General Practice - Where are we now and where are we going?

The current General Practice landscape is evolving partly out of necessity and partly in response to contractual and organisational changes. This has led to a feeling of uncertainty in many practices and a great deal of confusion among GPs. The aim of this document is to try and shed light on some the current developments, bust a few myths and try and provide some options for our future. It will contain a mixture of facts and opinion. These will be clearly signposted so as to avoid confusion.

Glossary

LMC

Fact
Local Medical Committee - Local Medical Committees evolved from Local Panel Committees which were established in 1911 by the National Insurance Act. They came fully into fruition in 1913 as LMCs well before the NHS was established in 1948. LMCs have therefore seen the following come and go: - Local Insurance Committees, NHS Executive Council, Family Practitioner Committees, Family Health Service Authorities (FHSAs), Health Authorities, PCGs and PCTs. Our role is enshrined in the NHS Act of 2013 and we will almost certainly outlast CCGs. LMCs are representative organisations.

Opinion
The strength of LMCs lies in their role as GP representatives. They are involved in negotiation and representation locally, regionally and nationally. As the GP workforce evolves to include many non-partners, part time and salaried GPs, the LMC is the only body looking after these groups.

CCGs

Fact
Clinical Commissioning Groups - Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. 211 groups were established in 2013 although since that time there have been some amalgamations. CCGs are clinically led groups that include all of the GP practices in their geographical area. The aim of this was to give GPs and other clinicians the power to influence commissioning decisions for their patients. Our CCG is Kernow CCG (https://www.kernowccg.nhs.uk). CCGs are membership organisations i.e. practices.

Opinion
It is likely that the future of CCGs is time limited if Accountable Care Organisations (ACOs) evolve and the purchaser provider split is abolished as seems likely (https://www.hsj.co.uk/stps-will-end-the-purchaser-provider-split-says-stevens/7016042.article). However, as the existence of CCGs was defined in the Health and Social Care Act of 2012 then we may need yet another act to see them off. Will they commission all GP services? Not for the near future in Cornwall at any rate but they will continue to commission and evolve Local Enhanced Services (LES). These services have been the subject of much speculation and there have been numerous attempts to bring them up to date, rationalise and modify them. The LMC is in continuous dialogue with KCCG about its plans. It is likely that as differing funding streams evolve that there will be a move to incorporate the LES contracts into a different offering.
Kernow Health CIC

Fact
Kernow Health CIC (Community Interest Company) is a practice membership provider organisation. All Cornish practices are members of Kernow Health CIC. Its board has GP and managerial members from across Cornwall.

Opinion
Here to stay and will be an important part of the transforming GP landscape in Cornwall. Holds funding for Sustainability and Transformation in addition to holding and bidding for ongoing contracts e.g. Community Services, Out of Hours, School Based Immunisation Programme. The CIC can do as much or as little as we want and has achieved a huge amount in its short existence. In general, this can include employing staff and being prime contract holder on behalf of a practice or group of practices. In future, it may be desirable for KHCIC to take a greater role in, for example, a super-practice contract.

STP
Fact
Sustainability and transformation plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities in different parts of England have come together to develop ‘place-based plans’ for the future of health and care services in their area. Draft plans were produced by June 2016 and ‘final’ plans were submitted in October 2016. You can find out more about STPs here: - https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

Opinion
Our ‘place’ is Cornwall and our plan can be found here: - https://www.cornwall.gov.uk/media/22983857/taking-control-shaping-our-future.pdf

STPs are a vehicle for transformational change and a stepping stone to collaborative working between Health and Social Care. Whether our document delivers all it promises or survives in its current form, the work will go on between the agencies involved. This is both logical and necessary. We believe that the LMC should be a part of this process. You will notice that our name is absent on page 4 of the Shaping our Future document largely because we did not have a formal role in the production of the document itself. we were and are in continuing discussions with the CCG about the STP process but also now have a place on the STP Transformation Board. Additionally, we now attend the STP Programme Board as representative of the community of General Practice.

