederation is not the main representative body for general practice and does not have significant numbers of primary care providers in its membership, although we work closely with several partner organisations that do and we regularly engage with GPs and other primary care professionals though our networks and forums. Our response to this consultation focuses on what our own membership of other providers and commissioners of NHS services, as well as our primary care partners, see as the role of general practice in the wider healthcare system.

KEY POINTS

- **Our members agree with the NAPC and others that through engaging more proactively with promoting the wellbeing of local populations, general practice can play an important role in meeting the challenges facing the NHS and reducing demand for services.**
- **An important means for general practice to proactively manage the health of their local population is through making effective use of risk and population profiling tools. In order to do this most effectively, general practice needs to work collaboratively with other practices within a CCG and with the wider health and social care system as well as with local authorities to share tools, knowledge and data which allow them to better understand and meet the needs of their community.**
- **We recognise that clinicians need protected time and support to develop innovative ideas that improve services. We think it is vital that these innovations are driven locally, based on an understanding and knowledge of local needs, rather than national priorities. We call for NHS England, local government and Monitor to work together to find an appropriate way to enable greater local input into commissioning of general practice and ensure that innovations meet the health needs of local populations most effectively.**
- **In order to get the funding necessary to innovate, we again call for NHS England and Monitor to work together to find a way to enable CCGs to align their budgets with NHS England's budget for primary care, so that there is more financial flexibility in the system to cover the up-front costs associated with changing the way services are delivered.**
- **We believe that there is a need to simplify the demands placed on practices, so that they are more flexible and to reduce the feel of a process-driven tick-box culture**.

- **We urge NHS England to encourage and support the scaling up of general practice through federations and networks that both extend across primary care (particularly by involving pharmacists) and go beyond primary care to involve other community services.**
- **We are convinced that the scale of the challenge demands an even more imaginative approach, which involves paying much more attention to the provision of preventative services. In order to fulfill this ambition, general practice needs a better understanding of what different services and agencies can contribute and what community initiatives are already going on.**
- **From a patient's perspective, communication about care between different parts of the health service can often be poor. We therefore believe that hospitals, which may have the resources needed, and general practice should work more collaboratively to share resources and the expertise needed to develop or purchase systems that work across providers and facilitate data sharing across health and social care.**
- **Financial incentives across health and social care, including those for GPs, should be aligned around a health and wellbeing agenda. More investment should be earmarked for primary and community care to make 24/7 care a reality across the system.**

INTRODUCTION

We welcome the opportunity to contribute to 'Improving General Practice – a call to action' and are keen to be involved in the ongoing development of NHS England's work in his area.

We think it's right that NHS England is engaging widely with those who work in general practice, CCGs, health and wellbeing boards and other community partners about how best to develop general practice services. We also think it's important that other NHS providers and commissioners can contribute to shaping the future of general practice. Our response draws on feedback and discussions with our members, as well as with individual GPs and other primary care professionals involved in our work.

We strongly agree with NHS England's underlying objectives for general practice. We believe that general practice needs to be supported and enabled to play an even stronger role at the heart of more integrated community-based services that deliver better outcomes, more personalised care, excellent patient experience, and make the most efficient possible use of NHS resources. In particular, many of our members have highlighted to us the view that support and investment in primary and community care is vital for addressing the pressures on urgent and emergency care services that they are currently facing.

However, achieving these ambitions cannot rest with general practice alone. We believe it will require the whole health and social care system including mental health, the acute and emergency care sector, health and social care commissioners,

community health and other local and central government departments (such as those with responsibility for housing, leisure and transport), to deliver a whole system solution that genuinely takes into account the health and wellbeing needs of the population.

Our response does not attempt to answer the individual questions which are in the 'call to action'. Instead, we have chosen to highlight a set of principles for improving general practice that aims to address many of the issues identified by NHS England, based on consultation with our members. These principles are presented around the subject headings under which the consultation paper has grouped its questions.

