
# Borders LMC

## Proposed GP Clusters June 2016

# GP CLUSTERS - Borders LMC Overview and Proposals June 2016

## Introduction.

There has been much discussion (and confusion) round the formation of **GP clusters groups**, and how they differ from **localities**. The following outlines some of the guidance and debate to date and is intended to inform and guide practices about cluster formation, rather than be definitive or instructive. It may be useful simply to have all the guidance in one place (see appendices), and we do anticipate further national guidance in due course. The rapid changes in legislation round Integrated Joint Boards has not been easy to follow, so there is an element of 'beginner's guide' here too, with apologies to the many of you who are already very familiar with this. A reminder that:

☐ Each IJB receives funding from its Council and the Health Board (and also 'directs' them in return)

☐ Each IJB has one Health and Social Care Partnership, led by its 'Chief Officer'

☐ The Borders Integrated Joint Board (IJB) is has **five localities** (historical geographic area divisions).

## LOCALITIES – what they are and what they are not!

- Localities have a defined role in determining service provision – and are to contribute to the IJBs Strategic Commissioning Plans (and conversely, if an IJB's strategic commissioning plan will have a significant impact on service provision, then that IJB should involve and consult with that locality).
- In Borders there are the 5 localities based around the historic geographical splits - Tweeddale, Teviot, Cheviot, Berwickshire and Central
- Localities are very multi-disciplinary and the intention is that there is input from secondary care, SW, housing and so on.
- Membership of the Locality is determined by the IJB s – but in conjunction with the LMC
- ***Previously*** QOF determined that a liaison GP from each practice was to link with HSCP staff (QS001).
- ***Instead, now***, the localities legislation outlines that localities are meant to have practice input – but that can take different formats: representation can be by other practice members, or be from the cluster rather than individual practices (further details, Appendix 1).

## CLUSTER Groups – what they are and what they are not!

- Cluster Groups are ***NOT*** IJB or HSCP bodies, but rather GP organisations defined by the Transitional Quality Arrangements (TQA) for our 2016-17 contract.
- Every practice – as a minimum - has to identify a Practice Quality Lead (PQL) who has to spend at least 2 hours per month *in the practice* undertaking quality work. This requires the PQL to review the extracted national data set and any other material agreed locally, and as a minimum should involve (per month) one hour reflection and one hour of discussion and agreement with the practice.
- ***ANY work outwith this needs to be funded*** separately; as does the full Cluster Quality Lead (CQL) post.

- Cluster Group membership and workings have to be established this year, but groups do not necessarily have to meet before April 2017. However, there are many advantages to an earlier start and this is encouraged in the TQA. The Cluster Group timetable (see below) encourages PQLs to liaise early to decide on their CQL.
- Cluster groups are where are new quality activity will take place, including review of national data sets (these have still to be agreed) and local data determined by the groups themselves. It is therefore crucial – *because of this core quality work including mutual examination, feedback and review, which may feel sensitive to some* – that GP clusters feel comfortable and right to practices. Reflecting this, the national guidance is for groupings of 6-8 practices.
- However it is very much up to GPs to choose what they would prefer – many are opting for larger groups than this, and there are advantages to that too, particularly in terms of feeding back about local services. Cluster Groups may wish to involve others - but Dr Alan McDevitt (Chair, Scottish GP Committee and GP negotiating lead) - has made it clear that GPs should retain control of this work: this is *our* forum. There will inevitably be a process of negotiation with existing localities and other local fora, where relationships are already established: we do not want to lose those, where they are embedded and working well.
- Some GPs may want to largely limit their activities to the narrower requirements round quality review (noting that that work requires cycles of quality improvement), not least as GPs and practices are so pushed for time.
- Others may want to also focus on the next level of engagement – contributing to service reform. It is hoped that cluster groups will feed back both to IJBs and the GP Sub-Committee about local services and how deficiencies could be improved. The TQA does make it clear that the Cluster Quality Lead should liaise with, and influence, the wider health and social care partnership setting.
- This will be the foundation of our future work with wider systems: it is in all our interests, from the start, to get Cluster Group working right.