ACS
Fact
Accountable Care System - a process where all NHS organisations in an area – commissioners and providers – sign up to a formal agreement to work as a system. In essence it is the team of organisations evolving and having responsibility for delivering the STP. In our area that team includes Cornwall County Council, Royal Cornwall Hospital, Treliske (RCHT), Cornwall Foundation Trust (CFT) and KCCCG in addition to the other providers listed on page 4 of the ‘Shaping our future’ plan. As yet the only formal agreement that exists is between CFT and RCHT to work closer together to deliver the STP.

Opinion
ACSs will probably evolve into ACOs
ACO

Fact
Accountable Care Organisation - An ACO brings together a number of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget. In some senses, they are the natural evolution of an ACS. They are a practical expression of ‘place-based’ working under which NHS organisations and their partners agree to collaborate in order to meet the needs of the population they serve.

More information can be found here: - https://www.kingsfund.org.uk/topics/integrated-care/accountable-care-organisations-explained

Opinion
ACOs sound powerful, scary and American. It is difficult to see where General Practice can fit into a healthcare landscape with these behemoths. However, it is also clear that ACOs need a sound and vibrant GP landscape to deliver their aspirations. If GP is going to operate in the environment of ACOs it needs strong representation (i.e. functioning and dynamic LMOs)

Place Based Working

Fact
A concept that was promoted by the Kings Fund in response to increasing demands in our healthcare system. More information here: - https://www.kingsfund.org.uk/publications/place-based-systems-care

For us place based care could be looked upon as the whole of Cornwall, our localities or indeed the community hubs espoused in our STP.

Opinion
This concept has evolved into the work of STPs

Primary Care Home

Fact
The PCH is a form of multispecialty community provider (MCP) model. More information can be found here: - http://www.napc.co.uk/primary-care-home.

St Austell Healthcare have been one of the 15 rapid test sites nationally for the primary care home and as such have received a limited amount of funding. Other GP Practices have recently been accepted as Primary Care Home sites but do not receive any additional funding

The Practices that have been accepted have come together in the following clusters for the purpose: - Penwith, North Cornwall, East Cornwall, South Kerrier, Lostwithiel, St Blazey and Fowey, Truro, Penryn and Perranporth.

Opinion
You would be forgiven if, having read the CCG document entitled ‘A Plan for General Practice in Cornwall and the Isles of Scilly’ (http://www.kernowlmc.co.uk/wp-content/uploads/2017/03/NHS-Kernow-Draft-Primary-Care-Plan-submission.pdf), that you thought PCH was the preferred method of delivering the aspirations of the STP or Place Based Care. It may well be but as yet as the secondary sites have no funding it is unlikely that this model will progress as envisaged by PCH or the CCG ‘plan’ without significant investment.

Multispeciality Community Provider (MCP)

Fact
This is taken from the King’s Fund document (https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view/multi-speciality-community-providers)

Under this new care model outlined in the NHS five year forward view, GPs practices come together in networks or federations and collaborate with other health and social care professionals to provide more integrated services outside of hospitals. This might include GPs working with some specialists currently working in acute hospitals, as well as nurses, community health services and social workers. Over time, GPs and their partners might take on responsibility for the health budget
for their whole population. MCP vanguard sites have been established to evolve this mode of care and to develop a contractual framework for General Practice (https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/)

Opinion
MCPs could sit under the umbrella of an ACS or ACO and could be aligned with the Place Based concept of care e.g. geographical localities, locality hubs etc. A new MCP contract is being evolved (https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmrk.pdf) but at present we can see no advantage in groups of practices opting for this contract which has significant risks for GPs and their practices. The BMA has issued guidance (https://www.bma.org.uk/advice/employment/contracts/gp-partner-contracts/mcp-contract-framework). It would be essential for any locality thinking of entering into an MCP style contract to discuss their intentions with the LMC who will be able to provide advice and guidance.

PACS (Primary and Acute Care Systems)

Fact
First outlined in the NHS five year forward view, a single entity or group of providers take responsibility for delivering the range of primary, community, mental health and hospital services for their local population, to improve co-ordination of services and move care out of hospital where appropriate. A PACS, like an MCP, is a population-based care model based on the GP registered list (https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf). The essential difference between an MCP and a PACS is that the latter includes hospital services. There are a number of PACS models being developed throughout the country

Opinion
Although not immediately attractive a PACS model could potentially solve recruitment and delivery problems in dense urban areas with high demand and where evolution of GP service has proved difficult. PACS models have been used in some areas e.g. Somerset to resolve the ‘last man standing’ issues of some practices.