DEFINING PRACTICE ACCOUNTABILITIES FOR HIGH QUALITY

Taking a population health approach

The NHS Confederation holds the view that GPs' responsibilities and accountabilities should be based on the widely recognised strengths of general practice that matter most to patients: the ability to provide whole-person care, with effective communication and compassion, in a timely manner. Our members also support the call from organisations like the National Association of Primary Care, (NAPC) who have argued for a more proactive approach from general practice, recognising that it has great potential for improving the health and wellbeing of local populations. **Our members agree with the NAPC and others that through engaging more proactively with promoting the wellbeing of local populations, general practice can play an important role in meeting the challenges facing the NHS and reducing demand for services.**

The paper 'Reclaiming a population health perspective', written by the NAPC for the Nuffield Trust,provides a definition of what is meant by taking a population health focus within general practice. In summary, the paper defines population health as having an interest in the health and wellbeing of local populations or communities as well as individuals and families. Furthermore it suggests that it means focusing on the distribution of health within populations, being proactive about preventative care for the healthy and those at risk as well as the chronically ill and also thinking about the health of those who do not attend their GP regularly. The paper identifies three key reasons for general practice being particularly well positioned to take this approach. These are:

- general practice is the most accessed part of the NHS
- the registered GP list, which is described as the 'basic tool' for a population health approach, providing GPs with a 'stable cohort of patients, who reside in a broadly defined geographical area'
- the generalist tradition of general practice in the NHS, which sees individual patients in their wider context and allows GPs to be uniquely positioned through working in local practices, where they are able to build and capitalise on their knowledge of their patients, contacts and community.

Taking a population health approach means being proactive about promoting health, wellbeing and independence for all and providing preventative care for those people who are healthy but at risk of illness in the future, as well as caring for those people who are already ill or in need of support.

While most primary care professionals already understand this to be a fundamental part of their role, there are many different factors impacting on the ability of general practice to focus more on wellbeing and prevention in this way. One such factor is the availability and use of high quality data and risk stratification tools. On several occasions our members have indicated that patient profiling and segmentation can be a powerful tool for identifying individuals at risk of developing a disease, or of deterioration in an existing condition. That ability to identify potential need and intervene early can help in the short term with, for example, preventing unscheduled hospital admissions and in the longer term with reducing the overall burden of disease in a population. Our members also emphasise the value of using tools such as shared patient records across the health and care system to help better monitor and tailor interventions.

We do, however, recognise the challenges in establishing effective disease and risk registers, including getting information on lifestyle indicators, like smoking and body mass index, that can predict the risk of future illness for people who do not normally come into contact with their GP. Obtaining this kind of data across whole populations will clearly require imaginative approaches to identifying those at risk and working collaboratively with other health care professions and partners from across the wider system, outside of the practice in community settings.

CCGs, which are expected to have a detailed understanding of their local populations' health needs, may have an important part to play in this, for example in commissioning risk and population profiling tools and ensuring practices get the support and training to be able to use these them effectively.

Overall, in order for general practice to make the most effective use of risk and population profiling tools, and to implement subsequent interventions to reduce need and demand, it will require greater collaborative working across practices within a CCG and with the wider health and social care system as well as with local authorities, many of which have already begun making use of population profiling tools themselves. Greater collaboration would allow the sharing of knowledge and data about the health and wellbeing of the population and individual patients. It would also enable resources, such as risk and population profiling tools to be shared amongst practices, helping them to better understand and more effectively meet the needs of their community.

The NHS Confederation recognises that good health is reliant on a range of contextual factors, including housing, employment and education, and not just on good healthcare. Whilst there is much that general practice can do to orientate their own services more towards prevention, our members believe there is a need for a more systemic approach to be taken to promoting health and wellbeing, which involves the voluntary sector as well as different public services and agencies in addressing the social and economic factors that can contribute and lead to ill health, such as poor housing or unemployment. In order for general practices to play their role in this effectively, they need to be aware of and have a relationship with a wide range of different agencies and organisations. This would help primary care professionals care for their existing patients in a more holistic way, for example, by

referring people to receive non-medical sources of support, such as community based initiatives, women's refuges and school based projects, and to work with other agencies to identify priorities for longer-term interventions for improving health and wellbeing. **Again, CCG and local authority commissioners have an important role to play here in ensuring information about other services and organisations is made available to general practice and that they are involved in the development of local health and wellbeing improvement strategies.**

