SOMERSET LMC

Newsletter Special Edition

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Where are we now?

Is it just me or does everything seem a bit fragmented at the moment? We keep hearing of another 'crisis' in the NHS, new (or old) bits of money floating about, more things that a special interest group, a government report, or the media think GPs aren't doing well enough and need training for. Initiatives here, there and everywhere all of which have acquired a plethora of initials that seem accepted by the NHS as agreed common language….and so forth. The list is endless. Unfortunately, so is the footfall coming through the door and all the initiatives in the world cannot reduce that quickly. So what can be done about this?

The LMC has previously acknowledged the anger expressed at the joint CCG/LMC meeting on the 8th January about the fact that there is too much being pushed through too quickly, and whilst those feelings may remain, there are some more hopeful things that have come out of that meeting. The purpose of this letter (and its attachments) is to try and bring a bit of order and direction to all the stuff going on at the moment.

FUNDS

We have covered this before but is worth repeating some of the definitions, although with the rider that none of these funds are new money but recycled … from somewhere. Be warned: many of the purposes of these funds appear to overlap, so expect to be confused.

Better Care Fund (BCF). In its revised form the only NHS target has to meet is to reduce emergency admissions. It is (or will be when every organisation agrees) be a sum of money released from other budget lines in NHS and Social services budgets. In Somerset, the vehicle for doing this will be the LIGs. (See the 'jargon busting section') and their Test and Learn Pilots.

The BCF structure in Somerset is steered by the **Leadership Group** on which the LMC Chair sits as an observer, and it is managed operationally by the **System Transformation Group** of which the LMC Medical Director is a member. The actual patient contact work will be done in **Local Implementation Groups** (LIGs), of which there are currently four in the county.

(The LMC is currently unclear quite how well this layer cake of meetings contributes to the overall plan given the limited management and other resources is available)

Primary Care Collaboration Fund. This is the £5 per head that CCGs were encouraged to identify and release for Community and Primary Care purposes. It is recurrent and here has been used towards increased District Nursing activities, Domiciliary Phlebotomy (hackles down please!), out of hours nursing services and also some small projects in Federations, some of which overlap with initiatives under the Test and Learn Pilots.

Resilience Fund. This is the money that has been identified to help provide extra, flexible, NHS capacity at peak demand times. For this year the GP element is the data collection that we are all doing every day on urgent care demand. It has been very useful so far in demonstrating to other organisations how much urgent work Practices soak up each day. This is the first time that Primary Care has had a slice of this fund and the LMC is working with the CCG to ensure that this continues.

Prime Ministers Challenge Fund (Wave 2). This is quite a large chunk of money that seemed to sneak up on us a bit and is intended to support initiatives that will help access to Primary Care. The CCG has made an application on behalf of Somerset practices for some of this funding that, if successful, will be used initially to accelerate IT connectivity improvements between local NHS and Social Care providers (the primary care element being co-ordinated by SPH) , and then to support some SPQS Test and Learn pilot work.

VANGUARD. This is the new kid on the block and it has a rather unfortunate name given that it is the same as that of the company associated with cataract surgery problems at Musgrove Park Hospital, but this is entirely separate national NHS development programme. It arose out of the 'accelerator' schemes promoted by NHS England following the publication of the Five Year Forward View (FYFV – again, see 'jargon busting') and relates to changing models of the provision of care. There will be 20 or so such awards nationally and we believe the chosen projects will be fully funded.

The Somerset application is based on support for the South Somerset/YDH initiative but it is in two stages. The first is to support implementation and assessment of the project. And then to disseminate the learning to other areas (the LMC hopes AFTER evaluation shows it has worked). If Somerset wins an award this should fund parallel working of both current and proposed working patterns, the point being that with the pressure of the current day job most GPs have no resources (time, money and so forth) to engage with new care models. Putting aside the problem of where the workforce will come from, winning this would therefore be a *good thing* since it will allow this 'double running'

MAIN CURRENT LIG PROJECTS. The largest projects at the moment are around South Somerset/YDH (which has morphed from 'Symphony' into the proposal for a larger Integrated Accountable Care Organisation), Taunton Deane and Mendip area initiatives. These have developed mainly under the Test and Learn banner and are mentioned in applications for some of the funds above. It is fair to say that there has been variable feedback about how far GPs are truly committed to the projects in the areas concerned, but if they succeed then it may be that they will provide a model that really can help Practices manage their workload. The LMC hopes to be involved in these projects at contract level to ensure that the best of General Practice, especially the autonomy of Practices, is retained, and that the interests of those Practices not included in these projects are protected. We welcome feedback from any Practices in these LIG areas, whether for, against or ambivalent about developments so that we can form a balanced view of opinions. As well as these well publicised projects, there are many smaller ones that have been successful in promoting different services working together in a very positive way to help GPs and patients.

