London Clinical Senate

Clinical Senate Forum

Next steps for general practice in London – scale, integration and incentives – what works?

Summary report

25 January 2018 at The King's Fund, London.

Next steps for general practice in London – scale, integration and incentives – what works?

Transforming general practice is critical to transforming the overall health and care system. "*Transforming Primary Care in London: A Strategic Commissioning Framework*", published in November 2014, set out the ambition to deliver more accessible, coordinated and proactive primary care for all patients. Since then, we have seen significant changes both in the way that primary care is delivered across London, and in the health and social care political and regulatory landscape. It is widely recognised that collaborating at scale is a vital enabler for general practice to deliver these ambitions, supporting greater resilience and sustainability of the general practice workforce, investment in development and innovation in areas such as estates and digital technology.

Developing a more explicit commitment to general practice at scale is an essential driver to transforming care in the capital, ensuring a consistent vision and pace of change to support new models of integrated care. To support this, and to help determine what is needed to achieve it, work is taking place across London to set out what "good" general practice at scale looks like considering for example, how care is delivered, how at scale general practice functions and how it participates in the wider system.

This meeting of the London Clinical Senate Forum contributed to developing the vision for general practice in the city and in considering how we can best use our people, processes, system and resources to deliver it. The output from the meeting has helped to highlight what support will assist local activities. This report gives summarises key issues and views from the meeting.

The Forum aims:

1. Develop a shared view of how general practice needs to transform to create a sustainable, integrated health and care system and effectively participate in new models of care across London;
2. Agree what needs to happen to achieve this vision and the early priorities.

The Forum opened with a number of speakers sharing their perspectives and learning. We heard what is important to patients in their experience of general practice and how patients and the public can contribute to developing general practice at scale. Regional leaders discussed the improvements made in primary care in recent years, why further change is needed to address challenges that persist, how general practice at scale can help to address these and the work taking place across London to develop and support delivery of a future vision. Different models of integration and approaches to general practice at scale were shared from the UK and internationally, with learning for transformation in London highlighted. We also heard the importance of organisational development in supporting system change and the factors it is particularly important to focus on to successfully achieve, and sustain, change. The programme and presentations are available here.

Integration and collaboration across general practices and primary care is already taking place in London and the majority of general practices belong to an at scale organisation e.g. a federation or a super-practice, though the nature and extent of collaboration beyond provision of extended access varies considerably. A significant part of the meeting provided space to consider the vision and journey so far for general practice at scale within London's five Sustainability and Transformation Partnerships and the key next steps they need to take.

The Forum involved over 130 participants from general practice and the wider health and care system across London. We would like to thank everyone for participating so enthusiastically to the discussions and taken the opportunity to share, listen and learn about the opportunities and impact that integration and collaboration can bring as well as being open about challenges and concerns. Particular thanks to our speakers for sharing their experiences, work and views which set the scene for a stimulating morning.

Key themes from the meeting

The next steps for general practice in London bring real opportunities to think differently and collaboratively about how systems and processes in general practice can be improved to enable effective participation in local health and care systems to improve care and outcomes and lead new models of care, including: how to enhance and further develop capabilities; how to develop and support the workforce; how leadership can be developed, the right form of governance and how to create it.

It is essential that the comprehensive and holistic approach to care which lies at the heart of general practice remains at the core of changes and developments that occur. General practice understands population health as well as care for individual people and therefore has a key role to play, working with other partners in a system (health, local authority and voluntary sector), in shaping and leading future models of care.

Engagement about the next steps for general practice across STPs needs to be more far reaching. Participants felt that all STPs have a vision for general practice "at scale" however many GPs, other health and care professionals and patients and the public are not aware of it. There was a strong call to involve, listen and respond to patients and the public on this journey using a co-production approach. Different terms are used which may or may not mean the same thing e.g. general practice at scale, super practices, federations - consistent and clear language will help to engage people. NHS terms e.g. general practice, primary care, community care, secondary care are meaningless to patients and the public who see and experience one NHS.

The development challenge is substantial and is where leadership is needed most, encouraging and supporting people on this journey, being mindful of concerns and possible risks and taking proactive action to address and mitigate these. **Delivering the vision requires support across the health and care system**, with everyone united behind shared goals.

Agreeing how changes introduced will be governed, especially clarity about the decisions that need to be made, how they are made and who makes them are important and to really enable change these arrangements need to be agreed at the outset. Views were also expressed that overly focusing on organisational form and contracting arrangements at an early stage can be a barrier to change and a balance needs to be struck. Governance in the NHS traditionally operates in a hierarchical way whereas a horizontal approach to governance is better aligned to a partnership and co-production approach. It was recognised too that some activities need to be done at different levels and not everyone needs to get involved in everything – determining the right level to do things at is important.