Significantly, some of our members have highlighted the need for greater system-wide collaboration to care for patients. They have suggested that it's unhelpful to speak about patient care in the framework of different sectors, such as primary care, secondary care, social care etc, and they recognise the need to integrate care effectively around the needs of the individual. This will require a change in culture and relationships, with greater emphasis on collaborative working between professionals across the different sectors. It will also require a shift towards collective responsibility for patients, which would mean for example that GPs would need to be informed about hospital admissions of patients who are registered with their practices, supported by technological tools like patient record/data sharing across practices and hospitals. **We encourage NHS England to think carefully about how to achieve this and encourage greater collaboration across the health and social care system, so that care is more integrated and learning and knowledge can be better shared across the system.**

Named accountable clinician

We believe that GPs have an important role to play in co-coordinating care and signposting people to the relevant health and non-health solutions. It is clearly desirable to ensure continuity of care, particularly for vulnerable older people and there is merit in the idea of identifying a named lead clinician to take responsibility for this. However, as we have said in our response to 'Getting it right for Vulnerable Older People', whoever the named clinician is, it is vital that they have the necessary skills for the role and that they understand the importance of integrating care around the patient. They should also be comfortable working as part of a team that includes health and social care professionals, community volunteers, carers and family members to properly support someone's needs.

Our members have cited GPs, community matrons and social workers as all being capable of taking on this task. Some argue GPs, who are by definition 'generalists', would not necessarily always have the knowledge to coordinate the best care and that in some instances other healthcare professionals/specialists would be better placed to undertake this role. However, others agree that GPs are naturally well-placed in the community to do this. **Before finalising plans to establish such roles, more work is required to clarify their purpose and explore the practical implications**.

CLINICAL LEADERSHIP AND INNOVATION

The NHS Confederation believes that it is vitally important for commissioners and providers to have the time and space to develop new integrated models of care that improve services for patients and deal with the needs of the local population. Some

of our members have specifically highlighted the importance of recognising that ideas and solutions will not come from commissioners alone, and that providers must be enabled to innovate. **Therefore, we ask that clinicians are given the protected time and support needed to develop and test their ideas.**

We also believe that if general practice is going to help address many of the pressures that are facing the NHS it will need to take an innovative approach to population health needs, which recognises that within any local population there will be varying healthcare demands. So, for example, in some areas there will be a higher proportion of vulnerable older people, whilst other communities will have higher numbers of students or teenagers. There will also be varying social and economic factors in every community. Meeting the needs of different populations will therefore require different types of services as well as greater collaboration between general practice and other agencies. **We believe that it is vital that innovations and changes to services are driven locally, based on an understanding and knowledge of local needs, rather than any national priorities**. This localised approach would allow new models of care to be developed for groups such as vulnerable older people, wherever they are most needed.

The NHS Confederation recognises and supports the argument that general practice commissioning requires input from those who have an in-depth knowledge of the health needs of the local population and can most effectively influence and support change in primary care. There is an argument on this basis that CCGs are best placed to commission general practice, but there is equally significant concern about the potential conflicts of interest that this could create. **We believe that it is vital that NHS England, local government and Monitor work together to find an appropriate way through, which enables greater local input into commissioning of general practice and ensures that innovations meet the health needs of local populations most effectively.**

Further to this, we also believe that part of the solution for enabling more innovation will be about getting the funding necessary to test and establish the new models of care. Obtaining this funding may be reliant on greater integration and alignment of the non-primary care budgets which are held by CCGs and the budgets held by NHS England for primary care, so that there is more financial flexibility in the system to cover the up front costs associated with changing the way services are delivered. **Again, we call on NHS England and Monitor to work together to find a way through which would enable CCGs to align their budgets with NHS England's budget for primary care, so that there is more financial flexibility in the system to cover the up-front costs, associated with changing the way services are delivered.**

The education and training of GPs and practice teams, as an integral part of the care system, will also be important for encouraging innovation and getting effective clinical leadership. **We need to ensure that staff in general practice are supported through appropriate leadership development and training that encourages and supports them to lead innovations and work more collaboratively across the health system and wider**. We need to ensure that there is investment in leadership training for GPs, at the same levels provided to

other provider sectors and CCGs, to ensure that general practice has the sort of leaders that are needed to improve services.

