

**Our Ref:** RW/letters/2008/77  
**Please Contact:** Rob Webster  
**Direct Dial:** 01422 281412  
**E-mail address:** [Rob.Webster@calderdale-pct.nhs.uk](mailto:Rob.Webster@calderdale-pct.nhs.uk)  
**Date:** 13 February 2008

4<sup>th</sup> Floor  
F Mill  
Dean Clough  
Halifax  
HX3 5AX  
Tel: 01422 281300  
Fax: 01422 281301

Ros Roughton  
Director of Strategy & System Reform  
NHS Yorkshire & the Humber  
Blenheim House  
Duncombe Street  
Leeds  
LS1 4TL

Dear Ros,

### **“OUR NHS, OUR FUTURE”: PRIMARY CARE GROUP**

You asked that I sponsor a piece of work to consider **primary care** issues in support of the ‘Our NHS, Our Future’ programme in Yorkshire and the Humber. The work is now complete and I wanted to write to you setting out broad themes and the findings of our work. I attach a set of slides that provide a rationale for our findings and more detail of further debate that is required in taking the work forward.

In summary, I would say that there is a compelling argument that we have a real opportunity to build on the genuine strengths of primary care in the region and to tackle some of the challenges, including unacceptable variations in health and care. This letter and the attached slides reflect the thinking and evidence that has informed:

- A vision for primary care in Yorkshire and the Humber;
- Our view on the tools and levers for supporting service improvement;
- Options for much stronger patient and public involvement; and
- A primary care dataset for commissioners and the public.

We believe our work can also support the procurement of extra practices that is now happening in the region.

### **Vision for Primary Care**

**The group felt it was important to set a vision for primary care that reflected the real strengths of our primary care model as well as some of the challenges. Too often these strengths are lost in the increasingly emotive access debate.**

**Chair:** Angela Monaghan (acting)  
**Chief Executive:** Rob Webster  
**Professional Executive Committee Co-Chair:** Sarah Antemes  
**Professional Executive Committee Co-Chair:** David Wild

Our vision can be articulated as follows:

*Primary Care is the cornerstone of the National Health Service in Yorkshire and the Humber. It ensures that the NHS provides appropriate care and helps people improve their health and well being. Primary care is the first port of call and main healthcare provider for the vast majority of people in Yorkshire and Humber. Our aim is to see universally high quality primary care that is flexible to respond to patients' needs, regardless of where, when, or to whom they are delivered.*

*General practices have a critical role as part of primary care. The practice will act as the navigator and co-ordinator of the care patients receive; it will focus on health and healthcare; and it will work in partnership with patients to ensure they are involved in determining how care is delivered for themselves and their communities.*

We need strong primary care. *Starfield et al* have shown that strong primary care in healthcare systems leads to lower overall costs, better prescribing practices, better patient outcomes and higher patient satisfaction. There is a wealth of opportunity in our practice registered list-based model of primary care – for example the use of data from the Quality and Outcomes Framework as an accurate and timely clinical database for commissioning purposes.

List based practice should remain a fundamental part of primary care. It is a model which has proven to be capable of delivering quality and measurable care in a proactive, patient focused and responsive manner. Practice-led primary care services will allow clinical leadership to remain central for influencing:

- Individual patient care
- Population health
- Commissioning of secondary care
- Service and care pathway redesign
- Education, training, and workforce requirements

GPs will be at the centre of a primary care service that will be increasingly delivered by a range of trained professionals in a range of settings working to deliver seamless, consistent and concordant care through a multidisciplinary team.

Services will continue to evolve to meet the requirements of society and patient, encouraging the development of the most appropriate care professional for each circumstance, and encouraging the functional integration of providers of all health and social care.

Pathway redesign will re-model the boundaries and remove barriers between all of primary, secondary and social care. More care will be delivered closer to home and there will be a greater emphasis on improving health and wellbeing through empowerment, education and support of patients.

Patient focused access to such services will be a priority, and all patients deserve access to the highest possible standards of care with the freedom to seek care from the provider of their choice in their community, based on services most appropriate to them.

GP service providers will have a high performing and continually improving culture with a strong emphasis on training, integrated governance and innovation, with their patients as partners in developing models of care.

**In developing this vision, we recognise that many of the mechanisms for delivery exist. Much of what needs to be done will require us to build a compelling vision that is clinically led, quality based and locally owned. We will then need to deliver. In particular, there are variations in the quality and accessibility of general practice in Yorkshire and the Humber. This has a knock-on impact on patient care right through the healthcare system and must be addressed.**

### **Delivering this vision**

**Commissioning is central to delivering this vision. The World Class Commissioning approach should be applied to primary care services with the same rigour as other services, recognising the centrality of primary care to patient care and the positive knock-on impact that high quality care will have on the rest of the system.** New contracts, investment on primary care and the health reform programme have created a range of opportunities to improve primary care services.