SOMERSET PRACTICE QUALITY PROGRAMME (SPQS). We are now at the stage of the year where those who are signed up are viewed with envy by those who have not and are dealing with the QOF lists coming through with a vengeance. There seems to be a growing national view that the value of QOF as it stands is in doubt and we anticipate SPQS will continue at least in to 2015/16. Early indications show that already we can demonstrate that quality of General Practices in managing conditions in areas that really matters to patients has not been sacrificed by the implementation of SPQS.

CO-COMMISSIONING. The LMC understand that roughly 60 or so CCG areas have gone for fully devolved commissioning powers or "Option 3". Whether this is an indication of confidence in their CCGs or a lack of it in their Area Team is unclear. In Somerset, acknowledging concern at that speed at which decisions were required, Practices have voted for joint commissioning "Option 2". This choice will protect the CCG against accusations of conflict of interest, but will allow it some freedom in putting money used for some projects felt locally to be not very helpful (such as QOF and some local and national enhanced services) to better use. The LMC will be involved in negotiations on this, and will again ensure that whatever is proposed really will be what is wanted by Practices and best for patients, whilst insisting on the need to protect the fundamentals of the national GMS contract

FEDERATIONS. So where does this leave Federations? Groups of Practices always have worked together, even before the CCG and nine current federations came into existence. Officially these groups have separate commissioning and provider roles, but all Practices know that GPs are generally more focused on providing rather than commissioning – that is why most of us have not volunteered to sit on the CCG but are (variably) grateful to those souls who have. It is also true that different Federations work at different levels of engagement and productivity. In addition there is reducing funding from the CCG for their function. It may be that to be more efficient and to free up clinician time, Federations should look at merging into three, four or five federation consortia and possibly SPH could have a role in supporting and co-coordinating joint activities for these larger Federations. This would help effectiveness and share resources. There is more about this suggestion in the attached joint LMC/SPH document. What is important is that individual Practices and local federations retain their autonomy but can continue to feed ideas in to the larger consortia.

SPH. This brings me nicely to SPH. Just to recap, SPH is a provider limited company, and in that respect is similar to

Virgin or any other commercial provider. The difference, of course, is that we GPs own it. Its initial purpose was to protect Practices from losing supplementary contracts to other providers. Those on the Executive of SPH have worked extremely hard at preparing recent bids (Health Checks, OOH and Domiciliary Phlebotomy) mainly in their own time and at little cost to the main SPH fund but certainly to their own energy levels. Practices therefore owe an enormous thanks to those who have done the work and it is disappointing that they have not been awarded any contracts so far. It is worth noting, however, that new providers in the market will typically have to make six bids before they win a contract, so to have been short listed for all they have bid for is an important achievement for SPH. The LMC, having been instrumental in promoting formation of SPH, has stood back from active involvement in the group. However we have recently met with SPH to see if the LMC can work closer together with them, within the current legal framework, to the benefit of Practices. Again, there is more of this in the joint letter attached.

COSTING SERVICES It is worth making one further point about such supplementary contracts. Practices should not assume that just because a price is attached to any service then it is automatically worthwhile doing. It is essential to work out whether it is truly cost effective

each time such a contract is offered. In the past the LMC has run sessions on this in our study days and included guidance on how to do evaluate contracts, However, from the questions we received after the Heath check contract release, it is clear that many Practices are still not doing this routinely. The LMC has recently sent out a sample spreadsheet to Practices about the costing of Health checks and we would encourage you to adapt this for other services. Please also remember that if the contract is awarded to an external bidder and then offered as a subcontract at a lower price this may encourage the devaluation of general practice time and effort, especially if there is no or minimal profit element . It is also a reason why we have ended up with so much unfunded work since Practices have historically 'just done it'.

UNFUNDED TRANSFER OF CARE WORK. This affects ALL of us – whether involved actively in Federations, SPH, the CCG clinicians, LMC or just plodding along keeping our heads down and hoping someone, somewhere sorts it all out. Well, the LMC is trying to tackle the problem. Thank you once again for all of you who have returned the forms from the survey. This information will be extremely helpful in current negotiations with the CCG about this matter and we are very hopeful that some aspects of this unfunded work can be included in a new form of enhanced service (tentatively called additional local services). The information you have provided will be a tool whereby funds may be unlocked to support some of this this activity and there may be a fresh opportunity to do this with the move to co-commissioning. Clearly this will take some time and in a separate report to be sent this week, the LMC have made some suggestions on what action you can take now.

