Our profession, our future

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Underfunding of healthcare in the UK

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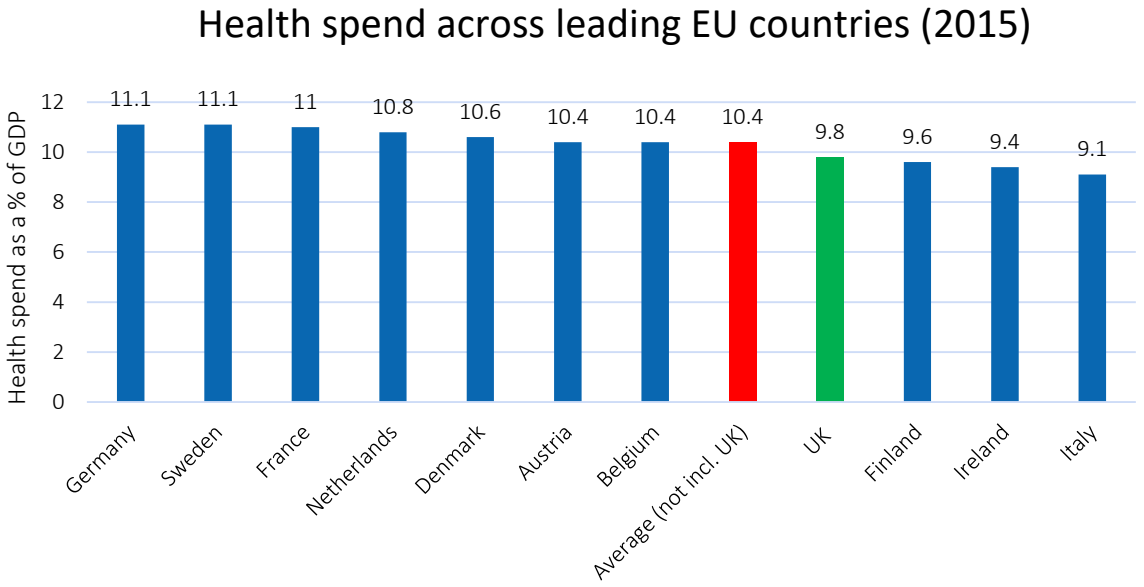
"Some may say aren't we spending at the European average?

Well, only if you think that bundling austerity shrunken Greek and Portuguese health spending should help shape the benchmark for Britain. If instead you think modern Britain should look more like Germany or France or Sweden then **we're underfunding our health services by £20-30 billion a year**"

Simon Stevens, November 2017



Funding gap in general practice

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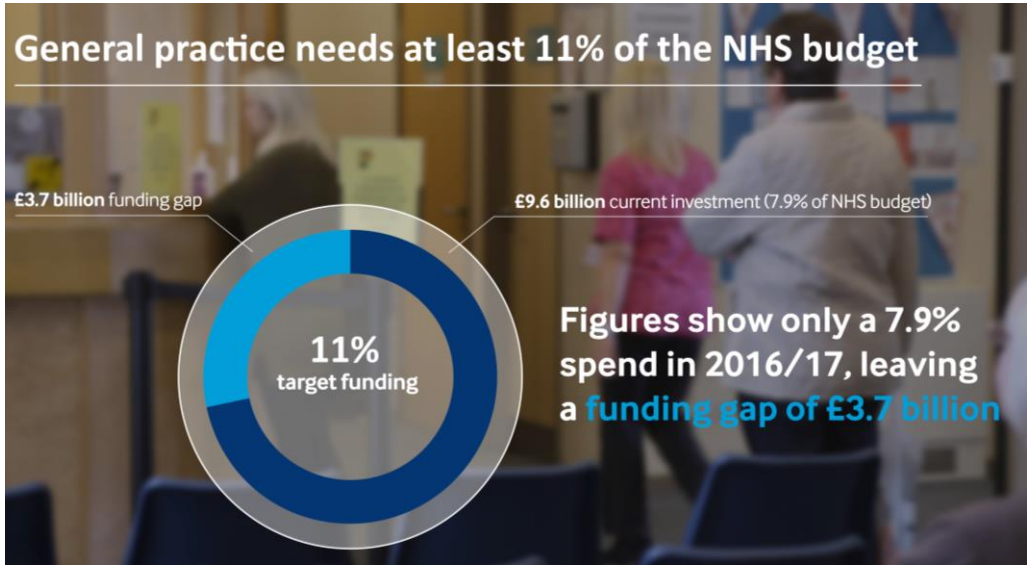
- The proportion of the NHS budget going to general practice, excluding the reimbursement of drugs, has fallen from 9.6% in 2005/06 to 7.9% in 2016/17.

