To:	**Renfrewshire Integration Joint Board**
On:	**16 September 2016**
Report by:	**Chief Officer**
Heading:	**GP Cluster Working and New GP Contract Arrangements**

1. Summary

1.1 As part of the Integration Work Programme, Renfrewshire HSCP has developed an effective and dynamic approach to 'locality' and 'cluster' based working to build collaboration and joint working between General Practitioners, HSCP services and staff to better support the needs of local patients, service users and communities.

1.2 The principle of practices working more closely together for the benefit of patients, and the wider health and social care system is reflected in the Scottish Government's Localities Guidance issued to support Health & Social Care integration and by the BMA Scottish GP Committee vision and UK RCGP 2022 vision.

1.3 The HSCP has made good progress in establishing GP practice based locality working to progress early gains from 'integration'. Over 2015/16 we have taken a structured approach through a series of individual GP practice meetingsand cluster based development sessions to involve and engage GPs, to ensure they are meaningfully part of the wider network and collaboration of team and service based working. These arrangements are continuing to mature and develop during 2016/17.

1.4 During 2015 Renfrewshire HSCP contributed to an extensive 'system wide' engagement and listening exercise undertaken together by NHS Greater Glasgow & Clyde with HSCP Chief Officers. The aim of this engagement process was to better understand the pressures facing GP services and to reach a shared view about what we should do to addresses these pressures. A detailed set of actions has now been developed which Renfrewshire HSCP will take forward in partnership with the Health Board, other HSCPs and the Local Medical Committee. Appendix 1 provides further detail.

1.5 In April 2016 changes were made to the National GP Contract. These changes move away from the Quality Outcomes Framework (QOF) approach therefore uncoupling the link between activity and payment for GP practices. The new arrangements have a sharper focus on multi-practice 'cluster' based working, the development of a Cluster Quality Improvement Programme, and the identification of a Practice Quality Lead (PQL) and Cluster Quality Leads (CQLs).

1.6 Renfrewshire HSCP established a short life working group to scope out the role and function of the PQL and CQLs and this work is now being used across all HSCPs in NHSGG&C to shape the emerging approaches to cluster working.

1.7 It is expected that there will be further changes to the GP contract in Scotland for 2017/20. The Chief Officer will provide the IJB with further information on these arrangements once information is available.

1.8 Renfrewshire HSCP has worked with local GP Practices to confirm a named GP within each practice (29) to fulfil the Practice Quality Lead role and work will commence in late September 2016 to identify and appoint the Cluster Quality Leads. They will provide a quality improvement leadership role in the cluster working to enable work between praactices and between practices and the the HSCP.

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2. Recommedation

It is recommended that the IJB:

- Note the progress made to establish GP Cluster Working;
- Note the new GP Contract Arrangements for 2016/17; and
- Note the work being undertaken by NHS Greater Glasgow & Clyde, HSCPs and the Local Medical Committee (LMC) to address pressures within GP services.

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3. Background

3.1 Clusters are small groups of geographically connected GP practices, who will work collaboratively, agreeing with relevant local partners a clear set of outcomes and a means to review these outcomes collaboratively, improving outcomes through further cycles with those same outcomes or moving onto other outcomes across the patient pathyway, in a repeating pattern, underpinned by an evidence based approach to improvement.

3.2 Renfrewshire has twenty-nine GP practices which were initally formed into 10 clusters, initially aligning with existing District Nursing Teams. As we worked with local practices we have now moved to a six cluster approach now established under our two localities - Paisley and West Renfrewshire. These are outlined in Appendix 2.

3.3 In Renfrewshire we held a series of half day Cluster Development Sessions earlier in 2016 which provided the opportunity for those responsible for the delivery of service to the cluster population to come together to consider how we unlock the benefits of integration and to begin to develop future ways of working. Through these sessions, each cluster has developed an initial Cluster Improvement Plan which is being progressed via 30, 60, 90 day improvement approach, with agreed timescales and named lead managers/GPs. Actions are themed to the type of change they are and are noted in improvement methodology terms as:

- Quick Wins (things that can be done now to improve how we work)
- Projects (work strands that take a bit more time, effort and may require input from others)
- Events (full scale rapid improvement work).