Health care is about people; there is a need to improve the experience of providing as well as receiving care. There is a strong link between staff satisfaction, quality of care and patient outcomes. Pressures and uncertainties, increasing demand for care, rising vacancies and a pay cap for several years has left many staff feeling undervalued and demoralised. There were some concerns that in developing general practice "at scale" there is a risk that resources do not follow patients and care provided in new ways out of hospital may simply lead to more work. Transformation needs to be about working smarter not harder. This is an opportunity to create an environment that motivates people working in general practice and wider primary care and build a less fragmented system.

The workforce challenges of developing general practice "at scale" and integration across the wider health and care system are significant, but the opportunities are significant too. Sharing responsibility and valuing people's diverse skills will require a culture shift for many. People need to come together across a pathway of care, understand their inter-professional responsibilities and learn how to work with and alongside colleagues from different disciplines in a multi professional team. More needs to be done to prepare for this and will require workforce development and education and training resources. London's Community Education Provider Networks (CEPN), with a remit to develop and deliver the workforce for a population health responsibility, could play an important role.

Focusing on the people who are making the changes is important – they need to be supported to learn, to develop and build relationships and need time and space to do this. We heard several examples of benefits that arise when people come together to develop and deliver a service in new ways and how this can – and is - being supported e.g. training in QI methodology, facilitated action learning, bespoke development programmes.

The recruitment challenges in general practice and the wider primary care teams are well known and recognised as key issues to be addressed. The Forum heard several examples of innovative new roles which aim to better meet population as well as individual needs whilst enabling scarce, professional skills to be targeted where they are most needed. Other examples involve communities and local professionals coming together as equal partners to solve problems and consider new ways of doing things through an asset based approach (making best use of community and professional assets).

Change carries risk and we need to be mindful of unintended consequences. Attention needs to be paid to the implications of vulnerable and marginalized groups, who may be particularly at risk during times of change. Changes should enable current inequalities to be reduced and not inadvertently widen them.

We need better sharing and use of data and better IT support to improve individualised care and population health – this is critical. Data is essential to understand population characteristics, needs and variation. There needs to be a single source of truth, shared and owned by all, which ensures care planning and deliver, for individuals and populations, is based on fact not assumption. Examples of highly developed solutions from the US were shared and we heard that excellent examples are emerging in the UK which are effective and which we can learn from, with primary care taking a lead. Data governance needs to be robust but should not be the major obstacle to change that it often is in practice.

Speakers highlighted many examples of change and innovation, in the UK as well as internationally, that support integration, are having a positive impact and offer learning. These include areas which are frequently cited as difficult to address, for instance UK examples of health and care systems sharing data with information governance arrangements in place supported by the Information Commissioners Office and NHS Digital.

As in previous Forums, participants raised the need for better ways of sharing and disseminating examples of good practice, innovation and learning to support spread, adoption and adaption and enable transformation to take place at greater scale. It was noted that many useful resources for sharing approaches and learning exist e.g. AGAINST THE ODDS: Successfully scaling innovation in the NHS published by the Innovation Unit and the Health Foundation (January 2018).

Barriers to change were identified that change processes need to acknowledged and address. In addition to engagement, data sharing and workforce, others include misaligned incentives and payment mechanisms, the regulatory framework and challenging behaviours such as professionally protected roles, restrictive practice, defending power bases. The new care models programme considered why it has been hard to deliver change across the system and leant that issues need to be tackled on all fronts. Some issues can only be addressed from a national perspective and this is recognized. Related work is underway, though resolutions will take time.

The optimal size for collaboration was discussed. Some participants found this to be a sticking point as different factors seemed to indicate different scales. Primary Care Home advocates a 30-50,000 population because there is some evidence that meeting the needs of this population requires a workforce of 100-150 people and effectively managing resources, decisions and integration on a large scale becomes increasingly bureaucratic. Examples of larger bodies, including federations, do exist however and it was noted that whatever the overall population size of an at scale organisation, resources, especially staff, are usually deployed in smaller units supporting parts of a population, often defined by people's needs.

There was support for an approach which seeks to makes a real, meaningful and sustainable difference in the short term and felt this would encourage engagement and be a way of addressing potential concerns i.e. do something that engages practices in an area of learning and development through an activity rather than simply talking about what could happen.

