

July 2009

# Focus on the Department of Health's *'Improving GP Services'* guidance

GPC guidance for LMCS and GPs  
(England only)



## CONTENTS

<b>1</b>	<b>Introduction</b>	<b>page 3</b>
<b>2</b>	<b>Practice performance assessment</b>	<b>page 3</b>
2.1	Patient choice	page 5
2.2	GPC concerns	page 5
2.3	GPC advice	page 6
<b>3</b>	<b>Primary care contract management</b>	<b>page 7</b>
3.1	GPC advice	page 9
<b>4</b>	<b>Opportunities for general practice</b>	<b>page 10</b>
4.1	Expanding practice allowance	page 10
4.2	Improving premises and estates	page 10

## 1 INTRODUCTION

The management of GP contracts in England is set to change following the publication in January 2009 of the document *'Primary and Community Services: Improving GP services'* by the Department of Health (DH). It can be found at:

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093830](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093830)

This document follows on from the NHS Next Stage Review, and is part of the World Class Commissioning (WCC) initiative. Where many GPs previously considered WCC to involve the commissioning of services in secondary and community care, this document seeks to manage the quality of primary care services commissioned by primary care trusts (PCTs) from all GP practices, and provides practical advice on how PCTs can do this. Throughout 2009/10, PCTs will look to begin a process of monitoring practice performance in a number of areas and managing practice contracts with this new data.

This represents a significant shift in the relationship between practices and PCTs. It is essential that practices and local medical committees (LMCs) familiarise themselves with this document to ensure that these mechanisms are not misused by PCTs. This DH guidance will become a central part of the function of PCTs; *"Get the commissioning of GP services right and the benefits will extend to the commissioning of wider NHS services, including hospital care"* (p13).

This 'focus on...' intends to explore: how PCTs will assess practice performance and how GPs/LMCs can influence this process; how PCTs have been advised to manage all primary care contracts; and the opportunities that this DH guidance presents for GPs.

## 2 PRACTICE PERFORMANCE ASSESSMENT

PCTs have been instructed to develop a baseline assessment of the existing provision of primary care services in all GP practices, whether GMS, PMS, APMS or PCTMS. Data is to be collected in the strands detailed in the box below.

### Capacity, including:

- number of GP consultations per 1,000 weighted population
- length and quality of all primary care consultations
- average patient list size per GP practice
- number of whole time equivalent GPs and other clinical staff (e.g. practice nurse, nurse practitioner, health care assistant) per 1,000 weighted population

### Quality, mapped across three areas:

- Organisational quality (including safety)
  - practice accreditation
  - premises
- Effectiveness
  - achievement in the clinical domain of the QOF
  - exception rates and comparisons between reported prevalence and expected prevalence of long-term conditions
  - local data, e.g. prescribing, referrals, clinical governance
- Patient Experience: GPs, practice nurses, reception staff, communications systems, parking, quality of premises etc., that all combine to make up the overall experience. PCTs may use the

new GP patient survey, or other forms of patient feedback or an analysis of complaints received to measure this.

**Access and responsiveness** as described by the specific DH guide on this issue, to be published soon. Measurements will include:

- patient satisfaction with access
- practice opening hours for clinical appointments
- disability access
- consultation languages
- choice of male and female GPs
- uptake of extended opening hours
- use of premium rate telephone number
- attendance at A&E or walk-in centres as a proportion of list size.

**Patient choice** including choice of hospital, choice of practice and support of personalised care planning

**Value for money** including GMS and PMS spend per head, referral and prescribing data

**Premises** – compliance with national standards

**Demand**, including:

- emergency referrals/spells per 1,000 weighted population
- A&E activity per 1,000 weighted population
- activity within out of hours settings, particularly for routine or planned care
- Better Care Better Value indicators for ambulatory care sensitive emergency admissions
- Better Care Better Value indicator on surgical thresholds
- Better Care Better Value indicator on out-patient referrals.

