Primary Care Strategy Meeting 5th November 2015

Hatherley Manor

Where are we Now? – *Andy Seymour*

Simon Stevens – Window of opportunity over the next few months to develop new models of care (with funding available?). Potential for imposition thereafter (threat)
(Opportunity to move on a locality by (sub)locality basis according to need and enthusiasm. Threat of imposition IMO is fairly hollow as there is no alternative. They couldn't force GPs to do anything in the past, even when there were enough GPs and hence an element of competition was possible, but the future will be very different. Co-operation will be the only game in town big enough to provide anything like universal primary care coverage without destroying secondary care in the blink of an eye.)

One 'strategy' that I have heard the DoH may use would be to announce the 'voluntary new contract' which is overtly only practical for larger (30,000+ patient) practices and then systematically run down GMS on a year by year basis to make it unsustainable.

This was posted anonymously on DNUK on 7/11/15:
"I have had a bit of an inside track into plans for the new voluntary GP contract. Here are my brief thoughts:
1) The old contract is being run down. Although the new additional contract is voluntary you will need to do it to stay meaningfully afloat.
*2) Make sure you get on well with your GP neighbours. In particular, **small bolshy practices have to be careful**. If nobody wants to play with you it could be a big problem. Some GPs will absolutely screw over others. The cold hard world of business is coming.*
3) 7 day working is happening but you personally don't have to do it yourself.
*4) **The chef du service model** is the only logical outcome. One GP to 3500 patients or even higher. Legions of ANP's, PA's, pharmacists and god knows what else.*
5) I think that it is absolutely the right time to become a partner (if it is in a big popular practice). Don't say you weren't warned. When this drawbridge goes up (and it will) you will want to be involved.
It will certainly be interesting."

With reference to Gloucester locality meeting in October – concern that a few practices think they're OK as they are, but may not have considered impact of unforeseen events on stability.
(Helen and Andy were a little taken aback at the recent Gloucester Locality 'dry-run' for this event by the apparent 'we're OK attitude from one or two of the PMs on their table (Longlevens and Churchdown?). Hence Andy's comments in his opening address).

We all need to think about the future, even those approaching retirement. Those of us with 10-20+ years of career left need to lead the process of change.
(Helen is keen to support a proposal from me and San Sumathipala that we should target the '40s club' of mid-career GP principals in Gloucester City and try to convene a meeting to start dialogs about change and working at scale. She has told a few people about the idea already as 'word has got back to me' from others.)

Actually did recognise that GPs do love the job at heart, but we shouldn't lose sight of that.

Challenges:

- Reduced proportion of NHS budget spent on primary care (We need to have accurate and agreed figures from the GPC and stick to them to avoid confusion i.e. including or excluding prescribing etc).
- Increased chronic disease (We have QoF data)
- Increased consultation rates (What actual evidence do we have of this?)
- Estates and premises.
- IT and plurality of Patient record systems (I'm starting to sense renewed interest in a 'recommended' provider? for Gloucestershire).
- Agenda to move care out of hospital
- Political agenda with '7 day working'
- Workforce, recruitment and retention

Workforce (national)

- 28% of full timers wanting to go part-time
- 34% of GPs considering retiring in the next 5 years
- 47% would recommend GP as a Career
- 75% of sessional GPs would consider a partnership at some point in the near future

Workforce (local) (Data from LMC Trainee Survey 2014 – I think we need to repeat it as a matter of urgency)

- 18 practices with vacancies (42% of responses)
- 2 practices in Gloucestershire and a list dispersal have handed back their contracts
- A further 5-6 practices currently under threat

Consensus of Initial Discussion on Tables:

- Maintaining Clinical Autonomy (Would a hospital trust dominated PACS set up really protect that? Seems much more achievable via MCP model to me)
- Maintaining the relationship between GPs and Patients (same comment as above)

(The multispecialty community provider model [MCP] is much better suited to GP ownership and leadership in my opinion. The best interests of GPs are indeed best looked after by having a plurality of options available for employment; salaried, sessional, portfolio and partner etc but as an LMC we should be strong in pushing for the ability of GPs to own and run their own business, and I include large multi-million pound organisations in that).

Emerging Models – *Dr Phil Yates*

GP in Bristol since 1983. Recently retired from practice at the age of 60. Previously PCG and PEC Chair for South Gloucestershire. Engaged with with Fundholding in the 1990s, which heralded some of the things we are now aspiring to once again in terms of getting services embedded in Primary Care.
(Lots of positive feedback about Phil's 'potted history' of Fundholding and what's happened since.)