Key points from presentations

What is important about General Practice? Patients' views
Trevor Begg, Patient Representative, London Clinical Senate Patient and Public Voice

- People have differing needs and want and expect different, personalised responses. People who are generally well want fast, convenient access to the right health care professional when they need it; people with long term and/or complex conditions generally value an ongoing relationship with a GP and practice nurse – we need to marry the two. A large amount of information on what patients think about general practice and how it could be improved already exists – we need to make better use of it.

- People have higher expectations around communication, knowledge and involvement than in the past and expect clinicians to listen and respond in ways they may not have not done previously; we need to listen and respond to patients and the public on this journey. Most of the time people look after themselves and may need support to do so. Self-care needs to be supported and enabled.

- The public (not just patients) recognise the challenges the NHS is facing; they can and would like to help – systems need to facilitate this. Include the public in conversations about change – see them as part of the workforce; train new staff to interact and work with patients; the large number of carers play a key role and need more support. Involvement and co-production within general practice and patient participation groups is variable across London.

- As new ways of accessing and delivering care develop e.g. digital options we need to make sure people unable to use these routes are not excluded. Prioritize the needs of marginalized members of the community in future plans – when the system is busy and under pressure they can slip through the net

- There are great examples of work taking place in general practice across all areas noted above and having an impact; we need to share, learn, spread and embed this across London as new models and approaches are develop. Everyone in the system must work together and put vested interests aside, particularly where difficult decisions need to be made.

Why we need to change? A regional perspective [click here]
Dr Jonty Heaversedge, Medical Director for Primary Care and Digital Transformation, NHS England (London Region) and Dr Michelle Drage, Chief Executive, Londonwide LMCs

- London has made significant steps in improving primary care in recent years and making progress towards the vision in "*Transforming Primary Care in London: A Strategic Commissioning Framework*" and the General Practice Forward View (GPFV) objectives through the Transforming Primary Care Programme. However substantial challenges remain, with common themes across London relating to workforce, quality improvement, infrastructure (estate and IT), resilience and patient satisfaction.

- There is increasing evidence across the country that working collaboratively supports general practice in addressing these challenges. The GPVF places general practice at the heart of effective, high quality primary care and the vision for integrated health and social care systems will require greater coherence and scale in general practice across relevant geographical areas. The approach needs to maintain support and care at both individual and population level. The majority of London's population is covered by an "at scale" organisation but these are developing at a different pace and with inconsistency in purpose.

- Significant work is therefore taking place across London to consider and describe the next steps, refreshing the vision for accessible, proactive and coordinated care with a focus on how general practice can collaborate to deliver it. This is starting to describe the benefits of working together and understand what good looks like i.e. key attributes of general practice "at scale" whilst also recognising the risks, taking an evidence based approach. This will be supported by a collaborative leadership approach at regional level.

- The need for resource to support delivery of this vision is recognised. Because of progress made in achieving extended access across London (the only English region with full coverage) it has been agreed with Sustainability and Transformation Partnerships (STPs) that some resource available through the GPFV will be used to create a Transformation Fund to accelerate development of general practice working "at scale". This will be delivered through STPs. The creation of a regional vision will allow more effective use the fund to ensure consistency in offer across London.

- In developing "at scale" organisational form it is essential that the intrinsic value of general practice is supported and protected, that opportunities are identified and taken to create an environment which motivates people working in general practice and primary care, and builds a less fragmented system. Delivering the vision requires support across the health and care system, with everyone united behind shared goals. The commissioning focus also needs to shift from hospitals to general practice supported by well-developed community services, social care, third sector i.e. a holistic approach.

- Support will be provided to every part of London, for example guidance and resources to share approaches and learning about how to make change happen and achieve greater collaboration, building on best practice in and out of London. This will assist both practices and commissioners e.g. how to utilise existing incentives to support practices to work together as well as the Transformation Fund and how quality improvement approaches can support change.

An introduction to Primary Care Home – an integrated, multi-professional approach [click here]
Dr Nav Chana, Chair of the National Association of Primary Care

- Primary Care Home (PCH) is one example of general practice working "at scale". It emerged from NHS England's new care models programme in 2016 and now has 210 sites across the country covering 15% of England's population. It is fundamentally about clinicians designing care around the needs of people they look after, involving people in the design and providing a service offer that meets individual and population needs.

- PCH has a quadruple aim: improving population health, individual experience, reducing the per capita cost of care and improving the experience of providing care – the last one is highlighted as critical to achieving our aspirations for transformation.

- PCH has four main characteristics: it is a placed based approach, providing care to a defined registered population of 30-50,000 (recognising that a lot of care will be delivered in smaller "units" and to discreet groups of people with particular needs); a combined focus on both improvements in population health outcomes and personalised care for individuals; aligned clinical and financial drivers - taking collective responsibility for resources available to look after the population; an integrated workforce with a strong focus on partnerships spanning primary, secondary and social care - by creating a vibrant multi- professional primary care team at a level that supports 30-50K population.