FREEING UP TIME AND RESOURCES

Our members have highlighted to us the importance of ensuring improved access to general practice in order to reduce the demand on hospital services. We do, however, recognise the huge pressures that general practice is facing in terms of workload, particularly with the increasing numbers of patients suffering from long-term illnesses. We have suggested that simplifying QoF and developing innovative models of care and new staff roles within practices are both important ways of relieving some of these pressures. However, our members have also told us that they agree with several primary care organisations, who have suggested that the solutions lie in more collaborative working between practices across primary care, hospitals and community services as well as with the wider social services, local government, government departments and voluntary sector. Moreover, we argue that this collaboration should be enabled by greater alignment of financial incentives and through using technology more innovatively.

Simplifying QoF

We recognise the value of the Quality Outcomes Framework (QoF) for driving up standards in general practice. However, we are aware that many GPs feel that some of the QoF targets are burdensome and bureaucratic. This was highlighted in the GPC 2013/14 Imposition survey[1], which showed that 97% of all GPs surveyed said they felt QOF bureaucracy and box ticking had increased, with 76% saying they had less time for patients other clinical needs because of changes. **We believe that there is a need to simplify the demands placed on practices, so that they are more flexible and to reduce the feel of a process-driven tick-box culture**. Furthermore, we think that the personalisation agenda within health means that there is a need to give greater emphasis to patients' own intended outcomes and how we might improve standards in that area, rather than top-down targets imposed nationally .

Innovating with staff and new models of care

Fundamental to freeing up time and resources is the development of new innovative models of care delivery, and as we have said this means encouraging and supporting general practice to develop and test new ideas. **We believe innovations will be enabled by making funding available through greater alignment of budgets between NHS England and CCGs, to create the financial flexibility necessary to allow for changes to be made to the way that care is delivered. It will also be reliant on empowering and enabling clinicians, through education and training, which specifically helps them to lead the changes and work more collaboratively to share ideas.**

[1] BMA ,GP workload survey, 2013/14l

We recognise and support the principle that many of the ideas and innovations which free up time and resources will involve making more effective use of existing practice staff and exploring the possibilities of using different kinds of staff in new ways. A variety of staff working in general practice, especially nurses, are already engaged in managing specific high risk patients and those with particular diseases, such as diabetes. This approach, as well as the introduction of new health care roles, is increasingly standard in many practices. For example, many of them have been using Physician's Assistants to provide support to GPs, by taking medical histories, performing examinations, analysing test results, diagnosing illness and in some case managing specific high-risk patients. **We think it's vital that general practice is supported to continue to innovate with staff roles in this way and to develop new ways of working.**

Scaling up general practice and encouraging wider NHS, local government, government agency and voluntary sector collaboration

Our members have also expressed their support for the ideas for freeing up time and resources suggested by the Royal College of General Practitioners (RCGP) in its paper 'The 2022 GP- A vision for general practice'[2]. In this they assert that groups of practices and primary care providers working in federated or networked organisations will allow for more pooling of resources and combined 'back office' functions, as well as helping to provide extended services (otherwise known as locally enhanced services). They suggest that these models can better enable the coordination of out-of-hours care, by pooling GP time across several practices and asking those GPs to work different shifts, covering longer hours. They also suggest that practices working together can help better monitor and understand inappropriate variability in clinical performance through sharing comparative data and peer review. Even more importantly, RCGP highlights how working collaboratively and sharing ideas across federations and networks can help to enable new models of care and new staff roles to emerge, which better meet the healthcare needs of the local population and support people to manage their own health.

We believe that federated models and GP networks, as described by RCGP, are part of the key to enabling general practices to draw on the skills of a wider pool of multi-disciplinary staff working across several practices. Allowing those staff to be engaged in various existing and new roles that help to free up GP time and resources, as well as helping to better meet the changing healthcare needs of the local population.

We urge NHS England to encourage and support the scaling up of general practice through federations and networks that go wider than just general practice, but that also extend across primary care, particularly involving pharmacists and community services. Our members have highlighted the need to work more collaboratively across organisational and professional boundaries. This means for example enabling community nurses and practice nurses to work together to care for patients and enabling generalists and specialists to work more

[2] http://www.rcgp.org.uk/~/media/Files/Policy/A-Z-policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx

collaboratively to share knowledge. In order to make sure this happens we need to ensure that there is flexibility in contracts, to allow specialists to move away from being hospital-based, to instead becoming an expert resource available to GPs in the wider the community.