Sessions have identified a number of actions which are common to most Clusters in Renfrewshire and some issues specific to one cluster. A number of individual cluster 'tests of change' have also been identfied, which will be progressed over 2016/17. Further detail can be provided on request.

Some examples of the work being undertaken are:

- Scoping of the value of 'Treatment Rooms' type services
- Supporting GPs with financial/benefit support for patients
- Developing ways of working and relationships between a cluster of GP Practices and local pharmacists, to improve prescribing related work flows
- Releasing GP capacity by realignment of the HSCPs Prescribing Support Pharmacists
- Identifying shared caseloads (between a practice and HSCP services) to look at improving how we work to support the patient/service users e.g. improving prevention and anticipatory care planning
- Direct access to self-referral services.

3.4 Three supporting subgroups have also been established to review how HSCP services currently work and to present options on future ways of working to support cluster working. These have specifically emerged from our Cluster Development Sessions and include:

- **Mental Health/Addictions Sub Groups (x2)**

  1) The GP Cluster Subgroup will review how Renfrewshire HSCP Mental Health Services currently work with GP practices and recommend options on how Mental Health and Addiction Community Services will work within a future Cluster Framework.

  2) The Unscheduled Care Sub Group will review unscheduled care within Mental Health and Addiction Services and will make recommendations to maximise effectiveness, resources and improve patient journey.

- **Practice Nursing (PN) / District Nursing (DN)**

  3) The PN/DN Sub Group will examine ways of PN/DN working smarter together or where necessary and appropriate interchangeably, on agreed areas of work with clear aim to optimise available resource versus workload.

3.5 Significant progress has already been made to ensure our other HSCP services align with clusters to minimally ensure we operate single points of access and contact wherever we can and to ensure that our services are fully connecting into wider primary care extended team/profession meetings. This is targetting at information sharing and building robust joint working.

3.6 A Clinical Leadership induction and development programme will be developed to support PQLs/CQLs, which will focus on building knowledge, understanding and awareness about the HSCP, its structures, how it works and also of the wider relevant NHS and Council arrangements and begin to shape ways of working between CQLs; between CQLs and PQLs and between CQLs with HSCP Managers.

Implications of the Report

- **Financial –** Practice Quality Lead (PQLs) are funded directly by Scottish Government. Chief Officer and Chief Finance Officer are agreeing arrangements to fund local Cluster Quality Leads (CQLs).
- **HR & Organisational Development – Nil**
- **Community Planning – Nil**
- **Legal – Nil**
- **Property/Assets – Nil**
- **Information Technology –** managing information and making information available may require ICT input.
- **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.
- **Health & Safety – Nil**
- **Procurement – Nil**
- **Risk – Nil**
- **Privacy Impact – Nil**

List of Background Papers: None

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Renfrewshire
Health & Social Care Partnership

Renfrewshire Council

NHS Greater Glasgow and Clyde

Appendix 1

Renfrewshire HSCP Clusters

Paisley = 13 Practices

Cluster	Practice Code	GP Practice	Most dep 15	List Size
5.	8752-1	Kelburn Medical Practice	18.56	4246
	8754-1	Greenlaw Medical Practice	15.99	6521
	8760-6	Barony Practice	25.12	6123
	8747-1	Anchormill Medical Practice	22.87	7877
	8762-5	Abbey Medical Practice	17.02	10541
	8751-7	Glenburn Medical	18.73	3249
	8746-6	The Charleston Surgery	16.17	5902
6.	8750-2	The Consulting Rooms	13.04	7193
	8748-5	The Tannahill Centre	66.67	3711
	8749-0	King Street Surgery	24.86	9390
	8757-4	St James Medical Centre	32.23	3133
	8755-5	Mirin Practice	25.04	8915
	8756-0	Love St Medical Centre	31.16	5820