**There are 4 stages to cluster development:**
**Stage 1 – first quarter of 2016/17 (ie to 30 June 2016)**
Practices choose their Practice Quality Lead and agree with the locality liaison person and LMC representatives as to which practices are in which cluster. Start considering issues outlined in Annexe A of Richard Foggo's letter:

1. Registers, coding and lifestyle advice
2. Flu immunisations
3. Quality, safety and prescribing
    a. Access – review last 2 PAAR reports; the practice must have access to a cluster access report
    b. Complex patients and anticipatory care plans – ACP's for those considered to benefit most, review existing ones as appropriate; assessment of quality using a template (latter not yet agreed)
    c. Quality prescribing – continue to work with prescribing advisors, support pharmacists etc. to decide appropriate actions for the practice.

**Stage 2 – second quarter (to 30.9.16)**
PQLs and the partnership/board and LMC, identify, appoint and empower a Cluster Quality lead: that post is funded separately. Continue to consider issues in Annex A (see box above) and agree other cluster alternatives for quality review.

**Stage 3 – third quarter (to 31.12.16)**
The PQLs and CQLs begin to build relationships locally via clusters, between and across practices, primary and secondary care, health and social care and between the public and third/voluntary sectors. Continue to work on Annex A issues.

**Stage 4 – fourth quarter (to 31.3.17)**
Practices and the local system take action on the priorities agreed at the end of quarter 3 and agree evaluation/outcome measures that will demonstrate quality improvement.

**Borders LMC**
There has been some discussion of Cluster Groups at the LMC – where it was felt that there were multiple possible approaches to this, but that the key thing was for GPs to be happy with their group composition. The LMC is very willing to have discussions with practices where this is not the case – but also recognises that for reasons of practicalities, it is likely that accommodation with others will have to be made to some extent.
Dr McDevitt has made it clear that we are not aiming for 'super-practices' as we see in some parts of England, but instead Clusters should support our current partnership models. Dismantling QOF means that we are now professionally responsible for our quality, so we need to demonstrate that we are doing that adequately, if we want to avoid the risk of unnecessarily prescriptive approaches in the future.

Our main areas of discussion have been:
**Group size.** The TQA document outlines a group of 6-8, and practices may wish to argue for this if they feel that proposed groups are too big. However others will feel that we are now used to sharing data, that larger groups can be more powerful in terms of wider change, but also that each Cluster Group will need a CQL working at least a day a month initially. We are very short of GPs with the time to take on this leadership role: more groups means more GPs involved in this activity, but also less HSCP funding for other work.

**Cluster Group Activity**. A balance will need to be struck between very essential core business (quality work) and wider reform of services (development work) and each Group will be able to decide its own priorities and approaches. Early word from the Inverclyde Pilot schemes is that involving other professionals was very helpful – allowing new models of care to develop more quickly and appropriately, and that group membership need not be static.

**That in the longer term**, this represents a key route for change in secondary care and other services too, giving chances for Scottish innovation, with new ways of working including co-operative approaches.

After taking local opinion, asking for feedback and discussing this matter at various meetings we have arrived at a proposal we would like to suggest. We are very aware that this will not "tick every box" for everyone but there needs to be a balance between arranging practices into groups that are practical, workable and literally in the same area. This last point may seem obvious but we need the Borders is a large area and PQL's beed to physically be able to get to the other practices to meet.

The proposal.