- Population needs are considered by grouping people with like needs (the population cube – see slides) the approach to population health management is to take responsibility for every group. PCH sites are supported through a development cycle using a community of practice model – learning has shown the importance of working through a series of developmental stages (see slides) in introducing a PCH type model and population health management approach. Tools have been developed to assist sites.

- PCH sites are beginning to see signs of positive impact in many areas including prevention, freeing up GP time, improving morale and recruitment. What appears to make a difference is people in general practice being given the freedom to innovate and able take actions, to make changes and transform with a supportive system around them – this creates energy to transform and a seat at the decision making table. Making opportunities to start building collaborative relationships is important. Two reports have explored the impact of PCH:
  Does the primary care home make a difference: understanding its impact (PA Consulting, March 2017)
  Primary Care Home: Evaluating a new model of primary care (The Nuffield Trust, August 2017)

Next steps for general practice in London: learning from international organisations [click here]
Dr Rebecca Rosen, GP and Senior Fellow, The Nuffield Trust.

Rebecca shared examples from three organisations to highlight innovative approaches relevant to themes that are central to the vision for general practice in London: people, integration and data.

- **People.** This example offers learning for the London priorities of proactive and coordinated care. iorahealth, an example from the US, is pushing the boundaries of skill mix and how to make best use of people in primary care. It delivers team based care, often for populations in deprived areas with poor health. Teams are doctor led, multi-professional, including health coaches recruited from the same communities as the population they look after so they understand and know people (teams cover 3-5,000 people). Teams take a holistic approach and bio-psycho-social model with daily "huddles" to discuss individual needs and use as mix of proactive and reactive interventions to meet needs and seek to change behaviours e.g. cooking classes, shopping with people on low incomes. Evidence is indicating that using a capitated budget in this way can reduce overall costs of care and improve outcomes.

- **Integration**. This example offers learning for the London priorities of accessible and coordinated care. It involves a primary care centre, provided by the ribera salud grupo, for a small community in Valencia, Spain. It is a polyclinic type model, open 24/7 for walk in clinics and booked appointments and data is fully integrated with the hospital. The same doctors cover both aspects of care (i.e. walk-in and booked), there are some specialist outpatient clinics alongside GP clinics. Whilst the model does not address all challenges it does demonstrate the concept of team based care which is able to combine rapid access and holistic care/ continuity in practice.

- **Data**. This example offers learning for London in enabling proactive and coordinated care. There are good examples of integrated health and social care data systems in the UK e.g. Kent, East Grinstead, this example, from Humana in the US, shows the potential impact of a much higher level of data pooling encompassing all areas of health and care i.e. hospital, community and primary care including pathology and prescribing plus the ability to feed in data from health questionnaires and devices. Large data warehouses allow manipulation and real time data analytics, constantly re-stratifying patients, providing real time clinical alerts and converting analysis into actionable clinical messages so needs and resources/work flows can be prioritized and targeted. Automated outputs support individual patients and clinicians e.g. risk factor summary with links to personalised information about what to do. It also supports population analysis and needs assessment e.g. heats maps showing levels of CPOD, diabetes.

Taken together these examples illustrate the potential of developing general practice e.g. an MDT team approach supporting individuals and populations enabled by rich data analytics to guide interactions and best use of clinical and less qualified (and costly) staff resources. There are also significant challenges in achieving effective team-based care and so developing and maintaining new approaches requires significant, and ongoing, effort. Effective leadership is essential and clear and agreed governance of changes is important. Is bigger better? Lessons for large-scale general practice explores these issues (The Nuffield Trust, July 2016).

Organisational development is essential to support system change – lessons from London's Primary Care Quality Academies [click here]
Professor Rebecca Malby, School of Health and Social Care, London South Bank University and Nick Downham, Independent Improvement Expert, Primary Care Quality Academy, London South Bank University

- The Primary Care Academy works as a development agency supporting organisations to develop through a series of interventions in a place i.e. facilitation, data support, courses and coaching for innovation and improvements to Federations and CCGs, spreading learning and practice across and between them. Each "place" has number of laboratory practices nominated to lead way; involving a course on core concepts of quality improvement (QI), teaching people as a group in their practices about the basic tenets of QI to help them develop their practice through knowledge about tools and techniques to apply to primary care, understanding data and working differently with the wider system.

- Learning is spread through a community of practice approach opened up to rest of CCG and system leaders are supported to be enablers able to create the environment in which general practice can develop and adapt.