**Enhanced services**, including access and uptake of these services

The DH will publish a toolkit detailing the individual indicators that PCTs are to use later in the year. Although the arrangements for practice accreditation, currently being piloted by the Royal College of General Practitioners, are far from concluded, practices should note that this will also be an element of the organisational quality indicator.

This range of indicators will be compiled into a 'balanced scorecard' with which PCTs will measure practice performance and benchmark it against local and national averages. Comparing this analysis of current provision with a local needs assessment (the Joint Strategic Needs Assessment) will highlight what PCTs will seek to change. This will form part of PCTs' 'strategic service model', which will include a 'patient offer', stating the range of services available to patients and what they can expect from GP services.

The DH intends that patients should be able to compare practices through publicly available information. Factual information about the practice such as opening hours, transport, parking, languages available, child-friendly facilities and services will be offered, as well as the balanced scorecard performance measurements. This comparative information will be available from traditional sources such as NHS Choices and PCT guides, but the DH also wishes to see it distributed by other public bodies, libraries and through 'proactive means', such as links on utility switching websites or mail-shots to new additions to the electoral register.

## 2.1 Patient choice

This is part of a central theme promoting patient choice that runs through the DH guidance. PCTs are to enable patients to choose which practice to register at, what type of care they receive, how they wish to access GP services and when they wish to do so. The DH is considering establishing a national online practice registration portal, while each PCT is being encouraged to develop a local call centre to support patients with registration and a 'How to move your registration guide'.

The DH envisages a future primary care environment where increased GMS funding per patient will incentivise practices to attract and retain patients, thereby supporting patient choice and stimulating local competition between practices.

## 2.2 GPC concerns

These proposals risk subjecting GP practices to an unprecedented level of scrutiny and performance management as well as encouraging patients to change practices. Much of this runs counter to the ethos of the GMS contract, with PCTs seeking to collect and use comparative data that is at, or beyond, the limit of contractual requirements. Some PCTs are already collecting a range of data similar to that specified in the DH guidance. Similarly, some PCTs are already presenting this data in a balanced scorecard format. However, the DH proposals direct that **all** PCTs should begin to collect information on indicators, some of which is of very questionable value to patients and the public. Prime among these are figures for the number of GP consultations/1000 patients. This simplistic quantitative measure makes no attempt to assess the quality of consultations, the use of skill-mix in consultation (e.g. nurse practitioners) nor the different ways that GPs manage different patient populations. Capacity indicators such as this also vary considerably day-to-day and week-to-week as GPs respond to their patients' needs. It is arguable that in providing this information, practices are revealing to competing providers the blueprint for how they provide primary care services as independent contractors.

The balanced scorecard approach assumes that practices will vary in their performance, that some practices will be 'better' than others and that all practices can therefore be ranked relative to each other. Although there may be a small number of genuinely poorly performing practices, the vast majority of practices in England provide excellent primary care. This ranking approach may undermine patients' confidence in general practice by drawing meaningless distinctions between practices.

In the proposed range of indicators, there is insufficient emphasis on trying to understand the reasons for variation between practices, or in offering patients an explanation for this. Variation may be a result of local practice circumstances and population case-mix, as practice populations can vary significantly in terms of deprivation, ethnicity etc. within individual PCTs. For some practices their 'performance' is limited by historic underinvestment or infrastructure constraints. For example, a practice with an insufficient number of consulting rooms may not be able to provide an adequate range and capacity of appointments and services. Given these premises constraints and a lack of PCT funding to improve the infrastructure or assist with relocation, it would be unfair for such a practice to be adversely judged on such outputs.

Where these balanced scorecards are to be published, it is essential that patients are made aware of the context in which the indicators have been assessed if they are to present honest information to the public. Without qualifying explanations, balanced scorecards risk becoming crude practice league tables that will deceive the public, and potentially distort the local health economy by encouraging patients to erroneously interpret the practice data. For example, half of all practices will inevitably be considered below average in a league table, but this will not reflect the high quality care provided by the vast majority of practices.

