Report of Meeting held at Department of Health 6th August 2013

Meeting with Secretary of Stare for Health and his senior policy advisor and Senior Managers in the DoH and NHS England.

Dr Mike Dixon (Chair of NHS Alliance) was asked by the Sec of State to arrange a group of GPs to meet with him and senior policy advisors to discuss primary care issues and especially the development of the policy related to the frail elderly due to be published in October.

Present were:

Rt Hon Jeremy Hunt – Sec of State
Edward Jones – Sec of State Senior Policy Advisor
Ian Dodds – Director of Strategy at NHS England
Ben Dyson – Head of Primary Care NHS England

Dr Mike Dixon – Chair NHS Alliance
Dr Donal Hynds – Vice Chair NHS Alliance
Professor Dennis Pereria-Gray – ex president RCGP and Academy of Royal Colleges and Chair of national patient participation group
Dr Niti Pall _ GP in Sandwell and Chair of a Social Enterprise
Dr Rebecca Rosen – GP Greenwich and Senior Fellow at the Nuffield Trust
Christine Oldham – Community Nurse and CEO of Queen's Nursing Institute
Dr Nick Brown – GP Wiltshire – CCG member
Dr Mark Spencer – GP Blackpool and Lead for Integrated care provider
Dr Stewart Finley – CCG Chair – Durham
Dr Robert Varham – GP and NHS Innovation
Caroline Kirby – Practice Manager - Brent

The group was formed about a week ago and has had extensive email correspondence and then had a telephone conference last night to prepare for today.

Sec of State was present for about ½ hour – during this time we focused on 2 questions we were posed:

1. The proposal of a named/accountable GP for the frail elderly

2. Out of Hours – how to provide a better service

Each frail elderly person should have a named or accountable GP

Pre-2004 every patient had a registered GP where ultimately the buck stops. Discussion about how accountable GPs can be for services provided outside the practice.

Consensus that similar to EOL care – it is not unreasonable that someone identified as frail elderly should have a named clinician who would probably

be a GP – who would not be responsible for providing all the care but would lead and be the coordinator.

There would be arrangements specific to each practice about how cover would be provided when the individual was unavailable.

Team approach to care was discussed and the importance of embedded practice district nursing teams was made strongly by me and supported by all the other (more later).

A contractual requirement needs to be defined.

The point was made about access being improved at the cost of personalised care - Mr Hunt restated he felt continuity was very important especially to those with LTC.

Most people thought that general practice was in crisis the contract was broken and needed fixing and we needs to support general practice to change and provide opportunities to make it fit for the 21st century.

OOHs

There was no suggestion that the responsibility for providing OOHs care should return to practices.

General agreement that GP Co-ops provide the best quality care esp. when they get “buy-in” from local GPs.

Discussion about how you move from the current model and allow tendering to deliver this sort of model.

A suggestion that urgent care should be the responsibility of general practice and the budget should follow this!

Mr Hunt stated that he was the most pro general practice Sec of State for 50 year and made some very positive statements about the importance of general practice and how much it is valued by patients and the population.

(I suggested to one of his advisors that he might wish to change his PR team as that is not how he is seen by GPs!)

He had 3 Cs

Continuity of care

Control – give GPs control so they can make it happen – practice control who directs CCG – I pointed out this was easier said than done.

Contract – this is seen as a barrier to change and not an enabler and he believes the contract needs to change and asked the group to consider what recommendations the group would make.

Contract changed could involve QoF and also incentivise care co-ordination for frail elderly.

Recognition that change would need to be created by incentives.

He has 4 areas of importance:

- Vulnerable elderly
- LTCs
- Mums and children
- Everyone else!

SoS has asked the group to continue to meet and has expressed a wish to meet with us again but next time for a longer period of time.

Sec of State left at this point but meeting continued.

General impression was that he was listening, clearly understands he has a challenging agenda and recognises the need to change – all the noises he made about general practice were positive and really put the practice back at the centre of care – but recognise the contractual issues are massive for the profession.

The meeting continued for a further hour

- £26bn sitting in FTs when the NHS is strapped for cash seems wrong.

- Some suggestion that need outcome measures for frail elderly – no one could suggest one that seems robust.

- Discussion about future practice (see Nuffield document Securing Future of general practice) brief discussion of super practice, networks and other options.

- Niti described her set up in Sandwell – which is so far from the norm it is on another planet – I reinforced the need to allow innovation but ensure the average GP and practice was supported.

- Since 2004 spending on hospitals has increased by 40% and is now a great % of the NHS budget and primary care has fallen from 26% to 24%.

- Electronic records – if we do not want to be responsible for providing 24h care – how do we allow OOHs GPs access to our clinical records – as this might solve many of the problems?

- Long discussion about community nursing – all agreed it they should be practice based teams working in partnership with us – yet most have got geographically based team – so discussion around how that is changed - seconding to a practice or group of practices, employing them or setting up a social enterprise – I was forceful that national action was needed not just words as this would not happen.

- Tendering and competition and the conflict with commissioning – we said that insufficient value was placed on local engagement and involvement and that competition and integration would seem to be at odds.

- Some discussion about PMS and what could happen in terms of innovation but a reality check about what will happen with the MPIG and PMS funding when we move to greater equity.

So was it worth going?

I think there was value in attending, it was useful to here the consensus of view amongst the GPs and the messages were received.

If this turns into an advisory group for the Sec of State even if it is time limited it is important that it is not just the NHS Alliance.