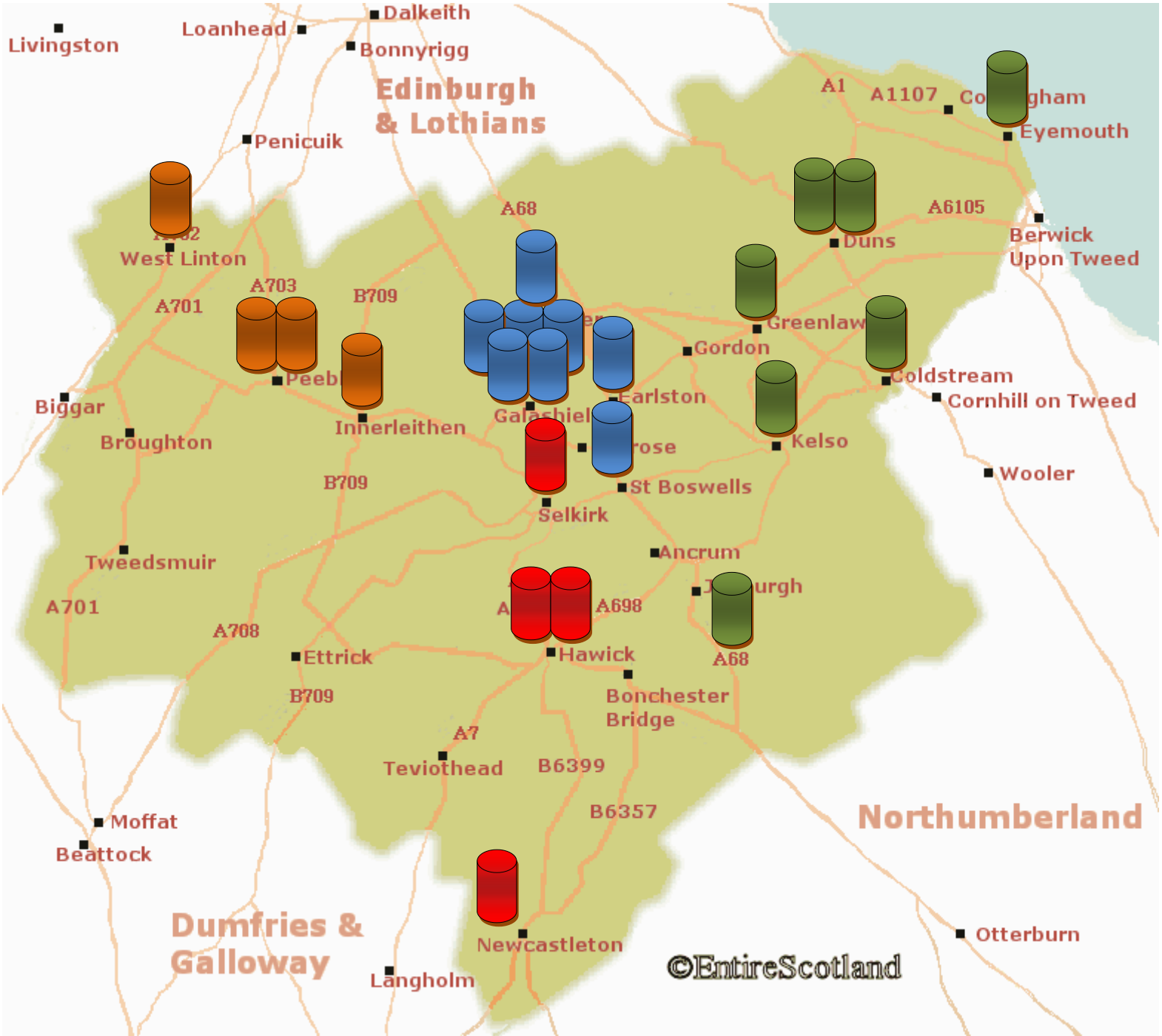
We are suggesting there should be FOUR Borders Gp Clusters, with the following practices aligned to each practice.

- **West Cluster** **Total = 17814**
  - West Linton (Population 2375)
  - Neidpath (5715)
  - Tweed (5348)
  - Innerleithen (4376)

- **South Cluster** **Total = 26568**
  - Selkirk (7443)
  - Teviot (10973)
  - O'Connell St (6609)
  - Newcastleton (1543)

- **Central Cluster** **Total = 31778**
  - Roxburgh St (3247)
  - Waverley (4956)
  - Glenfield (2039)
  - Ellwyn (3109)
  - Braeside (4619)
  - Eildon (6555)
  - Earlston (3009)
  - Stow/Lauder (4244)

- **Eastern Cluster** **Total = 38775**
  - Eyemouth (6227)
  - Duns (2921)
  - Merse (6387)
  - Coldstream (3707)
  - Greenlaw (1294)
  - Kelso (11744)
  - Jedburgh (6495)




## Proposed Clusters

East

(pop 38775)

Central

(pop 31778)

West

(pop 17814)

South

(pop 26568)