### 2.3 GPC advice

Much of the information that PCTs will seek to compile in the balanced scorecards is already in the public domain. However, there are some indicators which are not part of the routine contract data collected by PCTs, which practices will not wish to pass on, such as the access and capacity indicators.

However, section 77<sup>1</sup> of the GMS regulations and section 73<sup>2</sup> of the PMS regulations stipulate that practices must provide information reasonably required by the PCT. Moreover, the Freedom of Information Act 2000 states that all primary medical service providers are subject to requests of this Act, should they be made. It is therefore unfeasible for a practice to withhold this information from a PCT that requests it. Instead, GPs should proactively and collectively engage with PCTs, supported by their LMC, to influence the local use of such information and to mitigate against potentially adverse consequences of its publication.

The DH guidance is clear that it is up to the PCT to decide what information the public requires to make effective choices about their primary care provider. It also states that quality measures must be "*robust and balanced*" and that "*these should be developed in collaboration with local clinicians*" (p28).

LMCs should contact PCTs on behalf of their practices as soon as the PCT begins to undertake this process to determine how they intend to compile the balanced scorecards, and what indicators they will using. LMCs should discuss how indicators which seek to assess the quality of care by collecting quantitative data (such as the access and capacity indicators) will be used, and demand that indicators are not expressed without reference to the context in which the care is provided (case-mix within the practice population, historic under investment, infrastructure weaknesses, etc.) and that they are robust and balanced. For example, data regarding patient demand for A&E services may need to be considered in the context of the number of A&E departments available to patients, and their distance from patients. This context is essential to ensure that practices are not misrepresented to patients.

When in discussion with PCTs, LMCs should note that the DH guidance requires "*PCTs... to invest considerable time and effort in developing a close working relationship with every GP practice*" (p29). This implies that PCTs must be in a position to understand the context of the primary care provided by each practice; they should have an individual relationship with every practice and understand the local health economy, as opposed to acting as a detached data collector.

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<sup>1</sup> Schedule 6, part 5, section 77 of the GMS Regulations 2004: [www.opsi.gov.uk/si/si2004/20040291.htm#77c](http://www.opsi.gov.uk/si/si2004/20040291.htm#77c)

<sup>2</sup> Schedule 5, part 5, section 73 of the PMS Regulations 2004: [www.opsi.gov.uk/si/si2004/20040627.htm#sch5p73](http://www.opsi.gov.uk/si/si2004/20040627.htm#sch5p73)

To facilitate this, the DH guidance requires that PCTs develop sufficient capacity and capability to undertake this time- and resource-intensive process. Many PCTs already have difficulty providing adequate support for core initiatives such as practice based commissioning, and in such circumstances PCTs should be following the DH recommendations to:

- increase the size and capability of the core team
- pool resources across PCTs or collaborate on particular topics
- buy in additional support, for example through the use of Framework of External Support for Commissioners (FESC)

In cases where PCTs are not following these recommendations, and do not have the resources to develop a close working relationship with every practice, LMCs should strongly argue that PCTs are not in a position to understand the contextual factors affecting individual practices. In light of this, PCTs should discuss with the LMC how best to present the balanced scorecards to the public.

The emphasis on patient choice in this DH guidance is a growing theme throughout government communications. It is therefore more important than ever for practices to engage with their patients in discussion about their expectations and aspirations and respond if possible to their wishes to ensure that they present their best patient 'offer'. The GPC has produced a document containing some examples from practices already seeking to address patients' non-clinical needs, which it is hoped will help support practices looking to make changes in this area.