The group felt that the key **tools for commissioning and delivering improved services** were as follows:

- **Information:** High quality, timely and appropriate information will support service development and track population health. It will deliver effective benchmarks and empower patients through giving a better understanding of the range and quality of services they can expect.
- **A focus on quality.** Quality drives improvement. Focusing on minimum standards and supporting practices to deliver excellence is an agenda we can all share.
- **Clinical Governance:** Is central to commissioning and service improvement. It is a lever for change and should be at the heart of everything we do. Clinical Governance in primary care must be strong and practices must be supported in its delivery, using contracts, information and quality incentives.
- **Best practice and support** (including education and training): Primary care in Yorkshire and the Humber has a track record for innovation and entrepreneurialism. Service improvements should be shared across the patch and actively supported, building on past modernisation and improvement programmes.
- **The quality and outcomes framework**, is perhaps the best population level clinical database in the world. The QOF has led to significant improvement in the management of long term conditions across all practices in Yorkshire and the Humber. We now need to use the QOF to manage population health through commissioning. There is local flexibility to develop local variants of

**Chair:** Angela Monaghan (acting)

**Chief Executive:** Rob Webster

**Professional Executive Committee Co-Chair:** Sarah Antemes

**Professional Executive Committee Co-Chair:** David Wild

the QOF to incentivise better care on conditions that matter locally and we should build on this using the recommendations from the other “Our NHS, Our Health” work streams.

- **Contracts and financial incentives:** New contracts for all primary care providers offer local flexibility. This is true for dentistry, pharmacy, optometry and general practice [whether PMS, GMS or APMS].
- **Increasing capacity.** “Workload” has been an issue for many in general practice for years. We also know that capacity and quality are linked. Service expansion, including new entrants, will increase capacity, supporting improvements in existing practices – if handled carefully.
- **Practice Based Commissioning:** PBC puts primary care at the heart of commissioning. In time, the commissioning model should develop to ensure that PBC defines commissioning.

**Many PCTs are driving improvements in primary care using these tools. Some thought should be given to supporting PCTs across the region, building on previous work by the Improvement Foundation, the NHS Institute and Modernisation Agency.**

In our work we felt that it was important to focus particularly on two. These are set out below.

### **Much stronger patient and public involvement**

**We know that the NHS needs engagement with the public and patients to drive individual care; population health; and commissioning. This is particularly acute in primary care services given the links to commissioning, long term conditions management and public health. We need informed patients who are confident about what they should expect from primary care to maximise health and well being and to change unacceptable aspects of care.**

There are a number of strands to this:

#### ***Patient and public involvement at PCT level, including through PBC***

Genuine public and patient involvement, particularly at PCT level will help ensure that patients views are taken into account in strategic commissioning decisions. There is a concern that patient unwillingness to change or complaining about poor services is a result of fear of how they will be treated if they do so. This perception needs to change, and patients or patient groups should be represented on the PCT board through the PEC and PBC. They should also be involved in decision making about service priorities through PBC and this should be written into consortia arrangements and become a PEC duty in considering PBC plans.

#### ***Incentives for real engagement***

There are mechanisms that could be harnessed to promote stronger patient involvement in both delivery of primary care services and the commissioning of care. The quality and outcomes framework could be used to offer financial incentives for practices to engage patients and deliver services that respond to patients needs. For

example, PCTs could build on existing arrangements to trigger payments dependent on positive feedback from patients or patient forums about service improvements. Enhanced services could have a quality addition for positive patient experience scores and so on .

### ***A real debate about the practice area***

The practice area is a useful mechanism for ensuring practices serve local populations, particularly if home visits are required. However, we know that these are declining in many areas and that alternative providers can be put in place. Changes to Out of Hours responsibilities have also meant that the geographical arguments are reduced. However, boundary issues are best considered at a local level and PCTs should consider whether a debate on the expansion or removal of practice boundaries is required in order to expand the choice of practice available to patients.

### ***Information***

High quality and timely information about the effectiveness, quality and range of services that are available will empower patients and enable them to make informed choices about the services they can access.

Information needs to be made available in the way in which it is presented to patients. Information should be presented in a clear, simple and easily accessible format – for example through consistent presentation in practice leaflets that is then mirrored on PCT websites.

PCTs will also need to consider the engagement of groups who find it hard to access the NHS. The risk is that some patient groups are better equipped to use and act upon the information that is presented, and this has the potential to widen inequalities. The PCT will need to pro-actively seek out and engage some populations and ensure that services are tailored to meet their needs if we are to moderate the inverse care law.