- Data is critical. The starting point for this approach is to really understand what is going on in a practice, not simply to accept what people think is going on. This involves real time data capture to understand the flow of activity across the practice as a system then tackling the needs of the practice where they emerge - based on fact not assumption - using a breadth of OD support.

- Practices that are adapting use data to review their activity and improve flow within their practices and across the system, they look for examples and ideas outside their practice to manage demand and work collaboratively with local communities in an asset based approach.

- Findings have shown benefits from the approach in the short and medium term e.g.: showing that not all local demand is being met but there are also inappropriate appointments so capacity exists in the system overall to meet demand if some time can be released through more effective use of skill sets and contact time; changing the way practices work and reducing variation between clinicians; partnering effectively with care homes/other practices to manage the health of frail elderly people in care and reducing hospital admissions; co-producing new services with communities, led by communities; improving back office functions; identifying "super attenders" to understand and meet their needs better by managing them in a different way (see slides for detail on approach and impact).

- The approach has shown the assumption that time cannot be liberated quickly is not correct. Benefits include saving in time as well as money e.g. reduced locum salary costs in one example, which creates space for collaboration, having conversations, building relationships and development time. Experience also shows a neutral, non-judgmental partner can be helping in bringing objectivity to a situation.

New models of care: Insights from the national vanguards
Samantha Jones

- The new care models programme aims to join up fragmented care for people and support the workforce to provide the best possible care and support with a reduced cost base. General practice and primary care are fundamental to the improvements that the programme is seeking to deliver.

- Understanding data is critical. The new care models programme shows that a shared understanding of data and the population is essential. A "single source of truth" from which everyone understands where the variation and the need are and enables resources to be targeted appropriately. Technical support to do this is important. Sam shared an example from Israel, which has built a system that is significantly more advanced in its use and understanding of data, based on and driven by strong primary care.

- Resources are largely the people best placed to support individuals based on a real understanding of their needs not assumptions, so they are supported in the best way. Examples from new care models show the significant impact this can have. For example, e.g. a community based approach in Blackpool involves "Wellbeings" who are councilors and coaches and help to wrap support around care provided releasing time of stretched professional to focus their skills where they are needed most.

- It is essential to be clear about the population you are serving - use data to understand characteristics, needs and variation across the system. Be mindful that an unintended consequence of attempting to join things up is a risk that further fragmentation could occur -being clear about the population will mitigate this.

- Focus on the people who are trying to deliver change and who need time and space to do this. For example, in Frimley a 20/20 leadership programme has been created for people who are developing

new care models. Creating the environment to support people through leadership and empowerment is important.

- People working together in new care model sites which are more advanced and shown to be making an impact focused more on how decisions are made in the relationships/ partnerships/ organisations involved and less on architecture, structures and contracts.

- Language is important i.e. language used to explain and talk about why change is necessary and what it is aiming to achieve. Use plain English, avoid jargon and make sure everyone involved in the work understands the importance of this.

- Examples exist across the country to learn from with a lot of information available online:
    - NHS England - Home
    - New care models
    - Vanguards
    - About models of care
    - Multispecialty community provider vanguards
    - http://www.health.org.uk/sites/health/files/IAURushcliffe.pdf

Plenary feedback from table discussions

Is there a clear vision and strategy for transforming general practice and primary care across the STP?

- All STP discussion groups felt there was a vision in their STP area, and could point to different examples of changes that have taken/are taking place, however the extent to which all stakeholders were aware of, had a clear understanding and owned the vision was felt to vary. In general, people involved in the core STP teams and transformation programmes were more aware and had stronger ownership. Everyone felt there was significant further work to do on GP, practice and patient /community engagement.

- Key to this is being able to show how the next steps for transforming general practice will make a difference in the near future. The likelihood of achieving improvements which will have a positive impact on people's lives (clinician and patient) in the short term will enable engagement and have the potential to create space for further development.

- It is important that things are done at the right level – there is not one optimum level for everything e.g. QI work needs to be done with whole teams at practice level; development of more integrated services and population health needs to be at a PCH/equivalent level; a partnership needs to be created at borough level to drive this and develop a supportive and enabling environment; a common platform for IT support and also influencing large acute providers needs to be at STP level.

- If partnerships are really going to work need to involve whole system of care but have to be primary care led by "at scale" organisations.

What are the main barriers and challenges to developing general practice at scale?

- Data is a key one i.e. having one version of the truth that everyone understands and signs up to. To engage clinicians and patients on the ground this needs to be at practice level. Digital challenges were also highlighted and information governance often acts as a barrier rather than an enabler to data sharing. A wide range of tools exist but are often used inconsistently. This requires time, training and SOPs to address it.

