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PRIMARY CARE (CLUSTERS)

Inquiry by the National Assembly for Wales Health, Social Care and Sport Committee

Response by BMA Cymru Wales

7 February 2017

INTRODUCTION

1. BMA Cymru Wales is pleased to provide a response to the Health, Social Care and Sport Committee's inquiry on Primary care, and specifically primary care clusters.

2. The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 160,000, which continues to grow every year. BMA Cymru Wales represents over 7,500 members in Wales from every branch of the medical profession.

OVERVIEW

3. In our 2014 strategy document 'General Practice – A Prescription for a Healthy Future', we acknowledged the Welsh Government's long standing support of the provision of primary care services in Wales; demonstrated by the commitments of successive ministers to deliver a primary care led NHS and its "long-held ambition to make primary care the engine room of the Welsh NHS"[1]. Other previous commitments have included the development of extended and integrated primary care teams and the siting of these teams within purpose built resource centres. In that document we noted our concern that, despite these intentions, we have not seen change on the ground at the pace or scale of what is required to deal with the unprecedented pressures and challenges currently faced by GPs across Wales.

4. As attested in our October 2016 publication, 'An Urgent Prescription for General Practice in Wales', these challenges largely remain. Whilst there has been a greater recognition of these challenges, and some effort to alleviate them (such as the recent suspension of QoF) we strongly believe that greater and sustained momentum is needed. Our 2016 document explicitly sets out the need for urgent action, and offers solutions, in the areas of: recruitment; suitable workforce models; workload; finance; sustainability; and pertinently to this inquiry, clusters. We welcome the fact that the Committee's inquiry will be focusing on these key areas.

[1] Welsh Government, 2015: 'Our plan for a primary care service for Wales up to March 2018'

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5. Across the medical profession it is clear that there is widespread support for the concept of cluster working as a means to determine and meet the health needs of the local populace. Given the pressures on general practice it is widely acknowledged that new ways of working and new models of support are much needed. Clusters, if established and resourced effectively, could deliver this, although overall they are not currently at this stage. A survey conducted by BMA Cymru Wales in 2015, which is due to be repeated in the coming months, revealed very mixed reports across the country with some clusters flourishing but others struggling to develop.

6. Since 2013 - when Health Boards were set ambitious targets to establish local bodies with decision making and financial powers - it is clear that the pace of cluster development has not been uniform across the country and that the new money released by Welsh Government in April 2016 has not yet truly transformed services across Wales. Where there has been some transformative development, some of which is cited below, it is important that there is a renewed effort to embed that change; we do not know how sustainable the changes will be in the future without renewed effort.

7. Reports from Local Medical Committees (LMCs) paint a very mixed picture – many show that there remain barriers to cluster working in terms of spending allocated money; lack of clear direction; Health Boards rather than clusters setting the direction; and a need for clear leadership within clusters and a sharing/show casing of good practice and success.

8. Indeed, in 2016 the Welsh conference of Local Medical Committees passed the following motion:

   Conference demands that Health Boards urgently act to

   i. *Reduce bureaucracy and delay in releasing funding to clusters which currently compromises their ability to utilise earmarked funding and deliver services*
   ii. *Work with GPs to develop an effective process to properly evaluate the evolving platforms for delivering cluster working, such as federations.*
   iii. *Demands appropriate access to independent planning and financial experts to support development of clusters and inter-cluster working*
   iv. *Adhere to the "light touch" approach to cluster network funding as envisaged by the Welsh Government*
   v. *Suggests an independent survey of Welsh General Practitioners on their experience of network cluster groups.*

9. GPC Wales is fully committed to cluster networks. For the last two years we have worked with Welsh Government to embed cluster working in the GP contract - and especially in terms of cluster plans which should be closely aligned to HB integrated medium term plans, therefore (in theory) helping health boards to facilitate the transfer of resources towards primary care.

10. From the reports we have received from members and via LMCs it is apparent that clusters will only deliver if there is a fundamental change in attitude by Health Boards, who must devolve decision making and provide clusters with sufficient support and resources (personnel and financial). We believe that clusters should become true legal entities with clearer governance and financial frameworks, which will then enable those clusters that are flourishing to have the tools they need to develop further and sustain delivery, while allowing others to get fully off the ground.

RESPONSE

11. We will now seek to address the questions posed by the Committee; due to the commonality of the answers to certain questions, we have grouped together our stance on the key issues at hand.

Benefits of clusters

12. As previously stated, GPC Wales strongly supports the principles behind cluster working. General Practice is in a very challenging place presently, with ever increasing demand and workload pressures. Working collaboratively with other professionals across health, social and community care can work to both support the viability of individual practices and to develop and deliver effective and holistic services to local patient populations. The fostering of engagement and collaboration with public health, secondary care, key allied health and social care professionals is absolutely essential for the provision of holistic and relevant care; however currently this is variable.