'Developing general practice - Listening to patients' is available here:

[www.bma.org.uk/employmentandcontracts/independent\\_contractors/managing\\_your\\_practice/listenpatient.jsp](http://www.bma.org.uk/employmentandcontracts/independent_contractors/managing_your_practice/listenpatient.jsp)

### **3 PRIMARY CARE CONTRACT MANAGEMENT**

The development of balanced scorecards will allow PCTs to measure practice performance, and consequently manage practice contracts more closely. The DH guidance is clear that this process must be undertaken as part of a close working relationship between the practice and PCT.

PCTs will have to agree a formal process for managing practice contracts that will set out clearly and publicly:

- what standards practices are expected to meet
- when and how performance will be reviewed
- what will happen if performance is below the required standards
- what support will be offered to help practices improve
- what action will be taken if there is a failure to improve

The standards will fall into two categories:

- Minimum standards that must be met. Many of these will be contractual standards; failure to meet them will usually trigger a formal intervention.

- Aspirational or developmental standards to be worked towards. These will set out what PCTs would like practices to deliver, with developmental support available to assist with this. We would expect that such work would be undertaken as a Local Enhanced Service where it goes beyond the normal practice contract.

Further to this, it should also be noted that we understand that practices will have to register with the Care Quality Commission from 2011 onwards to ensure that minimum standards for quality are met, subject to final decisions in this area.

PCTs are required to develop a performance cycle. The DH suggests the time line below; although we understand that many PCTs have yet to engage with this process, so the dates for each section are indicative only. We would not expect that this process to unreasonable impact on GPs time.

When	What	Outcome
Jan – Feb	Negotiate objectives and development plan for the next year, ensuring that there is an appropriate blend of qualitative and quantitative objectives. Agree any contract variations. Objectives linked to PCT's strategy, such as incentives to tackle high priority areas like CHD, will be common to all providers. Others will be specific to individual practices (e.g. extend opening hours from x to y, or increase patient satisfaction by x %).	Draft agreement for each practice.
By Mar 31	Sign off agreement/contract variations with every practice.	Written plan/contract variation, signed by both parties.
May	Formal, senior level accountability review with every practice, assessing performance over previous 12 months.  Ensure any balancing payments/clawbacks relating to the previous year are agreed.	Annual letter to practice, to be shared at PCT Public Board meeting. This could include an overall 'traffic light' assessment of performance.  Practice to receive clear statement of performance.
July	Publish Q1 key performance metrics for each practice.	Data published on PCT website.
Oct	Formal mid-year review with every practice. Publish Q2 key performance metrics.	Letter outlining main points of review meeting. Data published on PCT website.
Nov – Dec	Review of performance framework and metrics.	Revised framework (if appropriate) published.
Jan	Publish Q3 key performance metrics.	Data published on PCT website.
April	Publish Q4 key performance metrics.	Data published on PCT website.

Where PCTs find that practice performance, as measured by the balanced scorecard, does not match the agreed standards, PCTs are first and foremost expected to support practices in working to meet the standards as soon as possible. If practices continually breach quality standards, and deliver poor or unresponsive services to patients, PCTs may use the following formal contract levers, once legal advice has been sought:

- decommissioning enhanced or additional services
- issuing remedial or breach notices
- terminating contracts



However, the standard position for PCTs should be that they will assist practices in improving their services. *“Direct support should be explicitly linked to the overall approach to managing performance... and PCTs should clearly define the circumstances in which they will provide support”* (p32). Support that PCTs should consider offering when required includes:

- the provision of PCT staff with specialist skills to work directly with practices
- sharing examples of best practice from other practices
- the establishment of local learning networks across practices
- brokering support for practices from support agencies

Some practices may need genuine investment to enable them to improve their performance from a base of historic low funding or poor infrastructure. Although this is not listed as an option in the DH guidance, practices and LMCs should nonetheless make the case to a PCT for this alternative where it is considered to be the only approach to be effective in increasing the performance and competitiveness of a practice.

As part of this process, the DH guidance encourages PCTs to incentivise practices to improve quality through commissioning Local Enhanced Services (LESs), or by building specific requirements into PMS or APMS contracts.