- Resources (money and workforce) can be significant barriers to change i.e. funding constraints and longer term uncertainty, understanding what shill and capabilities exist and are needed locally and matching supply to demand.

- Spreading, adopting and adapting good practice examples of change across STPs (and more widely) is challenging.
- The perceived time needed to achieve change is a barrier – engagement, data, transformation activities/finding space to think, have conversations and collaborate – all take time which is difficult to find amongst day to day service pressures. An inability to front loading a change to make it happen can be a barrier - people are busy with the day job and do not have enough time/resource to manage the transition where both things need to happen at once.

- Some GPs are fearful about their future and greater clarity is needed about what general practice "at scale" means for them. There are also suspicions about care and activity shifting from secondary care without resources following, increasing workload and pressure, and a view that the more you engage the more you leave yourself open to that.

- There are concerns that an "at scale" model for general practice might lead to patients losing access to their own practice – one PPV member shared an example of this happening. It will be important to ensure that individual patient connection with their own practice is not disrupted as models are developed.

- Competing strategic priorities can be a barrier to progress e.g. long standing issues relating to hospital configuration in south west London is taking up significant time and effort with a perception that there is less focus and capacity for primary care transformation.

- Progress on some initiatives may be delayed whilst the way forward for primary care transformation becomes clearer. Challenges of different agencies work together in this context were also raised.

- Some themes that should be cross cutting in all areas of transformation e.g. an example was given of improvements in mental health not being embedded in every workstream, which could result in gaps and worsen inequalities.

What are the next steps you need to take and what is required to progress these?

Key next steps involve:

- Greater engagement across the system (GPs, practices, patients, communities and the wider system) including greater focus on co-production.

- Shared leadership and shared goals are important for the next steps. Discussions highlighted the importance of making sure patients are sufficiently involved and that their views are taken on board.

- Another felt the priority should be agreeing across systems what good would look like, how progress and impact should be measured and how locally agreed data should be used to support change and drive up quality. This should involve all partners, patients and communities.

- Transparency was identified as an important issue for the next stage of development not just about care models but also resources. More needs to be done in signposting and navigation and making smarter use of the workforce.

- Put more focus on *how* to deliver change particularly how to develop good practice at scale and across CCGs, including tackling the silo working that still exists within some CCGs so that there is better working and relationship building across borders.

- Give people tools that help them free up time and create headspace to plan and deliver change so they have the time to do this alongside current service delivery pressures.

Appendix

Feedback from participants about what is important in taking forward local plans and support that would assist STPs

Points captured from table discussions

South East London

Thinking about how far along the journey of developing general practice at scale you are, how would you measure this?
• Be clear about what we expecting to see and measure this to evaluate if this is happening • Improving access to services is a key measure • Development of shared records is a potential indicator of progress
What do you think the main barriers and challenges are to developing general practice at scale?
• How can we make sure everyone is aware of what we are doing and why? • Data – needs to be unbiased and transparent – involve patient groups and Healthwatch • Population needs – if there are more vulnerable people/communities • Do we have enough workforce - find out what we need at local level? • Long term funding – concerns about services taken away and decommissioned
What are the next steps you need to take and what is required to progress these?
• Transparency – involve patients to enable this. • Resources – money and workforce – need to be clear on both • Not top down management – engage staff and communities, build dialogue, understanding, collaboration and co-design • Move to a culture of horizontal management between patients, managers and clinicians • Data – needs to be comprehensive, shared and understood • Shared leadership • Goals – clear and measurable
Other points raised
• There is a vision but not it is not clear and therefore not shared by everyone, in particular to patients. Sense there is a collective drive. • Variation in booking systems need to be addressed to facilitate at scale arrangements • A mismatch in that developing general practice at scale can lose focus on individual patients or local need – need to look out for and reduce the risk of unintended consequences • Better to have shared group practice? • Basic level of practice needed • Vision needs to suit a clinical need

South West London

Thinking about how far along the journey of developing general practice at scale you are, how would you measure this?
There is a vison and a strategy, but we are playing catch up on delivery – we don't have the enablers to deliver. If you ask someone, some will say "yes" some will say "what are you talking about" There is a clear vision (at the top) but it is hard to see at a distance or is impressionistic. There is a difference in [the clarity of the vision] between STP level and individual clinician perception. Strategy – working together towards a common purpose – not everyone can see this; not sure we are going in the same direction. We need a leadership model in general practice and there isn't one. Lack of confidence in vision and strategy and if it can be implemented and is implementable At the last refresh the STP strategy mentions GP 17 times and hospital 400 times – this is what GP colleagues will judge it by.

