AGENDA ITEM No.12

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 1 June 2016
Agenda Item	12
Title	General Medical Services Contract 2016/17

Summary

The purpose of this paper is to update IJB members on the changes to the General Medical Services (GMS) contract for 2016/17 including the ending of the previous Quality and Outcomes Framework (QOF) and the development of cluster working for GPs within the East Renfrewshire HSCP.

Presented by	Alan Mitchell, Clinical Director

Action Required

IJB members are asked to note the contents of the paper and agree to receive further reports on the development of quality clusters within East Renfrewshire HSCP.

Implications checklist – check box if applicable and include detail in report

☒ Financial	☐ Policy	☐ Legal	☐ Equalities
☐ Efficient Government	☐ Staffing	☐ Property	☐ IT

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

1 June 2016

Report by Clinical Director

GENERAL MEDICAL SERVICES CONTRACT 2016/17

PURPOSE OF REPORT

1. To update members on the development of the 2016/17 GP contract within East Renfrewshire including the development of cluster working for GPs and the associated requirements for cluster quality leads (CQLs) to be identified and practices to agree practice quality leads (PQLs).

RECOMMENDATION

2. IJB members are asked to note the contents of the report and agree to receive further updates on the development of GP clusters within East Renfrewshire.

BACKGROUND

3. In the debate on primary care in the Scottish Government on 15th December 2015 the Cabinet Secretary for Health, Wellbeing and Sport set out a programme for the redesign and modernisation of primary care to better meet patient need and revitalise general practice. This included the development of a Scottish GMS contract from 2017 an early priority for which was to develop a framework for quality and leadership within the new contract.

4. The QOF framework embedded within the 2004 contract has ended with the funding associated with those points being transferred into a core standard payment within a general practice's global sum.

5. The 2016/17 interim GMS contract, while acknowledging the unnecessary burden attached to the administration of the previous QOF arrangements will continue to rely on the professionalism of GPs and GP practice staff to provide all elements of that quality care that they (GPs and their staff) consider to be clinically appropriate.

6. An early priority is to develop a framework for quality and leadership for a new GMS contract from April 2017 onwards and to that end the Deputy Chief Medical Officer is chairing a group of partners including the Scottish General Practitioners Committee, NHS Boards, the Royal College of General Practitioners and NHS Health Improvement Scotland to develop such a framework collaboratively.

7. In the interim, transitional quality arrangements are to be developed across each HSCP. These transitional arrangements will include that practices:

   - Maintain current disease registers within the GP clinical system and code patients based on diagnoses while offering appropriate lifestyle advice.
   - Continue the current activity associated with flu vaccination particularly so with patients with coronary heart disease, stroke, diabetes and chronic obstructive pulmonary disease.

- Continue to work with their prescribing support pharmacists in further developing safe, quality and cost effective prescribing.
- Consider what could be done further to improve access arrangements in individual GP practices.
- Designate a PQL who's responsibility will include that a process is developed for ensuring that each GP and relevant others in the practice can be fully involved in quality work.
- Continue to develop practice based and anticipatory care plans maintaining patients as much as possible at home in line with their requests, reviewing an agreed dataset on high risk/cost/time patient and agreeing which further patients might benefit from the provision of an anticipatory care plan.
- Participate in a cluster quality peer review process whereby their clinical coding anticipatory care plans and prescribing will be assessed by the GP cluster who can offer support as appropriate.

8. It is proposed that each GP practice via their practice PQL will engage in a local cluster group with a nominated GP from that cluster having a leadership role as a cluster quality lead (CQL). In this way it is anticipated that each and every GP will have a role in continuous quality improvement within the practice with each practice quality lead engaging with the cluster quality lead. This aims to provide cluster quality leads with a mandate to improve quality in the wider health and social care system, including the use of secondary care, partly based on the input from each practice in the cluster.

REPORT

9. The arrangements for practice quality cluster working include that geographical clusters of GP practices be established within the HSCP. Currently within East Renfrewshire we have three GP localities, one in Levern Valley and two within the Eastwood area around which HSCP rehabilitation and enablement services (RES) are currently configured. It is anticipated that we may agree with local practices that we develop three areas of cluster working taking into account the need for these to be based largely on geography. A meeting is to take place with all GP practices on 26th May to discuss further how clusters might be developed within East Renfrewshire together with the role of both practice and cluster quality leads.

10. Work is being taken forward jointly by the GP sub-committee, HSCP Chief Officer's Group, and the NHSGGC Board to respond to the national changes to the GMS contract for 2016/17. This work includes how the role and expectations of both practice quality leads and cluster quality leads will be developed, and it is anticipated that this work will be further refined in advance of the 26th May meeting with local GPs.

11. It is anticipated that GP cluster groups will be agreed and practice quality leads identified by July 2016 and that cluster group development group priorities be agreed with cluster quality leads being appointed by October 2016.

FINANCE AND EFFICIENCY

12. The new contractual arrangements include that two hours of GP time per month are included within the practice's global sum for the time that it is anticipated that practice quality leads will need to spend locally reflecting on agreed data sets and

agreeing a response at practice level. It was also announced recently that four hours per month in 2016/17 would be afforded to practices in order that they could engage in discussions with the cluster quality lead and their peer practices regarding the development of local quality data sets and indicators. Funding for the cluster quality lead role and also any work asked of practice quality leads beyond that which is specified by the GP contract will require funding from outwith the GMS funding envelope, this to be agreed locally.

13. If three clusters are developed and cluster quality leads appointed the annual CQL cost will be around £15,240. It is anticipated that in 2016/17 the HSCP might benefit from some monies from the Scottish Government's primary care transformation fund to support such cluster working arrangements.

CONSULTATION & PARTNERSHIP WORKING

14. A meeting is being arranged for 26th May with local practices to further develop the HSCP's consideration of how we progress cluster development within East Renfrewshire.

IMPLICATIONS OF THE PROPOSALS

15. Staffing: a number of GP cluster quality leads, dependant on the number of clusters as agreed, require to be identified and appointed. There are no implications in respect of property; legal; IT; equalities; or sustainability arising from this report.

CONCLUSIONS

16. The dismantling of the Quality and Outcomes Framework which has been a part of the GMS contract since 2014 is a fundamental change to how the contribution general practice can make to patient outcomes as expressed within the GMS contract. At its heart this means moving away from the bureaucratic "top down" approach of QOF and relying more fully on the professionalism of GPs and maximising the benefits from promoting this professionalism in a structured collaborative context.

17. The development of GP clusters is a "peer-led, value-driven" approach which will begin the development of a framework for quality and leadership within the new GMS contract which it is anticipated will be in place from April 2017.

RECOMMENDATIONS

18. IJB members are invited to note the content of this report and to agree to receive further updates in due course.

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BACKGROUND PAPERS

19. GMS Contract 2016/17;
Richard Foggo letter to NHS Board Chief Executives 7th Jan 2016;
GP Contract 2016/17 GP Sub-Committee/HSCP Chief Officer's Group/NHSGGC letter to GPs 1st March 2016.

KEY WORDS

GMS contract; quality; contract; clusters