- The GPFV is not on track to deliver the full potential of its funding commitments.



- General practice investment is increasing at a slower rate compared to last year.

A service under pressure

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Workforce shortages

- 31% of practices were unable to fill GP vacancies in the last year
- Number of FTE GPs fell by 1252 (-3.7%) between March 2016 and March 2017)
- 1 in 3 GPs intend to retire in next 5 years

Increasing workload

- Consultations grew by more than 15% between 2010/11 and 2014/15 (Kings Fund 2016)
- More than eight out of 10 GPs believe their current workload is excessive or unmanageable
- 10% fewer practices open in 2017 than in 2013 (although figure includes mergers)
- 75% of sessionals are put off partnerships due to excessive workload

Despite the efficiencies of UK GP, we often hear…

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"Too much variability"

"Cannot guarantee universal coverage"

"Too many contracts to manage"

" Too small and vulnerable"

"Unable to hear a united voice of primary care"

"Unable to contribute to population based systems change"

"Unable to provide a corporate approach to the business of healthcare"

"At scale working is the only game in town"

"General practice protects itself from the wider system"

Is working collaboratively the answer?

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- An option for some (but not all) practices
- Different shapes and sizes – no one size fits all
- Different threats and opportunities depending on the model; common themes include:
    - Sustainability and resilience
    - Support for individual practices
    - Workforce support and development
    - Option to expand and integrate primary care services
- Does not make up for lack of resources; BMA will continue to call for general practice to be properly resourced. But offers opportunities regardless of the funding situation.
- BMA not promoting any particular model, but can offer support to interested practices

Federations

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- A group of practices working together, in a collective legal or organisational entity.
- Different organisational forms that a federation can take – for example:
  - a loose arrangement eg based on a MoU
  - a legal entity, such as a company limited by shares or guarantee, a community interest company or a limited liability partnership
- Different ownership, governance and management structures, to suit local aims and requirements.
- In all models individual practices remain independent organisations, but profit, contractual and pension arrangements may vary.
- This includes whether it is practices or the federation that hold GMS/PMS/APMCs contracts.

Taurus Federation – Herefordshire

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- Idea originated with LMC and anxiety about a ‘Virgin type private provider threat’.
- Philosophy is to support a varied GP landscape (inner City to very rural) and retain GMS.
- Latterly, with STP/ACO developments, hope to resist the political pressure of vertical integration in the system by making sure that a viable horizontal approach exists.
- Formed an LLC (a company limited by shares), all 24 practices in Herefordshire joined
- All practice are on EMIS Web, robust data sharing across the Federation
- 7 day extended services, based around 3 hubs. 53 local GPs work in the hubs. Open from 8-8 at the weekends and from 6pm and 8.30pm on weekdays.
- Other developments include: a 'Zero Tolerance Integrated patient service,' where violent/aggressive patients are seen in the Hubs; joint sexual health service; joint workforce strategy and development with clinical pharmacists, Physicians Associate ambassador and apprentices.

Super-partnerships

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- A number of individual practices forming a single businesses unit, covering multiple sites.
- For larger scale super-partnerships likely to involve a partnership agreement and a new structure, eg a company limited by shares, which can hold contracts and limit individual partner liability.
- The degree of autonomy retained by practices will vary according to the specific model (including profit sharing arrangements, retention of P/AP/GMS contracts, GPs' employment status, structure of the practice).
- Single, central structure can enable further economies of scale, centralisation and sharing.
- Large super-partnerships have greater capacity to bid for and deliver extended services, and potentially offer different workforce models and employment options.
- The following examples are the two of the biggest super-partnerships, to illustrate two different approaches. But super-partnerships can be done on a much smaller scale.

Our Health Partnership, Midlands and Shropshire

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- 38 practices, population covering 370,0000, originating in Birmingham
- Profit Centre model, common in industry, rare in medicine.
- Single partnership, with original contracts held centrally in trust.
- Small central corporate team paid for by levy of £2 per patient (tax deductible)
- Considerable local autonomy (both managerially and financially) within each practice
- Partner and salaried roles; practices retain individual practice managers
- Greater local and also national influence
- Central functions and economies of scale (back office, central accounting, buyers scheme discounts, reduced indemnity costs, joint training, single CQC inspection)
- Shared support for practices (eg peer support, quality team, shared pool of salaried doctors, GP bank, leadership development)

Modality, Birmingham (and beyond)

