Call to Action Debate
LMC Representative Comments

It seems conterintuitive to be incentivising the more expensive side of a system with PBR/Acivity based contracting whilst disincentivising activity in (cost effective) primary care with a capitation (formula) based funding system for core services. You mentioned that you are on the Primary care workstream at NHS England and I feel (with the increasing pressures on Core GP with exponential rises in LTC's and patient expectation for greater access) the only way of building the necessary capacity is to "bolt on" an activity based contract for Core GP access and LTC's. I feel this needs to be done at a National level and will take some political will, but desperate times call for desperate measures! The Area team has limited scope to move money around in the system and reusing QOF funds more efficiently will only scratch the surface of the real challenges we are facing. Releasing the "Core workload" pressure will then allow greater GP engagement with CCG's to really shift services and consider a strategic approach to IT/Workforce/Premises etc.

My responses to the questions you pose are as follows :-

1. Most effective contractual levers – GPs working in areas of social deprivation need to be paid substantially more than those working elsewhere, but that extra pay needs to be tied to performance related targets. However, we need fewer targets, focussing on the things that really matter. For example I would suggest just 5 targets for diabetes – smoking habits, eGFR & HbA1c levels, BP control & lipid control. Just paying extra allowances to GPs working in areas of deprivation, incentivises them to work there, but then not do very much to promote the health of their patients.

2. What model .... best supports integral working – Reinstate proper practice-based teams of Community Nurses, Health Visitors, Midwives & Social Workers. Over the last 20 years the trend has been in the opposite direction & it has proved disastrous. I would also like to see practices being given the choice and financial resources to employ their own Community Nurses, if they so wish.

3. Improving Morale – Fewer targets, stop cutting GPs pay, more autonomy for GPs and the reinstatement of practice-based teams as described in section 2.

4. Measuring quality – A combination of achievement of targets, more focussed as described above, and patient satisfaction surveys. These surveys need to be organised and administered by CCGs, leaving practices to get on with treating patients.

5. How can the wider system support front-line GPs – Ultimately we need to be aiming for a service where GPs can see patients in surgery at a rate of one every 15 minutes as recommended a few years ago by the RCGP. More urgently we need more Community Nurses, more Practice Nurses & more HCAs. This is going to be difficult to achieve in the present financial climate. The number one priority is more Community Nurses, as good community care prevents some patients being admitted to hospital, thereby saving money.

6. Freeing up time – Firstly I would scrap the DVT LES. One suspected DVT can wreck an entire surgery as it takes about 30 to 40 minutes of doctor time to deal with a patient who usually has a 10 minute appointment. It is also somewhat disruptive to Practice Nurses who have to fit them in as urgent extras. It would be much more satisfactory if we went over to the system that they have in East Kent where there is a dedicated DVT Nurse in A & E who deals with these patients. The other thing I would like to see changed is the QOF for CKD, in relation to patients with a eGFR in the range of 45 to 60 with no significant proteinuria, i.e. the majority of CKD patients that we see in general practice. A recent article in the BMJ, by an Australian Nephrologist (I think) suggested that about 1,000 patients in this category need to be treated to prevent one case of end-stage renal failure. It seems to me that these patients would be better managed with no routine drug therapy. Instead they would merely have their renal function, ACR & BP checked annually.

7. More robust processes of internal governance & accountability – Minutes of significant event analysis meetings should be made available to medically qualified officials of the CCG, as should details of complaints, including their outcomes, with the member(s) of staff concerned being named.

8. Finally I would like to see the Government, the SHAs & the CCGs genuinely going out of their way to support GPs & their staff rather than pandering to the wishes of the Daily Mail & its readers.

I fully agree with Robert about a national debate on end of life treatment. I also feel there needs to be national agreement on what can and cannot be afforded. I also feel that care free at the point of access should be reconsidered - a view I know not popular with many colleagues .I believe it should be part of the Call to Action debate. I don't disagree with larger models of care but have concerns about a salaried model and feel this will lead to less patent focused care reduced commitment and thus inability to deliver especially if care is to be extended 8-8 24/7. Personally I will retire with the advent of 8-8 24/7 although dont disagree with it from a patient/public perception .I think many GPs over 55 will vote with their feet. I am concerned about the ability to recruit to deliver a General Practice service at all. I don't disagree that we need to do things differently as we quite simply cant continue to absorb all the work so an integrated primary care community model might be the way forward. Although I think QOF has run its course I am concerned that with re badging we will be expected to continue doing what we are doing with additional targets/additional costs. Sorry dont think I have answered the questions also found the survey full of incomprehensible management speak! Best of luck with collating everything !