West Renfrewshire = 16 Practices

Cluster	Practice Code	GP Practice	Most dep 15	List Size
1.	8711-2	Bishopton Medical Practice	0.00	7135
	8718-4	Mains Medical Centre	0.00	8622
	8723-5	Bridgewater Medical Centre	0.08	2172
	8724-0	Bargarran Medical Practice	0.35	4351
2.	8769-7	Braehead Medical Practice	13.69	6697
	8770-0	Clydeview Medical Practice	16.47	8126
	8771-4	Kingsinch Medical Practice	13.02	6538
3.	8729-2	Ludovic Medical Practice	18.93	6745
	8733-9	Riverview Medical Centre	22.44	5074
	8772-9	Westfield Medical Practice	35.05	4976
	8714-6	Ranfurly Surgery	0.12	10256
	8740-9	The Health Centre,Linwood	12.68	5672
4.	8732-4	Ravenswood Surgery	16.51	6375
	8743-2	Mistylaw Medical Practice	0.98	4582
	8730-5	Quarryside Medical Practice	23.68	4637
	8734-3	Linden Medical Practice	25.00	3981

NHS GREATER GLASGOW AND CLYDE

Developing GP Services: Engaging and listening

Summary and next steps

Message from Board Chief Executive and Partnership Chief Officers

The services delivered by GPs and practice staff are the bedrock of the NHS. We established the engagement process to understand the pressures facing GP services and to reach a shared view about what we could do to address those pressures. The engagement and listening exercise has enabled us to hear from GPs and other primary care and community staff through a range of individual and collective discussions across Greater Glasgow and Clyde.

The actions outlined in this paper have been developed collaboratively and are our response to begin to address the issues which have been identified. We recognise that to sustain GP services, we must continue to work together to progress these actions – this will be done in partnership between the Health Board, our six Health and Social Care Partnerships and the Local Medical Committee.

We know there are real challenges to overcome but we have also heard a positive, consistent message that the endeavour to deliver high quality primary care services remains a compelling one for our GPs who continue to focus on the needs of patients. Levels of demand and workload pressures are now creating unsustainable pressures.....this programme is a commitment from us to focus real effort, energy and commitment to reduce those pressures.

We know that this local programme of work will not in itself be enough to address the issues and we will continue to work at National level to ensure that the changes required in terms of investment and workload are reflected in the new national contract. We will also continue to focus on ensuring our new Health and Social Care partnerships establish strong relationships with primary care.

Robert Calderwood, Chief Executive, NHS Greater Glasgow & Clyde

David Williams, Chief Officer, Glasgow City HSCP

David Leese, Chief Officer, Renfrewshire HSCP

Julie Murray, Chief Officer, East Renfrewshire HSCP

Keith Redpath, Chief Officer, West Dunbartonshire HSCP

Karen Murray, Chief Officer, East Dunbartonshire HSCP

Brian Moore, Chief Office, Inverclyde HSCP

1. Proposed Next Steps

During 2015 we increasingly heard from GPs about the pressures they were facing and established an engagement and listening exercise to help us to understand those pressures and to shape how the Board and HSCPs could respond.

This paper brings together the feedback from that work and sets out our work programme to respond to the issues which have been raised. The intention is to use the proposals in this paper to start to address the problems identified.

We will also continue engagement so that we build programmes of change which visibly and effectively address the issues which GPs have raised. We want to ensure our GPs and the staff who are aligned to and work with practices can deliver the best care to our patients and that our GP services are secure for the future.

The programme will operate at a number of levels:-

- Within Partnerships, which are responsible for working with GPs and for the delivery of all local health and social care services;
- Within the new clusters which are being established as part of the 2016/17 contract;
- Between Partnerships and across the Heath Board are where issues relate to contracts and systems of working;
- Between primary care and the Acute Services Division.

1.2 Workload and demand: GP described major workload pressures and we propose action as follows:-

- Implement the QoF changes and make similar changes to our local enhanced services to reduce bureaucracy to a minimum;
- Across the Board, and in each HSCP, identify with GPs areas of inappropriate or unnecessary workload and the action required to enable that workload to be stopped or dealt with elsewhere in the system;
- Identify care pathways where the GP function is as a gatekeeper not providing an appropriate clinical intervention and deliver alternative routes of access to these pathways;
- Invest in additional pharmacists to pilot ways to reduce GP workload;
- Work at a national level to ensure that the further development of the new national contract reduces GP workload;
- As HSCPs develop and deliver their plans to transform services to older people consider how a team approach can better deliver care;
- Take stock of support to care homes and identify actions which would complement and support the GP role;
- Review the potential to develop a patient engagement programme to reinforce the role of GPs and alternative services;
- Through the PCTF test new ways of assessing those patients who on account of illness are unable to attend in person their local GP surgery;
- Review the potential to provide support to GPs in dealing with complaints through HSCP teams;
- Work with the LMC to identify any additional ways in which we could support practices.