We know at a macro level there are pockets of innovation but don't have the infrastructure to allow this to happen at the same time. We are missing the enablers in the middle. What are the steps towards it? We may leave those behind who don't' know how to do it – which will only widen inequalities.
There is a top down strategy (FYFV) and some work happening from the bottom up – but not sure how this works with everything in the middle (London P Care; STP, which has just been refreshed; CCGs; GP Federations etc).
We need leadership (in the middle) to enable change – we are waiting for permission – we need to be brave, CCGs have done well in some areas, we need to just get on.
People need to feel empowered – use reflective practice which changes the equation - it's troubling when you go to see a clinician and they are more troubled than you (comment from a patient representative).
Change management, communications management need to be reflected in the workforce.
Leadership is making space for conversation – or you can get more paralysed – need to get together as social beings.
GPs responses on the ground are mixed; there is a problem with implementation - the refresh chapter on primary care was deliberately lacking detail – we can't write the strategy for GPs - need to work with and engage GPs.

How far along the journey of developing general practice at scale are you?
There is a willingness to start to build it [a strategy] but we aren't there yet.

- We are all up for change
- We know GP at scale and we have GP Federations
- We have some super-practices
- Different models are emerging

We have a vision but not the pathway. There are good examples but these haven't been translated into a strategy. There is a big issue with STPs that local government are holding up on initiatives and waiting for the STPs (and resources) – which is making some issues (e.g. alcohol) worse.

What do you think the main barriers and challenges are to developing general practice at scale?

There is a need for long term thinking and structural change – and the LAs need to play their part – this is a barrier.
Different agencies need to work together – this goes to micro-level within a practice. How do we help people do that?
Issues around inequalities - some issues/priorities need to be embedded in all workstreams and are not – e.g. MH, carers, alcohol and drugs, those in the criminal justice system – this reinforces inequalities. This needs to be more systematic
Working collaboratively – at the moment we are fragmented and our incentives are not aligned
NHS England is making it harder to close a surgery for the afternoon for training / education. This means we are not demonstrating the value of that time with the practice together / development time and the long term benefits to patients of spending the time on e.g. ALS, reflective learning / team working. What is HEE's role for making the case for this?

What are the next steps you need to take and what is required to progress these?

There is general practice at scale, there is a commissioning framework. We need next steps in London on

- Workforce issues
- Estates
- Demand
- Finances

We know we can't do as before – GP at scale – something needs to be done. But this needs to be defined at CCG level and then pulled together again.
We need the 'how to'. There are some great things being done – what's happening locally. How do you go

from A-B. We are in one STP but there is isolated working – we need to work peer to peer and across CCG borders; to work collaboratively we need to all sit round the table and have a frank discussion about how we serve our population. We need to embed the local vision in local services.
NHS England doesn't want to write the strategy but wants to help you write the strategy.
We need the tools to give the space to write the strategy – with the service stretched we need to have the tools (e.g. such as the LSBU work) to make the time
Would like to see a two-way discussion with the voluntary / carers sector and their clients. The commissioning model doesn't gel with client need
Primary care delivery group meeting with CCGs, GP Federations, LMC.
Define the CCG vision at CCG level and at STP level
GP at scale, commissioning at scale – we need to align our incentives

North West London

Thinking about how far along the journey of developing general practice at scale you are, how would you measure this?

CCG Chairs think they have a strategic vision, managing directors have some idea, GPs generally don't have a clue
Brent & Harrow don't know about but other 8 CCGs have vision – generally primary care home
Primary Care Home wraparound contracts exist
GP engagement and staff engagement (level of)
GP Federation Brent – don't know how this fits into STP – don't really understand the landscape
How do they filter from the STP – what is the output? How can we engage – not being communicated.
CCG – is STP thinking coming through here – individual CCGs and group CCG
Working at scale in order to ensure out of hospital (rather than make primary care more robust)
Workforce – looking at elements. GP representation.
CCGs - manage process around GP/commissioning of care. STP – bring together work across the patch - need to bring in care homes
Includes workforce *work needs to be done - are STP's represented here – need to get these models back -lack of joining up in terms of intelligence
Heard good examples today – STP work up federations, new ways of working
Confusion of ASCs' – new direction of travel?
How are things joined up? How do we share good things that are happening?

What do you think the main barriers and challenges are to developing general practice at scale?