The questions themselves give a feeling of doom but I am sure that this rediculous process could be stopped and moral be bought back. The inane buerocracy has alot to answer for as basically most of our increased work load is form filling and the majority of it does not help patients. We asked for local midwifes and DN when the |CCG was formed as that actually improves patient care and decreases work load. Personally I thing primary care will just become the front for secondary care and us literally just behaving as salaried gate keepers. we just dont have time or the inclination to carry out preventitive medicine and I wonder if it should be split off all together. My daughter is 2 years into her GP training and certainly does not want a partnership. If QUOF was much more simplle, like BP BS wt smoking on everyone and none of this nonsense about what level of serum rhubarb etc then we could make a real difference. Health check have been proved to really be no use and not cost effective but still they got ramroaded through. What is point of picking up more demntia when there is no real treatment of resorces to help? Patient choice just make the NHS more expensive. It should be reiterated that this is a free service and comes with restrictionds or people can elect to pay.

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* What are the most effective contractual levers to ensure good health outcomes for all will result?

Not entirely sure whether this means all NHS contracts or GP contracts. Tendering short term APMS contracts for GP services results in GPs and other providers not being to make long term plans for service delivery and discourages investment into general Practice. As we yearn for continuity of care for patients we should also be championing secure and attractive contractual methods for commissioning primary care services.

As was discussed at the last meeting GP services perhaps should also move to activity based payments rather than a block contract which leads to unfunded work being dumped on primary care.

* What model of primary care and community services best supports integrated working?

Local town teams working closely with GPs. Better monitoring of community services' contracts. Local GPs being lead clinicians, with the senior nurse, for the community nursing teams

* What actions would most help to improve morale amongst staff working in primary care?

Stop constant change of targets, payment methods, rules and make a long term/5 year plan of what we want to achieve and then give it time to be implemented.
Easier and supportive processes for dealing with complaints.
Better and primary care integrated public health campaigns.
Some positive publicity will be useful but am sure very unlikely to happen!

* How best can the wider system support front line GPs to harness innovation and spread good practice?

By investment. All Acute trust contracts should be transparent and enable unbundling of activity. This is the only way to shift activity into primary care. Moving the money into primary care with the activity is the only way to encourage further innovation.

* To free up time what can we safely stop doing, or do more smartly?

This is not upto us as most of the box ticking is politically/centrally driven. There needs to be a cull of the nonsense to free up time and resources for patient care and innovation.

In the end the only way NHS can survive is by managing demand and patients needs to be made aware of their responsibilities and not just their rights. We need to look at what we can deliver with the resources that we have and then try to get the message to the public. This is not going to happen till politicians keep using NHS as an electioneering tool.

NHS governing body/executive should be made independent along the lines of Bank of England so that the constant political interference can stop.

I hope I haven't rambled on too much! Oh yes and 7 day 8 to 8 routine GP services should be a very deep line in the sand never to be crossed.

We must ensure that GP reimbursement is related to prevalence of disease and work done, rather than just vague notions around deprivation. It is the elderly with a multitude of LTC's that are using a disproportionate amount our time and resources, both in primary and secondary care, and we must have an honest debate as to how this can be funded, and where care is best delivered. Mapping the Future is looking at this locally and it is important that we all have buy-in to the outcomes.

We need some extra resources in General Practice and without them there will be increasing problems which probably will get worse steadily.

The secondary care sector wants us to take over more work and our existing patients as they age will also need more from us. Add to this the certainty that there will be more ideas coming from government and more technical changes from research about extra things that will be possible ,you have a perfect storm of extra demand with diminishing resources and a diminishing workforce. It seems that there are no easy fixes.

It may help to release us from much of the duplication within QOF and Des work where we are asked to produce fairly pointless audits of for example A&E attendances and then have a long discussion and then an action plan which probably achieves little but takes many hours of people 'time .We need the money that this task delivers so we do it,we are not seeing patients or doing our real jobs while we do it.

