Derby & Derbyshire LMC

Dear Colleagues,

I am writing to highlight 2 important resources, which we feel may help you address your growing workload challenges.

Firstly, Derby and Derbyshire LMC have created a simple traffic light system see below for assessing 'extra work' to identify whether or not it is compatible with the GP Forward View. Our vision is that this simple document will allow you to decide whether or not new work is ***appropriate, and adequately resourced***. We hope it will give you a clear framework on which to base decisions, so you can act in the best interests of the practice and its patients.

Secondly, I am sure you are now all aware of the excellent BMA Quality First site, which gives practices tools to manage inappropriate workload shift into general practice.

In April 2016, in line with the GP Forward View, the new standard contract for secondary care trusts came in to force. This contract requires trusts to stop unnecessary bureaucratic workload shift onto GP practices. A letter reiterating these new requirements was sent to all CCGs and Chief Executives of NHS Trusts to remind them of their responsibilities.

In light of this contractual change, the Quality First site has been updated to include letter templates from practices to CCGs regarding new standard contract breaches. We would urge you to embed these letters into your computer systems. Please use these letters on each occasion there has been a breach, so that the hospital and CCG can fulfill their obligations and take necessary action.

You may also find it helpful to pass the following list on you your secretarial staff, so that they might be able to deal with some issues directly. The requirements are:

- Stopping hospitals adopting blanket policies under which patients who do not attend an outpatient clinic appointment are automatically discharged back to their GP for re-referral (this wastes an estimated 15 million GP appointments per year).

- Enabling hospital onward referral to and treatment by another professional within the same provider for a related condition, without the need to refer back to the GP. Re-referral for GP approval is only required for onward referral of non-urgent, unrelated conditions.

- A requirement for hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner; for example, telephoning the patient. Therefore, GPs should not be inappropriately used to relay to patients results of tests generated by hospital clinicians.

- Timely clinic letters to GP practices, no later than 14 days after the appointment, and with the intention of electronic transmission of clinic letters within 24 hours in the future.

- A requirement to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours.

- Providers to supply patients with medication following discharge from inpatient or day case care for the period established in local practice or protocols.

Many Thanks,

Susie Bayley

Derby & Derbyshire LMC

A traffic light system for assessing work changes in general practice and whether or not they are compatible with the General Practice Forward View

How general practice and your LMC can hold commissioners of health care to account

Context

General practice finds itself in a perilous state with morale rock bottom; GPs are leaving the profession and inadequate numbers joining. Although predicted for some years, NHS England now recognises this because of campaigning by LMCs, GPC and RCGP but also because of the obvious realities that the GP manpower problems are causing across England. The response is the General Practice forward View (GPFV) and that has been endorsed by the RCGP (Maureen Baker – campaign news May 2016) and also supported by the GPC. I think both organisations welcome the change in rhetoric, the promised resources that will flow to general practice and the cessation of dumping of un-resourced work onto general practice. There is however somewhat of a credibility gap between the GP on the coalface and the organisations that are welcoming this change in culture. Therefore, it is imperative that we hold NHS England to account. The resources promised need to flow and the culture change preventing the dumping of work on general practice needs to be felt. A major vehicle for delivering on the GP forward view we are told will be the new STP structure where the city council and public health have considerable influence. Thus we need to hold not only NHS England to account but any organisation that is influential in directing changes that positively affect the GP practice workforce practice – all such changes should be compatible with the spirit of the GPFV.

Proposal and strategy

This proposal and strategy looks at the culture change that the GPFV promises to promote and in particular addresses the question of work being 'dumped' on general practice, individual GPs being asked to do things that they feel is outside of their remit or contract for which they do not have the resources. The very things really which contribute greatly to anger frustration and demoralisation on a day-to-day basis for the average GP and its workforce. The GPFV of course promises support in other areas – occupational health for GPs, mental health services for GPs, support for staff and new roles and such. These also must be held to account but perhaps in different ways.

So how can we hold the processes to account?

At the end of six months it's not going to be satisfactory to just say that we were keeping an eye on things: Not only will that fail to give reassurance to the average GP and its management, not only will it not be quantifiable but in practical terms it won't make the difference that the GP profession needs.

It is clear that GPs and their management need to have teeth. GP practices and LMCs need to be identifying innovations and changes in practice that do not fulfil the spirit of the GPFV. Hopefully, together we can point this out and change things or if not at least identify them when the tally is reckoned and the GP profession and its management can decide whether or not the GPFV has made any difference.