JARGON BUSTING

Five Year Forward Plan (FYFV). This came out towards the end of 2014 and is a statement by Simon Stevens – the head of NHS England - about the priorities for the NHS over the next five years. It does not promote any particular party political view, and there was a kerfuffle amongst these main protagonists as there was nothing in it with which they could really disagree, but it did not necessarily fit with what they intended putting in their manifestos. From our perspective, the most important thing is that it reinforces general practice as the lynchpin of the NHS and also as central to managing the changes needed because of the service's current money and workforce problems. We therefore think it is a *good thing.* As ever, the proof of the pudding will be in the eating (or indigestion).

COBIC. Stands for Commissioning Outcome Based Incentivised Contracts. Related to the BCF and being looked at by the CCG for all providers, not only General Practice. It is all about moving from measuring activity by 'bean counting' and towards measuring patient experience and outcome. What is of concern to the LMC is that recent documents we have seen suggest that this is generally supported by Trusts and 'GPs'. Unfortunately we suspect that most of you do not know what this is about but we believe that the CCG will make this clearer in the quarterly meetings that they are arranging for Practices – the first of which is on the afternoon of 25th March. In primary care, the move from QOF to SPQS reflects this policy, but to date core GMS/PMS contracts have not been included in COBIC proposals.

LIGs. (LOCAL IMPLEMENTATION GROUPS). Are responsible for the test and learn pilots (under the BCF project) that have been set up by the CCG and Somerset County Council to co-ordinate local development of integrated care. Attendance at LIG meetings is not contractual (nor, indeed is taking part in test and learn pilots), but does count as

SPQS work.

MCP (Multispecialty Community Provider. An idea from the FYFV (you now know what that is) for a new way of organising care. This model that would consist of a group of GP Practices, district nurses, hospital specialists, community services, and so on who will work together to integrate out of hospital care.)

Primary and Acute Care System. Another model of care promoted by the FYFV. An acute hospital and GPs working together in a much close structure.

As regards both of these: isn't that what we USED to do?

RECRUITMENT AND RETENTION

I have not forgotten that there is still a recruitment and retention problem although it seems that recent training completers are increasingly interested in 'salaried with a view' positions, which may be worth remembering when you are next advertising.

There was a useful document released a couple of weeks ago by the GPC on models that groups of Practices can use to work together. It includes several ideas which may be worth considering to share resources whilst still retaining individual Practice identities LINK. There was also good news this week regarding reintroduction of 'golden handshakes' and 'handcuffs' as well as an outburst of common sense in looking at how to help those that have been out of active service for some time (i.e. retainers or those who have been abroad) get back into General Practice quickly.

AND FINALLY….

I apologise again for the length of this summary but I do not expect that it will be read at one gulp. It is there for reference. There is always the risk that as soon as the ink dries it will be out of date but at least it is a starting block for seeing from where future developments first came.

So where are the positives in all this? Well, although confusing it shows there is a lot going on in Somerset (as has been noted nationally), and this health community is trusted to innovate safely and effectively. Maybe we should start adding that to our adverts for new partners?

The importance of General Practice at the centre of things has been emphasised in the FYFV that sets the direction for the NHS until 2020. There is also recognition of the unfunded work that GPs are doing and action is planned to tackle as least some of this.

There is no doubt that 'collaborative working' is at the centre of all these developments. GPs started doing that years ago with GP OOH co-ops, so we have a track record on success in this, given the opportunity and freedom to do so. SPQS is beginning to show that when given the chance GP practices can produce the desired results.

Somerset used to be a fairly joined-up place to work, with only a few NHS organisations to which GPs needed to relate. With all the different things going on it would be good if we could remember that and try to work towards going regaining that benefit. We hope that bringing together in this document some of the current strands of development can help give a sense of where we are now, and an idea of where we are going. The LMC is shortly to produce a position paper on where we see General Practice is heading in the next few years, and we hope that will help give some framework to reduce the feeling of fragmentation felt across primary health services at the moment.

Fundamentally the LMC believes that patients are still best served by primary care based on the GP partnership model and whilst that will need to adapt for the future we will endeavour to ensure that any such changes maintain the principles of personal GP care based on a patient list.

So, although day to day life is exhausting in the surgery at the moment, I believe there is real hope that that can improve.

….and if you are exhausted reading this then consider how I feel after writing it!

Sue Roberts

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