Having a real link with our community nurses would help, some point of contact with whom you can discuss your patients with problems regularly.This would be a better way to organise this risk profiling area ,rather than a cumbersome MDT which is discussing things after the event.

A stable community matron team that again you can get to work with ,they are spread too thinly and cannot make much impact.

To aid conversations between primary and secondary care ,do we understand out 2ndary care colleagues and there problems ,do they know much about ours in primary care.

To maximise continuity of care wherever possible ,does a patient get better care seeing a different person each time in any setting ,probably not and I am certain this generates cost and inefficiency.

End of life care can be improved already good in places .

Is there anything that can be done about negative press etc ,this drip drip of anti GP stuff has an effect and starts to turn people off the specialty.

I think starting at practice level and working from there will yield benefits ,what we do not want is another complicated set of tick box type tasks.

Better use of technology wherever .

As I said in my little piece ,at the start of all this is the quality of the doctor or nurse /patient interaction,from this ripples out many consequences both positive and negative.

Just a bit more money for us to do something with within the practice,targeted if it needs to be.

I was very sorry to miss the debate on 10/10/13 but having read the notes would very much like to respond.

I recognize and welcome Mr Ridgwell's analysis of the current issues facing GPs. To the analysis I would add the longstanding issue of clarifying what the Government wish from GP and in turn what the public wish. I suspect that the answer is more and better. I do not think GPs have a problem with that. Unfortunately the rhetoric and funding has not made that direction of travel possible and we are currently looking at less and possibly not as good. We have a recruitment and retention crisis and particularly in E Kent and I suspect Medway.

We need to look at making GP an attractive career in K&M

To address a few specifics:

QOF: is not broken but it has been devalued by an overly tick box approach. It needs to be stripped back. It still has great value as the most internationally effective means of embedding and organizing Evidence Based Medicine. Do not forget that it started in E Kent as a result of the only time I remember of the CE disinvesting from hospital medicine to support a primary care programme. It needs to return to core principles and evidence base losing political targets.

Premises: There needs to be strategy of looking at where primary care facilities are needed in each area and a plan for investment when the fiscal policy changes. The co-location of community services is imperative.

Community Services: The contracts need to be broken up and GP enabled to bid for them and particularly enabled to integrate services.

Training: There is a desperate need for GPs with extra clinical skills ie minor surgery, dermatology etc. The funding needs to be provided to enable training either by making the contracts more attractive or a system akin to a student loan , repayable as part of service delivery.

Secondary Care Contracts: Clarity is needed as to the responsibility of secondary care to provide services. In detail the responsibility for follow up, organization of tests etc and a clear penalty mechanism when the service is not provided in full.

In summary K&M needs to demonstrate that they value GP in the area and wish to develop further. Strong GP has been shown to equate with better outcomes. The current model is not broken but is bowing to pressures. It needs to be strengthened. The long heralded secondary to primary care transfer needs to take place supporting premises, integration and career development.

Dear Mike and Kelly,

I'm sorry to be late in responding to your request for feedback about the call for action campaign following the LMC debate on 10th of October 2013.

Just a few comments which I will divide under two headings.

General practice within the wider context of the NHS which will require political commitment. (National general practice)

General practice within the local area which should be more locally managed with considerable room for innovation.(Local general practice) eg. Collaboration with CCGs

1) National general practice.

General practice in the UK is utterly unique in its free local provision of NHS services familiar to the public and well used by them. General practice should be first point of call for all medical services apart from emergencies. General practice premises have a presence within every community throughout the land and usuallyare within a mile or two for the vast majority of the UK population.

general practice provides a personal service with continuity through the generations which is so valuable to the individual and society as a whole.

It is the only NHS service that does not exclude particular groups of people with perhaps the only other exception being A&E which should have more well-defined criteria for accepting or excluding groups of patients.

it naturally follows that:

ALL other services that are delivered in the community should revolve around general practice premises and in particular the GP Teamservice.