We can do this by using a simple tool which we could all recognise and use when assessing requests to take on 'extra work', to change the way we work and to judge large-scale proposed or indeed imposed innovations or transformational practices would be very useful particularly if it started to be applied widely. The tool would give individual GP practices the opportunity to assess all of those everyday annoying and irritating requests from individuals or organisations for GP practices to do more. It would allow some strength and support for GP practices and mitigate against the daily annoyances that often accompanies the inappropriate dumping of work

onto general practice and it would also send very clear messages to commissioners as to what the wider GP practice felt about large-scale changes. A simple traffic light tool is proposed below as such a vehicle.

A simple traffic light system – red, amber and green tool

The proposal is that any GP or GP practice can apply the following criteria to make a judgement as to whether or not the proposal fulfils or indeed undermines the promises of the GPFV.

There would be three possible assessments for the change:

Green – the **proposal is fully adequately resourced and also introduces additional funding to general practice.** Here, the spirit of the GPFV is fully met – additional resources are accompanying a change in work practice and hopefully contributing towards a working environment that supports resilience and job and working environment satisfaction. That additional funding is considered essential to support general practice in delivering high quality core services and creating a context conducive to further transformational activity.

Amber – the **proposal is cost neutral.** Here the resources needed to fund the change in practice are present but it is not introducing any other resources to general practice. In effect, this change has done nothing to address years of underfunding, the current level of pain is not changed (neutral) the only differences is that the GP practice is somewhat busier (and of course manpower/workforce issues may be prohibitive). However, of course it's better than the previous common experience of work being just dumped with no or inadequate additional resources. Although resource neutral, there could be detrimental effects on the quality of patient care as capacity is stretched.

Red – the **proposal is under resourced**. Here the resources needed to fund the change are not present or are inadequate. This potential change in work practice would actually provide additional financial and personal and organisations stress to a GP practice. Far from there being any alleviation of the current scenario things are getting worse with further detrimental degradation of the quality of patient care which may result in a less than good rating with the Care Quality Commission (CQC) regulatory compliance.

What things are specifically excluded from assessment within this proposal and strategy?

1. **The assessment is not about an overall economic benefit to the NHS or society as a whole. This should be specifically excluded from consideration – arguments along the lines of**

"… If you could manage this type of patient in general practice it would save X hundreds of thousands of pounds to the budget of the CCG and we need to get the books to balance…"
This is a perverse and damaging reason not to appropriately fund the proposed service changes in general practice – it ignores the question of opportunity cost and above all ignores the perilous state of general practice which the GPFV is meant to address. If such savings could be achieved then some realistic and adequate funding should to meet the green assessment and flow into general practice to allow the change to occur.

2. **No account should be given to proposed resources in the future.**

"… If you could take on this work and demonstrate that you saved money at some point in the future we could change our contracts with the secondary care providers such that the resources came to you."
General practice is at a breaking point and the GPFV needs to give tangible help now. If a proposed change is worthwhile it should be pump primed.

3. **No account is made of clinical outcomes or the health needs of particular groups.**

Specifically, the traffic light system here is looking at resources and what general practice can do. Therefore in this process one assumes that clinical outcomes and such would already have been assessed and that if a change was being proposed there was good evidence that that was clinically worthwhile. However, that's not a matter for this tool – this tool just looks at whether or not GP practices have the capacity to deliver and whether or not the GPFV is the vehicle for providing the resources necessary to change the current workforce, workload, morale and stress issues.
Indeed, if a service is worthwhile providing for clinical or ethical reasons it is scandalous to pretend to meet that need whilst dumping it in an underfunded fashion on general practice and contributing to a set up that is likely to collapse.

What can be usefully undertaken by making these assessments?

1. By having clear ground rules it will focus the GP profession and its management on the **question of adequate resources**. Here a knowledge about the different models of general practice would be useful, the different challenges and weaknesses of small and large units, the question of costs in providing a service (direct and indirect overheads) and such.

2. These practical questions about resources can be introduced at an early stage in any form of transformational change proposed and hopefully that will allow realistic considerations by parties who in the past have simply expected general practice to soak things up.

3. If the system is adopted as a **common standard across the Midlands** it will provide teeth – any organisation proposing to shift work onto general practice may well reconsider if it comes with a red assessment.