13. Conversely, the impact of clusters failing to deliver or a failure to foster effective relationships can be very significant – the obvious impact is a lowering of workforce morale and a reluctance to engage further (change fatigue, effort and time with no results); the loss of link between GP clinicians and the communities they serve; destabilisation of primary care provision where new ways of working don't deliver; confusion for patients and communities; and of course a waste of precious resources (real or perceived).

14. Thus far the benefits of cluster working, in terms of transforming primary care for the benefit of the patient and GP across Wales, are not as tangible as we would expect at this stage of their existence, and productivity is hugely variable. Our 2015 survey highlighted as such. It revealed some examples of effectiveness and good practice, including:
    - *Developed a stop smoking shop, improved uptake of flu vaccination and smoking cessation services (ABHB)*
    - *One stop social services point of contact (BCUHB)*
    - *Uniform dementia screening within cluster*
    - *Established local dementia and local dermatology networks, and also enhanced obesity advisory training and service*

    Other respondents to the survey were not so positive. A significant number noted that while cluster working had improved local networking and enhanced peer support, palpable progress on service delivery was difficult to evidence. Some respondents cited the involvement of health board management as serving to dilute the effectiveness of local plans. Members also reported a general sense that clusters in practice needed to obtain health board approval before proceeding with plans; of subsequent difficulties in getting resources released; and of issues with regard to procuring staff or equipment thus hindering the release of resources needed to progress.

15. One of the long term aspirations of Welsh Government strategies such as *Setting the Direction* (2010) and later *Delivering Local Health Care* (2013) has been to develop 'locality working' structures responsive to the specific needs of the populace, informed by public health data and with the autonomy to act on this intelligence. While each cluster does maintain links with Public Health Wales and receives information on public health issues, the interface could be improved. As a result we remain to be convinced this aspiration has become reality, or that it is driving cluster working or priorities.

16. As has been widely reported, in recent years consultation rates and numbers have dramatically increased while the needs of many patients have become much more complex. The recent relaxation of QoF by Welsh Government until March 2017 is an acknowledgement of these pressures and will allow practices greater capacity to deal with them and focus on patient care. In our survey of clusters in 2015, 69.1% of respondents said that cluster work had adversely affected their clinical time. Engaging in cluster work thus has a consequence on direct clinical contact, and any engagement in such work must therefore have a demonstrable benefit to practices in addressing wider pressures.

Funding

17. We welcomed the extra £43m announced by Welsh Government for primary care, £10m of which was handed directly to the 64 primary care clusters. We wrote to all cluster leads in May 2016 urging them to think carefully about how this money could be used to most effectively to transform primary care. In that letter, we outlined a number of suggestions that cluster leads may wish to look at, this included: widening access to community pharmacists, musculoskeletal specialists and other specialists within practice; the establishment of a cluster-wide home visiting service consisting of a multi-disciplinary team; and new ways of triaging patients.

18. Unfortunately, we have become aware of significant delays in the release of these funds by Health Boards. As clusters do not exist as true legal entities many of the staffing solutions described previously require health boards to employ these staff, and the need to follow bureaucratic procurement processes means that monies have not been spent in many areas. Worryingly, we have also had reports of Health Boards using cluster under-spending to prop up services which should be resourced by other monies, outside of the cluster budget. We would expect Health Boards to demonstrate that all posts and services established through cluster funding are new and that cluster funding is only used for the purposes it was intended.

19. Clusters currently lack the facility to 'roll-over' funds into the next financial year and we would suggest that allowing the 'roll-over' of the monies would encourage longer term planning and alleviate some of the problems described in terms of processes. Currently the delays in accessing funds, coupled with the inability to roll-over funds, means that all too often very short term spending decisions are made which do not offer the best value for money. We would argue that, where a project has been approved but there has been unavoidable delay in procurement / recruitment, for instance, then provided that money has been ring-fenced against the appropriate project it should be carried over and made available at the earliest opportunity.

20. Clusters leads should work with all partners to consider how available funds can be best spent on delivering service transformation. We believe that direct access to budgets, with clear financial accountability structures, would ensure this could be done in a timely manner.

21. We strongly believe that there needs to be greater clarity on what cluster resources are being spent on. This forms part of a much wider need for the work and purpose of clusters to be more visible.

Sustainability and workforce

22. Our recent survey of members showed that 82.1% of respondents were worried about the sustainability of their practice. While the increased peer support available from cluster networks is hugely positive, it remains extremely worrying that 74.8% of respondents reported that the health of staff within their practice had been negatively impacted by workload pressures.