In our paper, 'A primary care approach to mental health and wellbeing', we have highlighted the commissioning approach developed by Sandwell and West Birmingham CCG as one way of successfully collaborating across organisational boundaries to deliver care. The collaborative primary care model for wellbeing adopted by Sandwell works on the principles of co-location, integration and collaboration and is aimed at aligning mental and physical wellbeing. It uses a stepped approach, with different levels of care to ensure consistent flow of service users, graduating from low to high intensity, starting with self-help and one to one support in community settings and stepping up gradually to psychological interventions and liaison psychiatry. The framework inverts the current focus on the specialist needs of the few to more population wellbeing, prevention and primary care.

As emphasised above, we are convinced that the scale of the challenges demands an even more imaginative approach, which involves paying much more attention to the provision of preventative services. This approach will undoubtedly mean collaborating more widely than just the NHS and will require thinking about non-health based solutions as well.

In order to fulfil this ambition, general practice needs a better understanding of what different services and agencies can contribute and what community initiatives are already going on. This approach and similar approaches are already going on in several places, including the Bromley by Bow centre in East London, where primary care services are co-located with a range of services designed to improve peoples access to employment, benefits and housing. We recognise that different models, involving different agencies will be needed to suit the particular needs of specific communities and we encourage NHS England to enable these models to be driven locally and support them to become more mainstream.

Technological innovation and data-sharing

We believe that using and innovating with technology in general practice has an important role to play in freeing up general practice time and resources through facilitating and enabling different parts of the system to collaborate more easily, as well as helping to ensure improved accessibility to GP services, which will in turn help to reduce pressures on the rest of the system.

From a patient's perspective, communication about care between different parts of the health service can often be poor. Much of this breakdown in communication or sharing of data can be laid at the door of incompatible IT systems. Having systems in place that do not talk to each other leads to a lack of clinical data on patients' arrival in hospital and post-discharge. This is an issue that was not only highlighted by members. In a recent NHS Confederation survey on integration, aimed at directors of adult social services and senior CCG leaders, the most frequently-cited factor

holding up integration efforts was 'data and IT systems' with 64% saying they are an impediment to delivering integrated services[3].

A lack of data-sharing in the health service also occurs because of concerns surrounding data protection rules, due to a lack of understanding about what those rules mean. Senior people in NHS and local authorities have highlighted employees' worries about breaching information rules and suggest this is as much to do with perception or lack of understanding, as worries over being disciplined.
Our members have highlighted to us the fact there is no externally-imposed imperative to develop shared data systems, and that the number of participants means that group initiatives are cumbersome and often fail. Furthermore, we believe that general practice has the most developed electronic patient record. However, our members recognise that many GP practices/practitioners do not have the resources to initiate the improvements necessary to allow for greater interoperability and more data sharing.

We therefore believe that hospitals, which may have the resources needed, and general practice should work more collaboratively to share resources and the expertise needed to develop or purchase systems that work across providers and facilitate data sharing across health and social care.

Our members also agree with several organisations, including the BMA, who have called for general practice to offer more alternatives to face-to-face consultations, such as dedicated telephone and/or Skype-like surgeries. We believe that general practitioners need to be encouraged and supported to develop new, innovative, secure ways of using technology to communicate with patients and make themselves more accessible to the population as a whole.

INCENTIVES FOR OUTCOMES

Incentives across health and social care, including those for GPs, should be aligned around a health and wellbeing agenda.

We believe that the key to meeting many of the demands on the NHS, including the challenge of greater numbers of patients with complex and multiple long term conditions, will be in developing services that help people to better manage their conditions at home and in community settings. With this in mind, we agree that the GP contract needs to develop so that it can better support wider NHS objectives and that there should be greater alignment of financial incentives and payment mechanisms to enable the whole-system approach that our members believe is necessary in order to meet the challenges facing the NHS now and for the future. At present, we note that monetary incentives exist in the acute sector which, some would argue, encourages more hospital activity. Equally, there are no financial disincentives to GPs admitting vulnerable older people to hospital. Our members think that the incentivisation of hospital activity is financially unsustainable, given the costs involved in treating greater numbers of people with multiple, long-term

[3] http://www.nhsconfed.org/priorities/latestnews/Pages/Poll-identifies-mixed-bag-of-challenges-to-genuine-integration.aspx

conditions in a hospital setting. Furthermore, we think that the current payment mechanisms prohibit the system from working in an integrated way to manage the health and wellbeing of the local population, by not incentivising preventative measures enough.

