BMA

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Local Medical Committee

GPDF
General Practitioners Defence Fund

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On a slightly snowy evening at the end of November, the BMA held an event, in partnership with Leeds LMC, to discuss collaborative, at-scale working in general practice.

As we all know, general practice is under increasing pressure. In response, some practices have adopted at-scale models, and in many parts of the country this is being encouraged by commissioners or STPs. The BMA is not promoting any particular model. However, as clearly recognised at the 2017 LMC conference, in areas where change is happening, GPs must be at the forefront, controlling the future of general practice for the benefit of patients and the profession.

We therefore wanted to work with Leeds LMC to provide GPs with an opportunity to come together to share and learn about some of the different models being pursued. However, we were also keen to hear about GPs' experiences and generate discussion on the future of general practice locally.

Dr Nicola Hambridge (Vice Chair, Leeds LMC) introduced the event, and welcomed Dr Simon Poole, a GP from Cambridgeshire and GPC policy lead for commissioning and new models of care, to give the opening presentation. Simon gave some background on the current state of the NHS, before describing different at-scale models (federations, super-partnerships, MCPs (multi-speciality community partnerships)/ACOs (accountable care organisations)/ACSs (accountable care systems), primary care home) with examples of how these models are being developed across the country. He concluded by raising some of the potential opportunities and threats of these models, inviting attendees to comment and share experiences.

Before breaking out into a group discussion, Dr Chris Mills, a GP from Leeds and clinical lead in primary care transformation for Leeds West CCG, spoke about the local context in Leeds. Chris highlighted that every practice is involved in at least one collaborative arrangement, which have developed a variety of initiatives, such as a frailty scheme. There is also a general feeling that practices are communicating and cooperating with each on a much more regular basis, which is aiding collaboration at all levels.

LMCs in the locality have developed good links with local federations and other provider groupings, which has helped strengthen the voice of general practice politically. The CCG has also funded locality clinical leads for one day a week. Discussions are underway across the city on extending collaborative working, potentially through a primary home type model and an ACS, and GP-led urgent treatment centres. The LMC and federations are both involved in these discussions.

Sustainability

The view in the room was that many smaller practices are looking to get bigger because, generally, they do not think they are sustainable in the long term. However, larger practices still saw benefits from working collaboratively with other practices in order to get involved in larger initiatives or service development.

In addition to financial challenges, some smaller practices reported struggles with recruitment and premises risks. It was felt that an at-scale model would help share liability for premises, and this in turn might make potential partnership more attractive. More generally it was felt that practices needed to do more to attract young GPs and that being larger enables practices to offer different opportunities. Many GPs felt they needed to ensure the sustainability of their own practice first, whether through a super-partnership or other model, before considering larger ACO-type models, which extend beyond primary care.

Dr Andy Parsons, GP and lead for the Modality super-partnership in the Airedale, Wharfedale and Craven, shared his experiences of trying to merge and subsequently joining a pre-existing super-partnership. Having spent a large sum on money on external project management to facilitate a local merger, the attempt ultimately failed. However, Andy's practice and five others subsequently met with Modality, a super-partnership originating in Birmingham, but now operating in a number of areas across the country.

It was only a matter of months from their first meeting with Modality before the practices became part of the super-partnership, a process made easier because of Modality's central resources and previous experience. The practices are supported by a central unit in Birmingham, which manages finance, payroll, IT, governance, HR and communications. However, as an area they have control over many aspects of the arrangement, including their profit centre and workforce model. The practices currently retain their existing GMS/PMS/APMS contracts, although in the long term they aim to merge their contracts and patient list.

The practices have chosen to retain their existing partnership structure, although they plan to reach parity of profit within the next two years. They have created three levels of salaried doctors, which they believe creates a career pathway primarily concerned with developing and retaining GPs, rather than necessarily leading to partnership. While the practices still face recruitment challenges and high levels of patient demand, they reported feeling more empowered, with interest from potential candidates and new ideas to try and tackle workload.

Population health and care

There was some discussion of the role of general practice. On the one hand, the role is defined by GMS contract requirements. However, general practice is generally recognised to have a wider role in population health and care. It was agreed that GPs should be at the centre of delivering community care, as local leaders and expert generalists who can provide continuity of care, without needing to be the first point of contact for all patients.

Attendees were clear that practices need to work together in order to encourage additional resources – currently only 8% of NHS spend goes to general practice – to be put into the community and general practice. However, clearly defining and developing the wider role of general practice is challenging, particularly in the face of increasing workload and the payment by results system.

Leadership

There was some discussion of the challenges of effective leadership within general practice, which is necessary if the profession is to sell itself, secure resources and be at the forefront of changes to the health and care system. At-scale arrangements offer alternative, but potentially competing voices to existing LMC structures. In addition to Leeds, where the LMC and federations are working together and have joint GP provider forum meetings, one attendee shared a positive example from Bradford, where it is felt the federation and LMC work hard to keep each other involved and informed when in discussions with the CCG and beyond. However, this has proved a challenge in other areas, particularly in the context of STP developments. Andy from Modality reflected that being part of a larger super-partnership has improved their GPs' ability to engage with the local CCG and trust.

We are keen to continue receiving feedback on your experiences of working collaboratively, and any support or guidance you might find helpful. Please contact info.policy@bma.org.uk and visit bma.org.uk/gpworkload for more information on collaborative working.