4. It will allow individual GP practices to make more informed choices concerning what work they are or are not able to take on**. It is very important to note that an assessment of green amber or red is not an instruction to a GP practice to accept a piece of work or decline it - that will be an individual choice for each GP practice depending on their contract and their individual settings.** For example there may be a piece of work with a green assessment that an individual practice has to refuse because they literally don't have the manpower and or workforce or indeed premises/room capacity. Equally, GP practices in large provider groups, with special interests or advantageous funding arrangements may well decide to take on work that appears in the red sector – **it is an individual choice.**

5. There will be a way to demonstrate whether the GPFV is having a real effect on the ground.

6. There may also be individual geographical or organisational variations that emerge. For example, it may become clear that a particular CCG, a particular city or a particular secondary care unit is dumping on general practice in greater amounts than other areas and organisations. That can be identified and challenged if LMCs and GP practices work together across wider regions.

A worked example

The CCGs in a city in combination with secondary care mental health services decide that patients with long-term chronic psychotic illness requiring long-term prophylactic medication should be discharged to general practice. The arguments are quite persuasive – it would be much cheaper and would free up mental health services for other challenges. Also it would help to destigmatise mental illness and allow patients to receive their care like anybody else in the primary care setting.

Under the new proposal the GPs would take over all responsibility for prescribing and looking after these patients. The mental health team suggest that this would simply require the patient to have a review every six months by the practice and some form of annual physical screening checks including blood tests and an ECG. If things deteriorated significantly then they could be referred back into the mental health services.

Green - What would green look like?

The commissioners provide an attached CPN. Depending on the size of the GP practice an individual CPN could be shared between a number of GP practices. That CPN would carry out the mental health assessment every six months and would be available should the client have some minor issues (social, housing, minor mood fluctuations et cetera) that don't require re-referral into secondary mental health care services. The CPN would be offering these services from the practice and therefore there would be appropriate funding of practice expenses to cover usage of a room and direct and indirect overheads through the increased footprint within the GP practice, usage of reception staff to book appointments, call and recall systems, the CPN using phones and faxes et cetera. There would also be funding for the GP practice nurse or phlebotomist to carry out the relevant blood tests and physical examination to support the prescribing and there would be funding for an annual appointment with the GP and patient (since the GP is responsible for the prescribing) and this would be an opportunity to ensure everything is being pulled together. There would also be funding to support educational needs for the GP and its workforce, if necessary and also an infrequent multidisciplinary meeting between the GP, CPN and practice nurse to discuss any clients of concern and cement team dynamics.

This would seem like an excellent service for the patient and an opportunity for the GP practice to provide near patient care of a high quality. Many GP practices might well take advantage of this, individual GPs could specialise and develop an expertise and there would be time to encourage and develop that sort of team dynamic and multidisciplinary working that would attract doctors into general practice. This would seem to epitomise the changes that the GPFV are trying to achieve.

Amber - What would amber look like?

This is a sort of halfway house – there has been an attempt to make a realistic assessment of the resources needed but they're not comprehensively dealt with. For example the resources are costed at two 10 minute appointments with the GP per year and a 5 minute appointment with the phlebotomist. Inevitably, these patients are likely to have some minor wobbles and additional consultations throughout the year, at best things are approaching neutrality but this has done nothing to increase resources or improve the working environment for the GP team – things are just busier and there remains the risk that patient care could suffer.

Red - What would red look like?

The CCG or other organisation offers a sum of money that makes no attempt to look at the real costs for providing a quality service, is clearly inadequate or indeed just wants this thrown into a "basket of care" that includes other "problematic" issues – diagnosis and ongoing management of dementia patients, prescribing of second-line immunosuppressant drugs for non-rheumatological conditions and such. The GP practice would be providing the service at a loss. Moreover, overall quality patient care would inevitably suffer.

Summary

Derby and Derbyshire LMC believes that this traffic light model will help individual practices analyse changes in work, will provide some welcome support for individuals or GP practices who feel they are been asked to take on additional adequately resourced work when they do not feel able to do so, may actually change the culture of commissioners if widely adopted and above all should provide that credibility check that is essential when trying to ascertain whether or not the GPFV has really delivered the change that we have been promised as a GP profession.
Individual GPs, their management, their GP practices and indeed the wider groupings within which they work clearly will make their own mind up as to whether or not this tool might help.

Discussed in the LMC meeting:
Outcome of the discussion:
Date:
Next steps:
Responsible person/s:

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