1.3 **Relationship with Secondary Care:** there was a strong and consistent theme of real challenges in working effectively with secondary care:-

- Through the existing interface group we will identify more comprehensive priority programmes of work which will make a real difference to GPs;
- We will establish a review of how a number of agreed priority complex care pathways are coordinated and how this could be done more efficiently and appropriately;
- We will ensure that the acute service change proposals which will be developed by HSCPs deliver positive benefits for GP services.

1.4 **Information Technology:** a range of issues about HIT were identified:-

- The Director of Health Information & Technology and a nominated Chief Officer will lead a short comprehensive review of the HIT available to GPs and how that links to other parts of the system to support efficient and informed patient flows.

1.5 **Access:** there are major issues about how patients access GP services, with pathways often defaulting to GP consultations when these are not required:-

- Each HSCP will work with GP practices in their area to develop pathways to ensure ready access to the most suitable healthcare professional and that the GP is not the routine default;
- As part of our use of the PCTF we will establish work to test approaches to address this issue.

1.6 **Primary Care and Community Teams** the clear message is that the way our wider community teams relate to GPs is a major issue**:-**

- Each HSCP will review the organisation and relationships between their employed staff and practices to develop proposals for improvement;
- As HSCPs develop they will explore how to deliver more productive and structured relationships between social care staff and systems and GP practices;
- We will establish a single system review to look at how our mental health services interface with GP practices and develop proposals for improvement;

1.7 In addition to these actions the rest of this section outlines how we will use the primary care transformation fund to support this work and the wider priorities which HSCPs will take forward in their planning which will impact on GPs.

1.8 **Cluster and Practice Quality leads and the Primary Care Transformation Fund**

The development of C and PQL's is a major opportunity to develop productive quality focussed working within and between practices and we want to ensure that we have proposed to Scottish Government that we have allocations as follows, to support the:-

- Development of cluster working with an allocation to each Partnership;
- New Ways Programme in Inverclyde;
- After clusters are established to develop with them transformation proposals for three areas:-
  - Chronic disease;
  - Acute interface with a focus on older people;
  - Home visiting.

1.9 Interface Priorities for HSCP Planning

The themes set out below have been agreed with Chief Officers they cover areas where the effective planning and delivery of changes in services are critical to the delivery of our Clinical Services Strategy; to the intent that the establishment of HSCPs will transform care and to the requirement to reshape acute care into an affordable configuration which can meet demand:-

- **Better management of older people and chronic disease in the community:-**
  - Improving out of hospital care and patient pathways including innovative support to GPs;
  - Improving systems and services to deliver early discharge;
  - Improving care in nursing homes;
  - Extended and integrating arrangements for domiciliary support;
  - Identifying developments which delivery the CSS joined up care system;
  - Reshaping out of hours services.

- **Enabling acute care to be focused on patients with acute needs;**
  - Action to enable patients to die at home;
  - Identifying care pathways which can be modified to reduce reliance on hospital services;
  - Delivery of the Paisley development programme outputs in each HSCP area
  - Shifting care from an unplanned to planned basis;
  - Further reducing delayed discharges.

- **Changes to address service pressures and inefficiencies;**
  - Identifying and addressing variation in use of diagnostics;
  - Identifying and addressing variation in the use of outpatient and inpatient services;
  - Reviewing a number of care pathways where there is potential for efficiency;
  - Transport

Finally, this paper has focussed on the changes we can make through local action. The development of the **new National contract** is the major opportunity to address workload pressures, to recognise the impact of deprivation in the distribution of resources and to deliver real additional investment in primary care.

We have derived from this engagement exercise a clear shared statement of what we think the new contract needs to deliver.