A wider element of the performance management process will involve the development of the primary care market. PCTs are required to develop a strategy for ensuring that the primary care provider market can meet current and future service needs. In doing so, PCTs will assess the capacity and capability of current provision, including the range of patient choice and competition, and the extent to which new providers could potentially develop new services. PCTs may seek to commission additional capacity as a result of this process, from either a new provider, through a new service or by expanding existing practices.

The DH guidance provides strong emphasis on the commissioning of new providers to ensure that there is sufficient choice and competition, and as a conduit for innovation. It also promotes the use of APMS contracts as the most appropriate option for these circumstances, although it does note that PMS contracts have also been designed to meet gaps in local primary care provision.

### **3.1 GPC advice**

It is essential that LMCs and practices engage with PCTs and work with them through the performance management process. The ethos and personality of individual PCTs may have a significant impact on how this process develops, so it is vital that a constructive relationship is sought.

Although this DH guidance takes the performance management of practices to a new level, GPs should not be unfamiliar with PCTs playing a role in managing the provision of primary care services. As the guidance implies, practices should be working closely with PCTs, so that problems are identified and addressed at an early stage. Practices already receive regular feedback from PCTs through processes such as the Annual Contract Review and should take note of any recommendations arising from these. The appropriate implementation of a formal contractual lever (as outlined above) should not come as a surprise to any practice. The

performance management process in no way supplants practices' formal contracts (whether GMS, PMS, APMS or PCTMS) which still govern the provision of primary medical services.

The DH encouragement of PCTs to use local incentives is positive, although LMCs should be wary of attempts to introduce local QOF-style indicators. All local services should be commissioned through the LES route, and LMCs should work with PCTs in their development. LMCs should also seek to keep abreast of any PMS and APMS contract negotiations. APMS contracts in particular are likely to be commonplace when new practices or new providers are being sought. The DH wishes to ensure that there is a sufficient variety of providers in local health economies to offer genuine patient choice and effective competition. As discussed above, existing practices should seek to make any necessary improvements to ensure that they can provide a competitive patient 'offer'.

## **4 OPPORTUNITIES FOR GENERAL PRACTICE**

Beyond offering support to practices and encouraging the use of local incentives, this document provides two specific opportunities for GPs.

### **4.1 Expanding existing practices**

Instead of commissioning new providers, PCTs may wish to expand existing services. Designed especially for this purpose, the Expanding Practice Allowance (EPA) model enables PCTs to provide practices with a one-off grant. This should be used to increase their infrastructure – usually in the form of additional staff – in anticipation of increased list sizes. It is one way of overcoming the time delay between additional patients actually registering with the practice and increased capitation-based payments. EPAs are granted at PCTs' discretion and decisions pertaining to their award should be made transparently and on the basis of locally agreed objective eligibility criteria. This is a positive development, and LMCs should seek to liaise with PCTs in the agreement of these criteria.

### **4.2 Improving premises and estates**

The DH guidance reaffirms that contractors are obliged to ensure that they operate from adequate and suitable premises, as defined by the NHS (GMS - Premises Costs) Directions 2004. Where premises do not meet basic requirements, the NHS Directions require practices and PCTs to agree an action plan to bring them up to at least minimum standards. A failure to deliver the necessary improvement is a breach of contract and could trigger a Breach Notice. Failure to comply with the terms of the Breach Notice could be grounds for terminating a contract.

Practices should seek to ensure that PCTs support the action plan with investment to enable genuine premises improvements. The DH indicates that PCTs should treat premises as part of their service strategy, so there may be financial incentives available to assist with this. Practices may benefit from close liaison with PCTs in the drafting of these incentives. It would be unacceptable for PCTs to expect practices to fund improvements alone, and then to issue a Breach Notice if they are unable to do so. A separate premises guide is expected from the DH in due course.