Data – one version of the truth and not investing adequately in data. Need whole system to share the data
Pay receptionists to gather the data – would be cheap to do.
Trust and money?
Digital challenge – e.g. GP at Hand; PCH's to take over; information governance and consent, standing operating procedures.
Conflicting programmes happening i.e. hospitals implementing ACOs and CCGs planning primary care homes.
Staff shortages – especially shortage of nurses
Lack of combined work with secondary care – A&E don't refer direct to specialised services – do via GPs – wastes time
Still need to solve problems of GP supply and demand;
Local things are happening in different areas e.g. some integrated community, care homes etc – responsibility sits somewhere else creates disjointed way of working.
Barriers = systems
People
How can short term gain bring about improvement? What is the next step that is benefit? We look at short term benefits and not long term – how can we move these along? Look to better future.
Following the money
Working at scale v economies of scale – no proof that economies of scale leads to better health care (and outcomes)

Shouldn't be about money – no industrial benefit. Gone down a procurement system, GP no longer in control.
End user (patient) – completely confused
General public have no understanding of difference (i.e. STP?)
Patient is looping back around
Need holistic working – bring in other areas
GP is gateway

What are the next steps you need to take and what is required to progress these?

Engagement – need a QI approach for federations and GP practices
Fully utilised data – need a London wide approach
Data not at wide level but individual practice level to hook them – needs to be local.
Care coordination – care coordinator - social prescribing service and making better use of voluntary sector.
Need to break professional boundaries
GPs run by locums

- Investment in time
- Expand scope whilst working within
- Different productivity rates

Utilise GP nurses – more prescribing
**Know your population - professional has to allow this to happen
Confidence – demonstrate their ability
How do you get people to that point? *LISTEN – do people at the top really listen?
How do you enable the voices that need to be heard? Ownership - leaders must empower others.
Stepping stones – not congruent of overall direction – disjointed.
We need to make the next step make a difference now – lead to improvement – more enjoyable.

Other points raised

How to give people the time, space and tools to make changes
PPG groups often not representative so don't adequately get the views of the population
Problem is hearts and minds of primary care professionals on the ground
Bottom up approach in CCGs hasn't really worked in past
Risk dashboard not used much – was poorly rolled out, could be used more consistently
How do we help change?
Locality meetings
Where are the touch points?

North Central London

Thinking about how far along the journey of developing general practice at scale you are, how would you measure this?

Haringey: patient rep, small practice, little knowledge of vision….so measure….is vision understood all the way down to practice and patient level. Current lack of engagement from some practices.

What do you think the main barriers and challenges are to developing general practice at scale?

Language confusing (Federations, neighbourhoods, CHINS….) – need consistency of message
Technology – services being able to share patient data
Alignment of STP pathway work e.g. MSK, with primary care change to working at scale
GPs fearful of their future and need clarity
Huge suspicion that "care closer to home" is just shifting work without the following resources.

What are the next steps you need to take and what is required to progress these?

Data available at an individual practice level to help educate/sell the vision.

Other points raised

Hand offs between primary care and secondary care are still inefficient

Little or no “up front” loading of change
We cannot waste money on 8-8 access for predominantly well patients – reducing confidence of primary care
Lack of clarity re contracting longer term. Prevents practices engaging

North East London

Thinking about how far along the journey of developing general practice at scale you are, how would you measure this?

We have a strong vision for primary care quality which is shared and understood by members of our ELH&CP programme
We need to ensure we share and communicate this vision with the wider primary care workforce and across our NEL system
Definitions such as primary, community, secondary care and mean nothing to patients so need to use a language that is meaningful to everyone and reflects an integrated approach (one NHS, one care system)

We discussed a working definition of our vision for primary care and the wider system:
Our future models of care are based on primary care led partnerships at borough level, which have strong links to local authorities - in line with the primary care home model.

Measures might include changes to patient flows aligned to new care models.
Need to systematise measures - outcomes, staff satisfaction, patient experience, efficiency

What do you think the main barriers and challenges are to developing general practice at scale?

Payment mechanisms and misaligned incentives – need payment reform
Language / lack of a shared vision/ fragmentation
Interoperability - shared access to records and access to clinical data
Current big providers – balance with alternative bigger organisations, build partnerships which are primary care led

What are the next steps you need to take and what is required to progress these?

System support to enable our vision

- High-quality locally available datasets
- Excellent IT systems, with a common approach across NEL where possible
- Common approach to monitoring quality (e.g. across four key domains: outcomes/efficiency/patient & staff satisfaction)
- Support with developing enabling governance arrangements to local systems.

Other points raised

We need to ensure primary care is in a position of strength to lead these changes and new models, otherwise they may be led by other larger providers, losing many of the positive attributes of a primary care led service, such as a focus on holistic care and the psychosocial needs of individuals.

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Contact: England.londonclinicalsenate@nhs.net
Website: www.londonsenate.nhs.uk