2. <u>Introduction and Background</u>

General Practice, with registered patient lists, everyone having access to a family doctor, delivering continuity of care, is one of the great strengths of the NHS. Our model of GP services brings together the management of illness and disease, increasingly complex, with continuity, empathy and humanity. GP services are the bedrock of the NHS delivering over 90% of our patient contacts, skilfully assessing undifferentiated patient presentations and managing the care of the overwhelming majority of patients within their own practices. NHS Greater Glasgow and Clyde has over 240 practices with nearly 800 GPs and we spend £154 million on our GP services.

In September 2015 we launched a programme to engage a wide range of interests in developing a direction for GP services in NHS Greater Glasgow and Clyde. There were a number of different **reasons for the timing of the engagement:-**

- We heard from GPs about the pressures they are experiencing in the level of demand, the complexity of the care they need to deliver; the challenges of responding to the needs of deprived patients; the growing number of patients with chronic diseases and an increasing elderly population;
- As well as those general pressures, many of our practices are involved on the Deep End national group which brings together GPs from the most deprived practices in Scotland. This Group has worked to highlight the major issue of unmet needs for patients in deprived areas;
- GPs also describe extensive inappropriate use of their time and skills with demands from a range of routes including in relation to social security benefits, acute hospital services and NHS 24, these pressures are in addition to the increasing demands for care from patients;
- There are major challenges in recruiting and retaining GPs and attracting junior doctors into GP training;
- These pressures on GP services are compounded by pressures elsewhere in the system including on our acute hospitals, on mental health services, on NHS community and social care services and on voluntary and community service organisations;
- We have developed a clinical services strategy for the services which we deliver. The strategy relies on supporting and developing the services which GPs provide;
- There is a Scotland wide process under way to develop a new, Scottish, contract for GP services.....we are the largest Health Board in Scotland and we want to work closely with the Government and with GPs to shape that new contract;
- Our new health and social care partnerships need to establish close relationships with GP practices so that GPs have a central role in the Partnership's responsibilities to plan and commission hospital services for their populations;
- We need to look at the way our employed community staff work with GP practices;
- New information systems enable us to take a fresh look at how GPs and hospital services share information about patients;
- It is increasingly difficult to staff the current out of hours GP services;
- In the current contract it is difficult for GP practices to work together although that may help them address some of these issues and work better with other NHS services.

Part of the pressure of demand relates to the rising needs of our ageing population with increased chronic disease and the health issues created by deprivation. But it is also the case that patients often go to their GPs with issues which could be dealt with elsewhere and do not require skilled medical intervention. The open access nature of GP services, an important strength, means that GPs are a point of service for a wide range of demands.
In setting out the engagement programme we described **our thinking on the changes which need to happen in primary care:-**

- More services organised around groups of GP practices, more resources for primary care and new models of primary care delivery;
- More investment in social care services to support people living in the community and in care homes;
- Concentration of specialist inpatients services accessed for the shortest possible periods of intervention;
- More people supported to die in the setting of their preference;
- Services which enable people to manage their own conditions;
- Specialist NHS medical and nursing skills supporting local and community based services, including care homes rather than focussing on hospitals;
- Care homes used more flexibly, providing better care and meeting higher levels of physical and mental frailty and need, with more input from specialist clinical services to support this change;

- Creating a reshaped workforce to deliver this strategic direction with, more staff in community settings and more care delivered by multi disciplinary teams.

The engagement exercise included:-

- Discussions within each Partnership;
- A widely publicised website aimed at GPs and their staff, at patients, at hospital staff and other staff working in the community;
- Discussion in the Board's Advisory Committees.

The purpose of this paper is to summarise the responses we received and create a discussion about the way we will address the issues which have been identified.

Since we ran the engagement there have been three significant national changes:-

- The QoF has been dismantled, reducing the pressures of bureaucracy on GPs and creating the space to establish a new approach to quality in primary care;
- That new approach includes practice quality leads and new clusters of GPs working together with a cluster quality lead;
- A National Primary Care Transformation Fund has been established to develop and support new ways of working.

In addition, of significance to our local position are:-

- The Inverclyde test of change programme linked to the work to develop the new national contract;
- Initiatives to support GP services, including providing link workers in Drumchapel, the Govan project and additional pharmacists to try to reduce workload.