### **A primary care dataset**

**Information will be a key driver of improvement. There is a lot of high quality primary care information available and good analysis being carried out in localities across Yorkshire and the Humber. However there is a need to standardise, co-ordinate and quality assure this data and analysis if it is to be useful to commissioners, providers and (possibly) the public. We recommend that a single dataset is created for Yorkshire and the Humber, providing timely and quality assured practice level information.**

This information would be available to clinicians, to understand the practices relative position, and to PCTs to understand and benchmark the performance of their organisations. The dataset will also be a key input for the information that is offered to patients, although PCTs will need to consider the best way for this to be presented to maximise impact with patients.

**Chair:** Angela Monaghan (acting)

**Chief Executive:** Rob Webster

**Professional Executive Committee Co-Chair:** Sarah Antemes

**Professional Executive Committee Co-Chair:** David Wild

Although the exact details will need to be worked through, we have identified an initial dataset to include information around:

- Population and public health: including QOF analysis of disease prevalence; patient mortality by cause; demographic and socio-economic information; clustering of practice type by characteristics
- Access to services: including patient satisfaction with various aspects of access to services (i.e. opening hours, advanced booking speed of access); performance against 24/48 hour access targets; closed lists; and information on extended opening hours
- Quality of services: including QOF performance; analysis of exception reporting information; patient satisfaction surveys.
- Approach to care, disease management: including prescribing information, for example statins, aspirin; referral rates for procedures that could be carried out in primary care; variations in emergency attendances; triangulation of underlying deprivation, primary care interventions and secondary care interventions.

The majority of this information is already available through a range of different sources such as the Public Health Observatory, NHS Comparators, NHS Choices, the Information Centre, and the Department of Health.

The key tasks going forward are bringing together existing data, carrying out any additional analysis to fill the gaps, presenting the data in a simple and user friendly way, and over time scanning for further information that could be included.

We propose that a group including clinicians, PCT leads, SHA analysts and the Public Health Observatory be set up to deliver this.

### **The Darzi Procurements**

The group naturally had discussions about the forthcoming procurements of health centres and general practices in under-served areas. Our view is that these procurements should improve the quality of services for all patients, including those of incumbent practices as well as delivering high quality new services. We have a range of views on how this will be achieved and have developed some thinking on funding flows, clinical networks and service development. We would be happy to nominate members of the think tank to be involved in these processes.

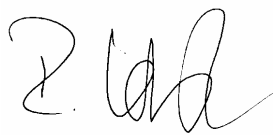
### **Caveat**

These findings have been produced over a period of a few weeks. There were two formal meetings to consolidate views and allow challenge. The original terms of reference are at Annex A and membership of the group is at Annex B. Naturally, the think tank could not cover everything in detail and our findings need to be read with that in mind.

## **Conclusion**

Primary care provides most of our care. It supports population health too and will drive commissioning in the future. It delivers at scale and with innovation. Variation in quality and access and a particular requirement to focus on areas of highest deprivation means that the system requires positive and urgent attention. I believe that our findings will help deliver this, alongside a sustained requirement to develop world class commissioning of primary care.

We were supported in our work by Ian Holmes and Helen Parkin. I want to thank them for their hard work and effort in engaging the group and pulling together supporting evidence and the summary slide pack.

A handwritten signature in black ink, appearing to read 'R. Webster', written in a cursive style.

**Rob Webster**  
**Chief Executive, Calderdale PCT**  
**Chair, 'Our NHS, our future' primary care think tank**

## **Annex A: Terms of Reference**

- (1) To examine the variations in the quality of, and access to, primary care, and set out the impact of those variations on patients and the public
- (2) To identify ways in which, using the current levers available to PCTs, these variations are being tackled, or could be tackled
- (3) To make any further proposals
- (4) To produce a short report to inform the eight clinical pathway groups

## **Annex B: Group Membership**

Rob Webster - Calderdale PCT (Chair)  
Ian Holmes – Y&H SHA (Secretariat)  
Mark Purvis - Yorkshire Deanery  
Keith Parsons – Hull PCT  
Chris Edwards - Rotherham PCT  
Robin Carlisle - Rotherham PCT  
Julie Bolus - Doncaster PCT  
Anne Houghton - GP, Leeds PCT  
Damian Riley - GP, Leeds PCT  
Ailsa Claire - Barnsley PCT  
Phil Earnshaw - GP, Wakefield PCT  
Peter Melton - GP, NE Lincs PCT  
Chris Clarke - NE Lincs PCT  
Helen Parkin – Y&H SHA  
Helen Dowdy – Y&H SHA  
David Anderson - Kirklees PCT

**Chair:** Angela Monaghan (acting)

**Chief Executive:** Rob Webster

**Professional Executive Committee Co-Chair:** Sarah Antemes

**Professional Executive Committee Co-Chair:** David Wild