General Practice at Scale

Fact

It could include Federations of Practices, GP networks, Super-Partnerships or the Primary Care Home model. What is clear is that no one can define this for Cornwall but ourselves. However, if we think of working ‘clinically at scale’ then some of the solutions to this conundrum may become a bit clearer

Opinion
One of the risks of talking about GP at scale is that of putting form before function. Function must precede the elaboration of any at scale model as in some cases form may not be needed in the sense that most people describe. Large scale General Practice in all of its forms may in fact be very suitable in urban areas but may not be at all suitable in rural, geographically widespread areas such as Cornwall. We would prefer to talk about delivering General Practice Clinically at Scale which would fit with the aspirations of our STP and the CCG Plan for General Practice. So, what are the implications of delivering at scale and is it the death knell of small practices? It is to these specifics that the rest of this document will be dedicated.
Alliance Contracting

Fact
Alliance contracting is a contracting structure in which multiple organisations both commissioners and providers, agree to work collaboratively to delivery agreed services. The overarching agreement may be a legally binding agreement or a non-legally binding memorandum of understanding or charter, though a legally binding arrangement would add complexity. (http://www.hempsons.co.uk/can-alliance-contracting-help-deliver-integrated-care/). An example of Alliance contracting is the current Community Services Contract in Cornwall

Opinion
Alliance contracting assumes the presence of a commissioner and may only last as long as CCGs or as long as we have a purchaser-provider split both of which we believe are time limited. Whilst useful, these contracts need tight controls so that true partnership working can occur. Our Alliance contract at the moment has not been as flexible as we might have hoped.

The Future of General Practice in Cornwall
Everyone has an opinion on the future of General Practice in Cornwall but it will depend on a number of differing factors some of which are under ‘our’ control in the Health Economy sense and some of which are under ‘our’ control in the business sense. The latter, in other words our businesses, will be shaped by our practices and GPs who run or own a stake in those practices i.e. partners. However, we will have to flex depending on the shape of and viability of the local and national Health Economy. This will be driven by National (GMS or MCP) Contracting with local variation (LES contracts or MCP). If you have read the STP document Shaping our Future and the KCCG document, A Plan for General Practice in Cornwall and the Isles of Scilly you cannot fail but to notice that General Practice is fundamental to any service delivery change. In other words, we are the engine for change for the Future of Healthcare in Cornwall and if our Healthcare economy is to evolve then it needs a healthy, vibrant General Practice to sustain it.
If we are agreed that General Practice is here to stay, why is it struggling? A prolonged discussion of the issues facing General Practice both locally and nationally is beyond the scope of this paper but we can identify some core issues which may inform our ‘form’ and ultimately our ‘function’ and indeed vice versa. They are broadly as follows:

- Recruitment
- Retention
- The future of Partnership
- Premises
- Investment
- Pay and conditions
- Workload
- Work/life balance
- Medical indemnity
- Extended hours 0800-2000 hrs.
- 7 day GP services
- Increasingly elderly and frail population
- Population growth
- Increasing demand for healthcare

Fact
Workforce: - We have fewer clinicians to deliver the increasing demands from our ageing population and the expansion of core hours will stretch our workforce if we continue to try and deliver primary care in the same way as at present. Our STP and the KCCG plan for General Practice have identified areas where we might use people other than GPs to provide Primary Care Services. We will need to identify these practitioners and facilitate their incorporation into our workforce.
The future of Partnership: - A diminishing number of GPs want to commit to partnership in its current form and the unlimited liability of GP partnerships in times of increasing uncertainty represent a significant financial risk. Limited Liability Partnerships (LLPs) are unable at present to hold either a GMS or PMS contract. Some practices e.g. Penryn have looked at the development of an alternative model of partnership to reduce liabilities for incoming partners.