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- National super-partnership, originating in Birmingham, but now operating in Walsall, Sandwell, Airedale, Wharfedale, Calderdale, Hull & Wokingham. Population over 200,000
- Integrated front of house and back office approach:
    - Centralised management team and support unit, HR, finance, IT, performance target teams, call centres, templates and processes
    - In Birmingham, all patients triaged first by phone – circa 30% then have a face-to-face appointment
- Local areas determine their workforce model. In Birmingham there are three levels of partnership and three levels of salaried doctors, creating different career pathways
- Specialised clinics, services and staff; increased access, with a universal offer and standards

ACOs and MCPs

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- MCPs (multispecialty community provider) – new care model in the Five Year Forward View, described as a new type of integrated provider.
- Could potentially combine the planning, budgets and delivery of primary and community care services.
- Responsible for providing care to the whole population, based on registered lists of participating practices, covering at least 30,000 – 50,000 people.
- NHS England now focusing more on ACOs (accountable care organisations) and ACSs (accountable care systems) – similar to MCPs but would likely include secondary care.
- Three different models – two will involve a new contract held by the ACO/MCP organisation and a new payment model.
- Extent of general practice integration will be determined by local GPs – all new contractual options are **voluntary**.

Key concerns

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- Consultation on regulatory changes (Autumn 2017). Full consultation expected in 2018
- Key concerns:
    - Risk of further private sector encroachment
    - Fully integrated model incompatible with GP independent contractor status and any ‘right to return’ unlikely to work in reality
    - Lack of clarity regarding how staff will be employed – locally negotiated employment contracts, no guarantee model T&Cs will be met
    - Any change requires time and investment; need to address current funding crisis
    - Need full engagement with doctors and patients, and proper, wider consultation on proposals

Virtually integrated

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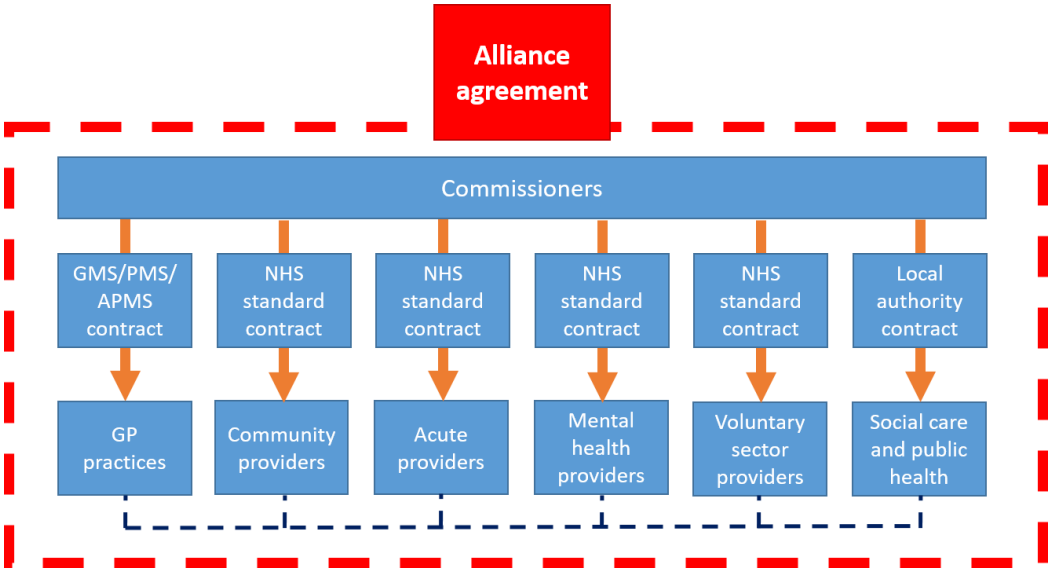
All contracts and accountabilities remain in place, but overlaid with an alliance agreement outlining how commissioners and providers will work together to create better integration of services.

Enables providers to work in collaboration under existing contracts.

Essentially an ACS (accountable care system) rather than an ACO (accountable care organisation).