Social services in particular needs representation within every practice in the land in order to make for efficient delivery of the increasing burden of social care that escalates year-on-year. this leads to be a named person with ongoing commitment to deal with the social issues that are relevant to patients presenting in general practice. It is vital that this is personalised to each patient and the GPs and social workers have access to each other's services constantly. This will help the patient pathway as well as ease the obvious inefficiencies in current medical care e.g.discharging patients to a safe locality once their medical needs have been addressed within the hospital setting

Mental health provision is an increasing burden within general practice especially in regard to dementia and elderly care. Mental health services should provide a named regular mental health professional, competent in dementia care, who is also able to provide a personalised contact for patients and their carers. as with other services there should be a regular presence within the practice and free flow of communication with the practice team.

we deplore the fragmentation and depersonalisation of GP community services that have occurred over the last two to three decades with the separation and distancing of district nurses, health visitors and midwives from their integral place within the practice team. this trend needs to be reversed, with named community nurses meeting regularly with the GP practice team within GP premises.

I believe that a significant part of the public disenchantment with some of the NHS services is due to the depersonalisation of the service provided, lack of continuity and often lack of commitment to provide the best possible service for the individual patient. users value a personal service especially with medical services.

I also believe that the increasing difficulty (pressure of workload and tick box mentality) of providing a personal and caring service within the general practice context is frustrating hordes of highly competent GPs and nurses and causing many to leave the profession early. as well as putting off potential new recruits who might otherwise pursue a medical career. These will usually be highly able people who do not wish to become " medical technicians". I think that the Staffordshire report clearly reinforces all this.

Politicians of all persuasions need to be acquainted with the increasing disillusionment of so many within the caring professions.

They can help by financially incentivising a GP services structure where a personalised service is genuinely valued, maintains the highest competency and encourages innovative local initiatives in providing medical and allied care.

What is needed?

More GPs will be required, though not vast numbers, to manage the increasing burden of elderly care and especially the secondary to primary-care shift of workload which MUST have substantial finance transferred to primary-care along with the workload. Inevitably some hospital services will need to be significantly slimmed down and more hospital general physicians e.g. geriatricians will need to be working in the community context through local practices, with greater use of technology e.g. remote patient monitoring.

More investment in primary care services directly will be needed.

Recent very large tranches of finance allocated to the social services should be earmarked to be delivered within the context of primary-care where it can be targeted much more efficiently in so many cases. This will keep many patients at home longer before requiring residential or nursing care, remove bed blockers within the hospital setting and transfer them quickly either to home or an alternative intermediate care facility.

2) local general practice

CCGs' now have a unique opportunity to influence the local practice environment to the benefit of patients and practice teams. I agree other LMC members, however, that much of what they can do to help will only be 'tinkering at the margins' if the more fundamental issues mentioned above are not addressed nationally.
Just a few comments or suggestions:

encourage a favourable environment for the new integration, or reintegration of support services such as social services, mental health services, dementia care services, district nurses, health visitors, midwives etc within each practice team.

be trustworthy advocates of the fair financing of primary care services and tno less so when it comes to moving money from secondary care to primary-care because the service has moved in that direction. There is suspicion that this is not currently the case all too often.

in applying AQP give due recognition to the value of local practices to the community and insist on any AQP communicating transparently with local practices and that their work will enhance the function of the local practice team and not detract from it.

Recognise the value of Sessional GPs who provide just under 50% of the GP workforce. They can do this by consulting more with sessional GPs as a group and encouraging practices to provide working conditions and remuneration that reflects their true value to the practice. As opportunities expand within primary care for general practice recruitment, it is the more flexible sessional GPs many of whom have excellent portfolio credentials who will be attracted to work for other not-for-profit or commercial organisations. These other organisations will often have short term agendas rather than long-term stable commitment that general practice requires.They will often have no genuinely heartfelt interest in maintaining the unique cohesiveness of UK general practice and what it can offer to patients, the community and the wider medical profession. Sessional GPs need to be encouraged to stay committed to local practices And this will need incentivising.

recognise that those very able people who work within the general practice setting are more likely to respond positively and enthusiastically when given breathing space to apply their own innovative methods of achieving high quality and personal medical care within the general practice setting. This is in contrast to the top-down, straitjacket approach of recent years (especially QOF) encouraging the development of impersonal medical technicians who can easily neglect the presenting patient's own much more important agenda in so many cases. A sensible balance needs to be struck.

Sorry Mike, I think I got a little carried away! This is all too easy with the dictation software I have used to write this email so please forgive the typographical and grammatical errors that I have not had time today to go through and correct.