Publications:

- GPC – "Responsive, safe and sustainable. Towards a new general practice" (Sept 2015)
- RCGP – "A blueprint for building the new deal for general practice in England" (May 2015)
- NHS England – "Five year forward view" (Oct 2014)
- Kings Fund – "Commissioning and Funding General Practice" (Feb 2014)
- Nuffield Trust – "Transforming general practice: what are the levers for change? (June 2014)
- Primary Care Workforce Commission – "The future of primary care. Creating teams for tomorrow" (July 2015)

5 Year Forward View:

- Technological (linked Record systems and fewer face to face appts)
- Higher focus on health maintenance and prevents
- More care in the community
- Rebalancing of investment between hospital and community sectors.
- Reducing silos and the way that specialists work.

MCP (Multispecialty Community Provider):

- NHS England definitely sees the benefit of list-based primary care given it's potential for prevention.
- Groups of practices with minimum size of 30,000 (Kings Fund talking of units up to 100,000)
- Potential to leverage GP specialist interests
- Potential to integrate community trust activity like DNs.
- Integrate social prescribing and demedicalisation.
- leads towards ACO (Accountable Care Organisations)

PACS (Primary and Acute Care Systems)

- Single organisation providing GP, community and hospital services.
- Potential for delegated, total capitated based funding
- Like Kaiser Permanente, when resources get direct upstream into prevention.
- Also leads towards ACO (Accountable Care Organisations)

Devolution

- E.G Devo-Manc with pooled H&SC budget

Round Table Feedback

Stroud

- Services Delivered as Locally as possibly inc Comm Hospitals and MIUs an
- Employing Community Staff inc ICTs
- Demand Management
- Skill Sharing (at least federation)
- Unifying IT system
- ***PAC model allows access to the money saved*** (interesting point)
- Kill QoF?

FoD

- Work towards getting the practices working together first. (Early stages obviously)

Gloucester

- Making GP attractive
- Reducing the Daily Grind
- Services – Back Office, District/Community, GOAM, Mental Health, Dermatology, Rheum, MSK
- Model – accommodating all comers.
- Need to know more about future of liability and reducing and rules about coalescing.
- Control over planning e.g. Nursing Homes.
- ?Unified Nursing Home Service (Not something we've previously discussed)
- Greater work/life balance
- Continuity retained but leading a mixed team.
- GPs leading ICTs and MSK and working with consultants in community
- Mix modality of access to practice and service by patients.

- Health Promotion
- *MCP definitely preferred to PAC model.*
- Single practice entity unlikely but mergers ARE likely to reduce total numbers
- Need to know more about funding visibility, role of medical schools and RISK
- Need funded development time.
- Make some changes to premises in short term
- Identify a LEADER and support that post.

Cheltenham+Tewkesbury

- Shared Vision – quality care and attractive place to work for all staff
- DNs services
- Back Office
- CCG Locum Pool to allow 'space' for reorganisation
- Plurality where possible as 'one size doesn't fit all'
- Constrained by small practices in owned (listed) buildings!
- Economies of scale
- Practices need to work together better.
- ***Some practices may need to work with the acute trust (PAC Model)*** (I am concerned by this)

(The turn out pro-rata was lower for Cheltenham than other localities. I have recently discussed the future with Robin Hollands, and he was present at the event. He has described to me his feeling that tie-ups with the acute trust will be what happens. He's uncharacteristically down-beat when talking about it, possibly because he's struggling to get other practices to work together?)

South Cotswolds

- Taking over Community Hospital
- Umbrella/Federation
- Autonomy
- ***MCP model favoured***
- GP leadership training
- Continuity
- Take over the totality of Community and Community Hospital functions
- MCP model preferred over the PAC model
- **Will to change!**

North Cotswolds

- Preserve family medicine and continuity for complexity
- Federation type back-office Buying group
- Paramedic home visiting
- Diagnostics in house
- Additional management monies to support local leadership.
- Local 'summit' early in 2016 with identified
- ***Consider federation or Super Partnership***
- Federation/cooperation with entities outside of locality

Timescales – I had a chat with one of the CCG lay board members (Colin Greaves). In the past he's been regarded as not necessarily as 'pro-GP' as he might be. However, on Thursday he was very enthusiastic after the event. He was talking about proposals being ready for end of February, with view to getting submitted by EoY (April).

Bob Hodges
(Gloucestershire LMC Exec)