Many of our members have expressed the belief that financial incentives for primary care providers, along with other parts of the health and social care system, need to be aligned so that acute trusts, community care and primary care are all working together to prevent illness, manage people's conditions and prevent unnecessary hospital admissions. **In order to resolve this situation, financial incentives across health and social care, including those for GPs, should be aligned around a health and wellbeing agenda.**

Long-term Investment

More investment should be earmarked for primary and community care to make 24/7 care a reality across the system. This should be a priority and was an issue highlighted by our members in a recent survey on A&E pressures. Our members say the rising numbers of frail older people with complex, often long-term conditions is the biggest cause increasing pressures on A&E services. In turn, they say that further investment in primary and community care would make the biggest impact in relieving those pressures[4]. Ensuring 24/7 access in the community to care services that can treat urgent healthcare needs would relieve pressure on A&Es and the acute sector, ensuring that the latter can effectively treat those emergency cases that need to be dealt with within a hospital. In turn, involving community and primary care in the discharge process, including ensuring that discharged patients return to an environment which can appropriately deal locally with their post-discharge needs, will prevent re-admission and thus further pressures on the system. GPs, and primary and community health care in general, can play a key role in implementing a new, flexible model of collaboration across sectors - whether it is implemented through multi-disciplinary teams including specialist acute and primary health medical staff who will work together across the healthcare sectors, or through co-location of GPs at the front door of hospitals.

INFORMATION, CHOICE AND CONTROL

The NHS Confederation recognises the increasing demand for clear, comparative public information and we have said that information must become central to the patient decision making processes. We believe that choice is a fundamental part of health care delivery in the 21st century and we support choice and competition where it is in the interests of patients and taxpayers. We welcome a diverse mix of providers as a means of driving efficiency, expanding innovation and improving quality of care and we believe that people need to be encouraged and supported to take a proactive role in understanding and managing their own health.

We do however, still recognise that there are differing opinions amongst our members regarding the effectiveness of expanding patient choice in different

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[4] *Emergency Care: An Accident Waiting to Happen?,* NHS Confederation, September 2013.

circumstances. We are also aware that some GPs themselves do not necessarily agree about the value and effectiveness of patient choice in general practice. These differing opinions in themselves may act as a barrier to enabling choice.

We believe that there are several further issues worth highlighting, which are currently acting as barriers to choice in health care, including in general practice. In particular, our independent sector members have expressed concerns that patient choice and any qualified provider are not being fully implemented at a local level. In response**, we have called for the final version of the Mandate to re-emphasise the importance of delivering the existing objective on patients' rights to choice and ensuring that progress with this is systematically monitored.**

We would also seek to draw your attention to the work done by the Cabinet Office, which published a Barriers to Choice Review in January this year. The review[5], which heard directly from service users and also commissioned Ipsos MORI to conduct a survey looking at people's choice in practice, identified the following issues: access to GP lists and appointments, transport, GP surgery capacity, bureaucracy and difficulty in accessing and interpreting relevant, basic information, as all being important barriers to choice. **With these barriers in mind, we call for data to be made more easily accessible and for people to be actively supported in making informed choices. Furthermore, we would encourage the development of different organised primary care models, in the form of networks and federations in order to overcome some of the barriers people have in accessing the GP services.**

The starting point for designing and providing access to community services must always be about understanding what kind of choices and options people want and need, rather than achieving a particular configuration of providers and markets.

We also share NHS England's view that robust, comparative data can and should play an important role in addressing variation in the quality of general practice and we believe this information, along with greater use of peer reviews should be used to stimulate quality improvements. Furthermore, we believe strongly that by scaling up general practice through the establishment of networks and federations of providers, general practice will be better able to understand and manage any inappropriate variability in quality, through various joint learning and quality improvement mechanisms, such as audits and peer review.

For any further information relating to this response ,please contact Matthew.Macnair-Smith@nhsconfed.org

[5] The Barriers to Choice Review, Cabinet Office, David Boyle, January 2013