Premises: - In Cornwall most of our buildings are GP owned and represent a significant investment for partners as well as a valuable source of income through the cost rent scheme. With a diminishing number of partners in some practices, the financial cost and risk of buying into a building is substantial. We know from previous surveys that many GPs would like to be free of this risk. Some of our premises are probably not fit for purpose. Kernow Health CIC and the LMC have been looking at premises options and will, within the next 2-3 months, produce an options paper which we think will have some potential solutions to this issue. This will address property investment and sale and lease-back options. As a health economy, we will have a substantial ongoing financial commitment to our LIFT premises e.g. Truro Health Park

Workload: - Workload is in increasing in volume and complexity and having a negative impact on partnership recruitment. In order to cope with increasing volumes of work many GPs are looking at their work/life balance and reducing their number of their patient facing sessions.

Medical Indemnity: - Costs are rising for all clinicians. This is a national problem although the Academic Health Science Network (AHSN) has been looking at local (Regional) solutions.

Extended Hours/7 day GP services: - Already being delivered in some parts of the country by MCP Vanguards and will be coming to Cornwall. There is funding attached and it will be up to us as a health community to deliver this in a fashion we feel is suitable for our population.

Frailty: - Already signaled in QOF for 2017-18 as an area for particular focus, this will become and increasing apart of our workload because of the increasingly elderly population leading to an increasing demand for healthcare.

Opinion

Workforce: - Increasing use of non-GP primary care clinicians e.g. pharmacists, paramedics although welcome will not resolve our workforce issues. We will need to ensure that Cornwall is an attractive place to live and work with a good work/life balance. This will require innovative recruitment and retention policies that must be developed locally as well as nationally. The LMC and Kernow Health CIC continue to develop policies that are aimed at encouraging recruitment. The future of Partnership we believe is wrapped up with that of Premises and until we can find some solutions to the later issue it is likely that there will be a continuing question over the former. Hopefully the ongoing premises work between the CIC and the LMC will resolve some of these issues.

Workload will increase as will the increasing problem of frailty our local population gets older. The STP recognises these issues and recognises our increasing need to invoke the third sector in our management of the frail elderly as well as putting an increased emphasis on disease prevention. These solutions are long term and will not help mitigate the increasing and complex workload. In the light of these facts the delivery of extended hours and 7 day GP services looks fanciful. However, use of our existing Out of Hours (OOH) company, Cornwall Health or its successor organisation is likely to play a role in the delivery model for a 7-day service.

If we look at the challenges facing us and the issues outlined above, it is clear that carrying on as we are will be difficult if not unsustainable. If we think of function in terms of our future we will have to cope with increasing workload, expanded services in an environment of increasing demand and complexity within a fiscal envelope that is unlikely to increase substantially. In addition, new funding streams are likely to be directed at larger organisations that can deliver GP at scale.

For a lot of us, General Practice at scale sounds like huge monolithic organisations in control of us. Those of us who are partners were attracted to General Practice because of the ability to determine our own futures and provide care in the way that we want. Simon Stevens has already stated that the NHS offer needs to be more uniform and it is likely that for General Practice this will mean enhanced availability (8 ‘till 8, seven days a week), and perhaps a more uniform offer in
terms of appointments (pre-bookable, phone, virtual). This is an offer we would all struggle to make
given the constraints discussed above. Well the good news is that in all likelihood we won’t have to
offer a seven day a week service as individual practices but we will have to work together to deliver
this at scale.
In many ways, we are already functioning at scale. We work in locality groups and try and address
issues specific to those localities but as yet there is no ability to attract funding at a locality level or
share functions. Some practices in the South West are already offering extended services e.g. St
Austell Healthcare - an advantage of a larger multisite organisation. One of the current major
barriers to closer more integrated working is our IT infrastructure. Those local practices that have
enlarged are using common web based IT systems (EMIS web and Systmone). We either need
some advanced system commonality or interoperability for read and write functions. Our current
solutions in Cornwall do not meet these needs and we await GP connect in the absence of any
major IT investment or changes.

So, what are our options for the form of General Practice in Cornwall?