3. Issues from Responses

We had a wide range of responses for GPs, practice staff, and patients. This section draws out the key themes and issues from the response we received.

3.1 Workload and Demand: the most consistent and significant issue raised is the excessive burden of work carried by GPs, the impact of that on their working life's, morale, commitment to continue in the profession and on the ability to attract and retain new GPs.

- The pressures created by growing numbers of older people with complex chronic conditions, who need more time with GPs;
- Patient expectations and demands, often inappropriately including for minor self limiting illnesses and demands for urgent access when that is not required. A major theme was the need to re educate patients and to stop unreasonable demand;
- QoF and our local enhanced services creating unhelpful bureaucracy;
- GPs being used as a gatekeeper for a wide range of other services and functions including health care but also access to benefits, sick notes and other state processes;
- Acting as the only point of for coordination complex care;
- Increasing demand for house calls;
- Repeat prescriptions and medications management and underutilisation of the community pharmacy chronic medication service;
- Pressures generated by nursing homes;
- Services being deliver by GPs which could be delivered by others, examples included immunisation;
- Opening hours should not be extended;

- GPs should have maximum list sizes and a clearly defined role;
- Too much time on administrative work;
- Complaints were repeatedly raised as a further source of pressure;
- The need for longer appointments.

3.2 **Relationships with Secondary Care:** there was a strong and consistent theme of real challenges in working effectively with secondary care, issues included:-

- A feeling that workload is being transferred from secondary care without matching resources;
- Real challenges in working with secondary care, with positive examples of what works well, including direct access to consultants and wider forms of urgent care secondary care;
- IT and info flow not working well;
- Variation between specialties and consultants;
- Direct contact should be norm and is key;
- Workload shifting including phlebotomy, results coordination and dealing with DNAs;
- Continuity in complex cases relies on the GP.

Thoughts on how these points could be addressed included shared education, more outreach and better transfer of information.

3.3 **Working with Other Contractors:** the exercise identified:-

- The potential to extend and support the development of additional patient services and access to other contractors;
- This would require clear systems of care, lines of accountability and information sharing.

3.4 **Information Technology:** a range of issues about HIT were identified including:-

- Sharing information with community health staff;
- Links between other contractors and GPs;
- Continuing issues with systems across GPs and acute.

3.5 **Workforce:** a range of issues were raised:-

- The age profile of current GPs and primary care staff creates serious risk of exodus;
- Need more and different roles in practices, pharmacists most often mentioned;
- Recurrent theme of other staff not working to the full potential, extent to which this reduces work they can take from GPs;
- The projects in Glasgow with links workers and social care staff were highlighted as very positive for GPs;
- Lack of access to locums is a major issue.

3.6 **Access:** there are major issues about patients access GP services:-

- there is no limit to demands on GPs or their responsibilities;
- as the easiest place to get a service the model of access to GP attracts work which could be dealt with elsewhere as many other services have barriers to entry.

3.7 **Primary Care and Community Teams:** the clear message is that the way our wider community teams relate to GPs is an issue.

- Where effective relationships and ways of working are described they generate highly positive experience and comment; but the reality is that there is a common theme from GPs and those wider staff, across a range of our teams, that the relationships and ways of working are not as effective as they could be;
- There is a strong sense that as legitimate changes to the delivery of these wider services take place relationships with GPs have fractured;
- There were particularly strong views about the value of access to social worker and social care services but the difficulties in establishing effective ways of working;
- Mental health services were also repeatedly raised as highly positive when access and relationships worked but with real challenges in achieving that. Clear message that we need new models of team working.

4 Conclusion

This paper has focussed on the areas and issues highlighted as in need of change, but it is also important to acknowledged consistent positive feedback about GP services:-

- Continuity of care and lifelong relationships;
- Universal coverage;
- A focus in local communities;
- The effectiveness of the gatekeeper role to wider health services;
- A focus on wider health promotion and prevention;
- Access is free and unimpeded;
- Single point of contact for other services.

A consistent message is that GPs still enjoy seeing patients, the core role is great, the levels of demand and workload pressures are not.....The aim of the work programme outlined in this paper is to deliver change which will support GP practices by addressing pressures.

Final version June 2016