



Dear Colleague,

The new NHS landscape as it affects us all in London

Your provider role as a GP contract holder, your practice payments, and contract performance

CCGs, Quality and Transformation

And so, with hope for the future in mind, and with best wishes for a happy and peaceful New Year, on behalf of all of my staff at Londonwide LMCs, I wish you a very happy holiday season, and a very merry Christmas.

Please feel free to send your comments and thoughts to Mword@lmc.org.uk.

My best wishes,

Dr Michelle Drage FRCGP
CEO Londonwide LMCs

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1. The new NHS landscape as it affects us all in London

The NHS Commissioning Board (NHSCB) is the Authority running the NHS in England. It functions as a Head Office with four regional sub-offices, one of which is the NHSCB in London. The London Regional Office of the NHSCB (let's call it LRO for short) is intended to be a delivery agent for National NHSCB objectives. Unlike all previous NHS changes the LRO will have no formal strategic role for London's NHS. Its role will be to hold CCGs to account for their decisions, improvement in quality of services (including GP services) and spending in accordance with national comparators ie outcomes and performance standards set nationally. These national comparators are unlikely to take into account London's diversity or complexity - a bit like the managerial equivalent of having one national funding formula with no London weighting. So as ever, we will have our work cut out in ensuring London's general practices get the recognition we deserve given the nature of our populations.

2. Your provider role as a GP contract holder, your practice payments, and contract performance.

As I said in July and previously, there will be no Clusters and there will be no PCTs. This is how the government has met its commitment to ‘reduce bureaucracy’. Instead, the LRO will be directly responsible for your GP contract (including payments, performers List management and performance management of your contract, for GP Appraisal, and for overseeing GP Revalidation. It will operate across 3 geographical sectors – North West, North Central & East, and South, but it will be operated by one team based at the LRO office in Victoria covering 3 sectors, using a single national model. In other words, there is little official scope for local interpretation and variation. Your core contract payments will be ‘lifted and shifted’ into these arrangements. My team at Londonwide LMCs has been preparing the ground for working with this new system from April, and, famous last words, has been advised by the LRO that we can have confidence that it will work.

3. CCGs, Quality and Transformation

CCGs will be picking up a number of the old statutory functions of PCTs but as a result of our constant lobbying, they will NOT be picking up the management or performance of your GP contracts. These will be managed by the LRO team as above. CCGs will however be responsible for improving the quality of primary care and primary medical services which is not the same as performance managing your GP contracts. Quality in general practice depends in particular on having sufficient resource to do the job properly to our professional best, at practice level, across practices and from diagnostic and community services. In particular it should include using LESs to promote good quality in general practice, and freeing practices from unnecessary bureaucracy to release clinical time. Improvement should be peer-led, peer-supported, and educational not punitive.

From 2014 CCGs will have the ability to commission all but your GP contracted services from Any Qualified Providers if they so choose, but will have to account for their decisions to both the LRO and the Local Authority (LA). We at Londonwide LMCs are of course working to minimise that future risk. Local Authorities, through their newly acquired Public Health departments, will also be able to commission LESs along with the CCG, and we at Londonwide LMCs along with your LMC will be working to get the most out of LES and other local opportunities for practices. This will be crucially important as the economic situation tightens further and your core GMS and PMS contracts continue to get squeezed by HM Treasury.

Much activity will take place in the system this coming year and much will be said about Transformation, and 'transformation of General Practice and Primary Care' in particular. Indeed the LRO has established an entire directorate to manage Transformation, and has published a report commissioned from the Kings Fund to underpin its approach. It says some useful things and it says some risky things. We recently circulated our Londonwide LMCs response to the Kings Fund report, which I would urge you to read, or at least the foreword of our response, written by yours truly. The NCB LRO programme of Transformation is closely linked to the agenda to rationalise hospitals, transfer more care into the community, and increase efficiency and productivity. There are two ways of doing this. Up until now all the thinking under the old NHS London regime has been secondary care driven. CCGs now provide us with the opportunity to turn that on its head and make it primary care and general practice driven. Remember we provide 90% of NHS activity with 10% of the resource, and a 10% shift in funding could deliver a near doubling of resource for primary care and general practice. And what of practice staff training and development? Well, the same logic applies to workforce, education and training monies now held by the LETBs (Local Education and Training Boards) which is why we have been at pains to ensure they have GP provider and commissioner representation.

So there is the challenge for us as providers of general practice, and to CCGs as erstwhile commissioners and drivers of the Transformation. Jointly we have a one-off opportunity to set this Transformation agenda in favour of general practice and primary care.

CCGs will be responsible for the commissioning of non-Primary Medical NHS services. That means hospital and community services (let's call them HCHS) within an ever more tightly controlled 'financial envelope' - what you and I call a budget. They can do this in a number of ways. For example they could do what PCTs have done and focus on how they can reduce demand on HCHS by increasing pressure on your referrals and prescribing and force you to deliver more with less. Or they could be transformational and commission to reduce unnecessary demand on ourselves to enable us to reduce demand on HCHS. Examples of how we can achieve this are:

faster patient access to more comprehensive and more convenient but good quality diagnostics and results
better patient centred communications at outpatients, and intelligent discharge management from hospitals, particularly on Fridays
resourcing LESs to fund service improvements and by not diverting scarce NHS resources to AQPs who are not GP contract holders.

This list is not exhaustive but you get my drift. Integrated care is being presented to us as a new concept, but we invented it. Those who can recall the days of community nurses, health visitors and social workers attending extended primary care team meetings will understand. Those new to practice should see this as the transformational way to go. It's not just about long-term conditions, it's about hope for the future of General Practice and in particular a future for those who have decided to pursue a GP career for the next twenty years.