Partially integrated

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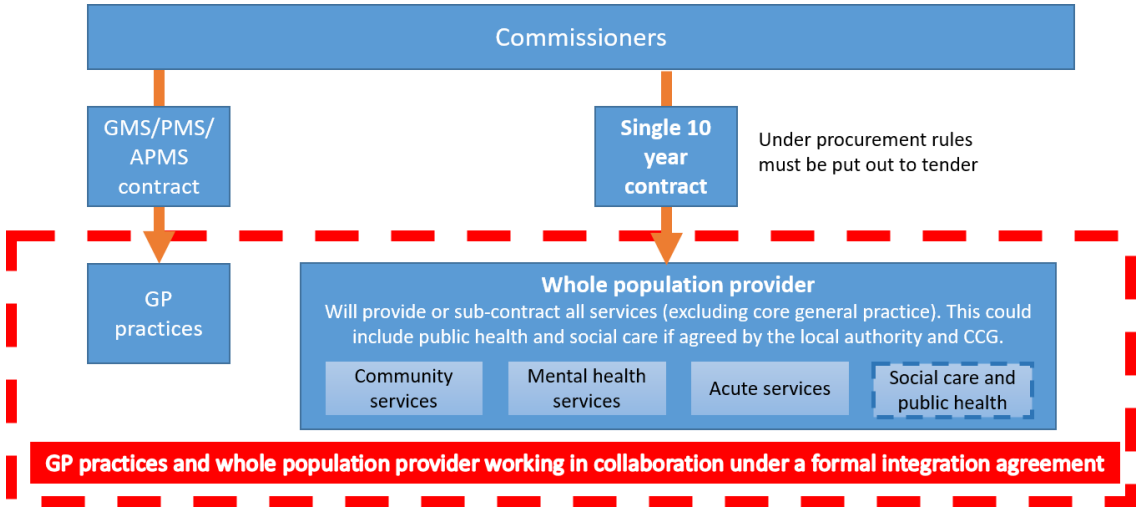
Single contract held between the commissioners and providers (except core GP services).

Under procurement rules this must be put out to tender.

GP contracts remain in place.

Formal integration agreement between the whole population provider and GP practices to work together.



Fully integrated

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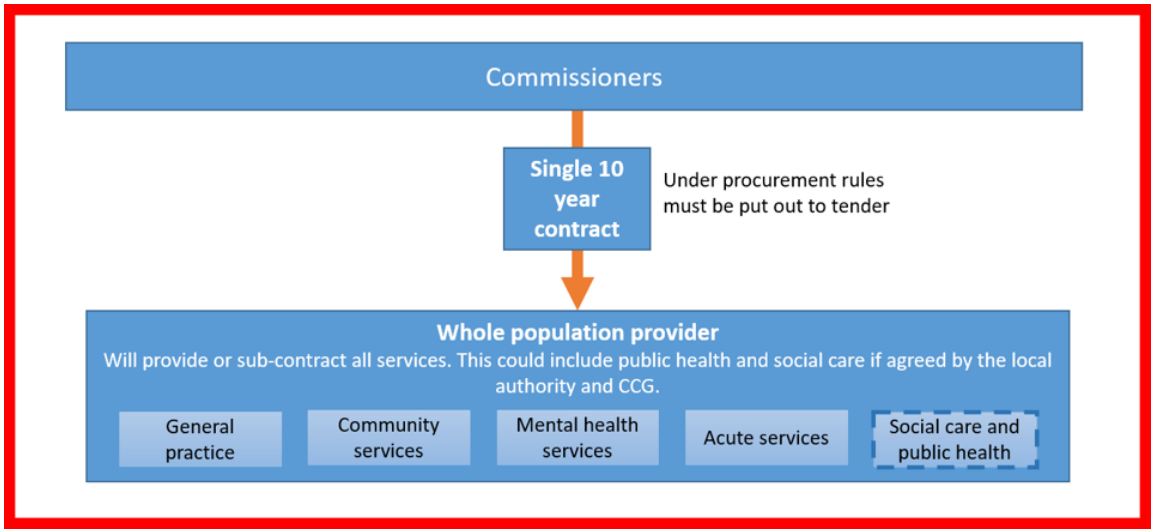
A single contract between the whole population provider and the commissioners.

Under procurement rules this must be put out to tender.

Provides or sub-contracts all services.



Hampshire – Better Local Care

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- All changes to date have been achieved under existing contractual arrangements, but with vanguard funding.
- Looking to pursue one of the voluntary contractual options as a catalyst for further change and improvements, and reduced barriers.
- Spent time building relationships between the local trust, GP practices and commissioners; all are partners in the MCP.
- Developments have included care navigators, fully funded clinical pharmacists in practices, data sharing and shared IT systems, eConsult, same-day primary care access hubs.
- The trust have also stepped in (with GPs' support) to take over struggling practices in Gosport. Doctors are now employed by the trust on a permanent contract, either at partner or salaried level.

Primary Care Home

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- This is a model developed by the NAPC (National Association of Primary Care), with 15 original ‘Rapid Test Sites’ and a wider community of practice involving over 100 sites.
- Combined focus on the personalisation of care with improvements in population health, using an integrated multi-disciplinary workforce.
- Groupings of practices that cover 30,000-50,000 people
- Highlighted by NHS England as one possible way of developing the ‘building blocks’ of an MCP.
- PCHs are expected to deliver whole population health, host community-based professionals, deliver extended access, deliver holistic, personalised care, be part of a local network delivering urgent and long-term care and reduce unwarranted variation and demand.

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Questions, comments and discussion