23. We believe that as a priority established clusters need to convene teams to consider both practice and cluster sustainability at a strategic level. As part of this there is a need to consider how clusters can work more closely with each other (including the use of "at scale" models) and evaluate whether there is a need to enhance (in some cases, build) relationships with consultant colleagues, social care and those from other professions (e.g. optometrists, pharmacists).

24. The exploration of alternative models, such as practice federations, is necessary to address sustainability challenges. The GPC UK document 'Collaborative GP networks', offers food for thought (rather than detailed guidance) for the establishment of new structures with varying levels of involvement and integration. There is a need for greater working at scale to share costs and resources (e.g. workforce and facilities), which clusters cannot enable due to their lack of status as legal entities. Federations of practices could exist within, or between, cluster networks and could potentially offer greater flexibility in terms of employment options both for GPs and the wider primary care team such as pharmacists, physiotherapists, and advanced paramedics.

Cluster Leadership & maturity

25. As noted previously, there is significant variation in terms of the maturity of clusters and their stage of development. Where clusters have succeeded, it is largely where individuals have shown proactive leadership to develop and operate a successful model. This under-resourced time commitment is additional to other practice and clinical responsibilities and most cluster leads, we understand, are not remunerated for this role despite the level of responsibility and commitment it entails.

26. LMC reports suggest that smaller practices (especially single-handed practices) and those with unfilled vacancies often find it difficult to engage with cluster development. They also report that practice and cluster plans are overly prescriptive, and that there is a need to allow for strategic development and thinking time at both practice and cluster level to enable onward development of this model. We reiterate the call made in our *'Urgent Prescription for general practice in Wales'* for appropriate training and support to be provided to enable clusters to deliver as anticipated. A good working relationship between all parties is essential to this.

27. LMCs have revealed frustration around the timeliness of feedback and with regard to seeing actual movement on projects, leading to a general perception that cluster work will not lead to a return in value. Supporting the provision of timely and relevant information and feedback, as well as a greater degree of wider communication on cluster work (and spend), is essential for ensuring professional engagement

28. A recurrent theme from our members is that there is insufficient space for clusters to act autonomously, and at arms-length from Health Boards. This, coupled with the aforementioned delays in releasing finance, severally hampers the effectiveness of clusters to act upon their own plans and deliver according to local needs. The knock-on effect these experiences is that they deter individuals from prioritising engagement with their cluster – at a time of enormous pressure on healthcare and healthcare professionals there needs to be some visible value and purpose to cluster working.

CONCLUSION

29. GPC Wales has long supported the concept of cluster working; to us it presents an opportunity to alleviating the endemic pressures of workload, recruitment and sustainability for General Practice in tandem with the delivery of relevant, timely and more holistic care through the greater use of multidisciplinary teams and partnerships. In this way, clusters can help all partners work seamlessly to meet the physical and mental health and social care needs of local

populations – and if truly working to potential, can foster a more social model of care with wider stakeholders and agencies in society (for instance, housing, education, transport, leisure environment, carers, and the third and independent sectors). Although being uniformly a long way from occupying this space presently, clusters should clearly regard this as the end goal.

30. The views gathered from our membership across Wales, as outlined throughout this paper, suggests that clusters are not currently fulfilling their potential or developing at an even pace and that some barriers to effective working remain. However it is evident that there has been improvement over the last twelve months with the availability of the new resources.

31. GPC Wales welcomes the commitment made by Welsh Government by investing in, and driving, moves to cluster working. GPC Wales remains committed to playing a full and active role in ensuring that clusters develop effectively and that they deliver sustained change – indeed, some are now showing signs of making a difference to patients and services in their areas. It is now vital that all clusters are enabled to deliver this, and that the delivery is sustainable.

32. In our view, the actions now needed include:

    - The effective use of cluster monies must be a priority. Cluster leads must consider how available funding can be best spent on making the working day less pressured, with the goal of transforming service availability and care to patients.
    - The necessary governance frameworks must be put in place to enable clusters to act autonomously and at arm's length from Local Health Boards.
    - Appropriate training and ongoing support should be put in place across Wales to enable clusters to deliver effectively.
    - Enable clusters to have direct access to budgets as a means of avoiding delays to the delivery of new services and to support innovation and empowerment.
    - Allow the carry-over of resources if attached to an approved project but not yet delivered through no fault of the cluster.
    - Provide an effective means of showcasing and sharing best practice across Wales to further stimulate the development of the clusters.
    - Look at a means for developing and supporting additional "at scale" working that supports a sustainable future for general practice in Wales.
    - Evaluate cluster initiatives; we consider this essential in order to ensure return on investment, learn lessons and share to best practice.