1. Do nothing - wait and see what happens and cope with the consequences. There has always
been change, this is nothing new. We’re OK, we can recruit and we are managing at the
moment.
   We think this is a risky strategy for the reasons outlined earlier in the paper. At the very least all
practices should look at their business model and complete the Sustainability Toolkit that was
part of the PMS settlement for 2016-17. A significant number of practices have failed to do this
depriving themselves of funding and access to Sustainability and Transformation funds held by
Kernow Health CIC on behalf of KCCG.

2. Get bigger - an option that has already been successfully taken by the practices in St Austell
(http://www.staustellhealthcare.co.uk) and Pool (http://www.carntocoast.co.uk). These
practices have been able to develop their management structures, have unified
their existing computer systems and expanded the number and nature of their workforce. They
have formed alliances with the third sector and attracted additional funding streams. Is bigger
better (https://www.nuffieldtrust.org.uk/research/is-bigger-better-lessons-for-large-scale-
general-practice)? Getting bigger for some is a necessity rather than a choice and can reduce
financial
   risks for partners depending on the structure of the partnership. Larger practices can offer
differing packages to attract personnel and can justify employing additional healthcare workers
e.g. paramedics, pharmacists, nurses etc. Many of us worry about continuity of care in larger
organisations but this is an increasing issue with our predominantly part time workforce. We
must find ways of ensuring clinical continuity to ensure good governance.

3. Collaborate - we are already doing this and it is perfectly possible to stay as we are, in the
organisational sense but work more collaboratively in our localities. This does leave a number of
issues unresolved. How do we cost work, attract funding, manage the collaboration? Who
does what and when and how do we share any profits (if any)? Not insurmountable but needs
to be addressed in addition to defining the levers that need to be used to encourage
participation.

4. Locality Partnerships - Some of you will remember when we ran our Future of General Practice
meetings a few years ago, we discussed the possibility of forming locality based companies in
addition to a Cornwall-wide company. It was decided that the formation of Kernow Health was
our preferred vehicle at that time and that there was no need and no desire for locality based
organisations. We are working in localities and collaborating, this would in some senses a
natural evolution of what we are already doing. Additionally, it would solve some of the issues in (3) above.

5. **Super-Partnership - OHP in Birmingham** ([http://www.ourhealthpartnership.com](http://www.ourhealthpartnership.com)) is a partnership of approximately 300,000 patients. It has 37 surgeries which still deliver General Practice as they always have but they have a single partnership deed and are treated as a single organisation by the regulators. They have in house accounting and centralised banking. They still operate their own lists. They are in essence a franchise organisation. It would theoretically be possible to create a similar model in Cornwall, perhaps even under Kernow Health. Despite some theoretical efficiencies as outlined for OHP, practices would have to work together to deliver the *at scale offering* and agree to unify their differing modi operandi. Theoretically such an an umbrella organisation would not stop individual practice amalgamation.

6. **PACS - Some areas that have been struggling to recruit and retain have developed a PACS type system e.g. Yeovil ([https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/primary-acute-sites/south-somerset/](https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/primary-acute-sites/south-somerset/)). This is a theoretical possibility for some areas but probably not the whole of the county.**

7. **Locality Based Hubs - Working together in geographical locations to provide extended services.** This has been trialled successfully in Richmond, London ([http://www.richmondgpalliance.co.uk](http://www.richmondgpalliance.co.uk)) where the group has developed an IT solution to provide interoperability between systems and practices which are largely using In Practice Vision. Other areas using similar models e.g. in Manchester, Wessex are using common IT, EMIS web and Systmone respectively

**Summary**

We are faced with an evolving Primary Care environment. The STP and the ideas contained within it are a basis on which to deliver the future of Cornwall’s healthcare. The concepts espoused within the STP are not unique to our county and they are not going to go away. Staying the same is an option that is not desired by our employers. The LMC has a role in the STP process and we will be sure to enunciate carefully both what is desirable and possible to deliver in Primary Care and General Practice. We should see this is a unique opportunity for General Practice. Our pre-eminent role in the delivery of healthcare has been recognised and we will be the engine for change in this evolving healthcare landscape. We have an opportunity to lead or be led and now is the time to make up your minds. It’s a well-worn expression that is stated ad nauseam by GPs that “this is the end of General Practice as we know it”. This time it really is.