SOMERSET LMC

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SECURING THE FUTURE OF GENERAL PRACTICE IN SOMERSET

Introduction

Despite the historical capacity of general practice to adapt to changes in the broader NHS and absorb the constantly increasing demand through efficiency improvements and sheer hard work, we have now passed the point at which the workload in primary care is sustainable. Although it is encouraging that this has at last been recognised by NHS England and the Department of Health, politicians continue to promise the impossible and ignore the pressing problems that beset the service. This paper is intended to raise some questions and provoke a debate about what practices might consider doing *now* to ensure business continuity through these difficult times, and to form the basis for discussion at the LMC Study Day on 14th May. It is certainly not prescriptive about what practices need to do, but for only the most fortunate will the answer be "nothing".

The paper covers two separate but related areas. The first is about the options for joint working between practices, and the second discusses what you might do to prevent or ameliorate a practice closure.

1. Sustainable General Practice

Background

The popularity of general practice as a career choice for medical graduates has always waxed and waned, with a nadir in 1964 when mass resignations were collected by the BMA which prompted the Robinson reforms and the subsequent steady 20 year rise in GP standing and recruitment. But General practice in 2015 has become far more complex in every respect, and its structural problems are not amenable to such quick solutions. The underlying causes are all familiar:

- A steady increase in absolute and relative workload with a diminishing proportion of NHS funding.
- Growing contractual, regulatory and professional requirements and obligatory standards.
- A shift in the status of GPs from professional advisers to public service providers.
- The prioritisation of ready access over continuity of care.
- A rising number of complaint and malpractice suits coupled with relentless hostile media coverage.
- Fewer graduates seeking to join GP training schemes – despite national pressure to increase this to 50%.
- Fewer training completers wishing to become partners, and more choosing part-time and portfolio careers.
- Attrition of the established workforce as younger doctors find the work incompatible with family and other commitments, and older GPs reduce their hours of work or seek early retirement.
- Locum support is becoming increasingly challenging as the cost of sessional doctors rises and their relative productivity is perceived to be falling as primary care working becomes ever more complex and tailored. Despite some recruitment to the locum pool from doctors leaving partnership or salaried posts before retirement, a significant number of sessions cannot currently be covered.
- Diminishing support available for practices as the NHS body holding their contracts becomes ever more remote.
- Failure by governments to take the necessary steps to reform the NHS for fear of the electoral consequences.
- Growing concern about a potential gap between the price and value of GP premises as the pattern of service provision becomes less and less certain.
- Falling profits for partners as service funding is continually squeezed.

However, there are a number of positive things about the present circumstances which provide hope that a sustainable future for an evolved model of professional contractor provided general practice can be found.

These include:

- Visionary senior leadership at NHS England that is willing to unlock bureaucratic contractual and other restrictions.
- Anticipated flexibility in who can hold GMS and PMS contracts.
- A highly trained and flexible cohort of recently qualified GPs.
- Increasing willingness amongst NHS commissioners and providers to reconfigure patterns of care.
- A recognition amongst GP practices that change is not only desirable but necessary.
- The likelihood that when the situation deteriorates the government of the day will be prepared to invest in primary care services rather than risk the public opprobrium that would follow any significant loss of general practice coverage.
- Somerset specific advantages, including a high quality and stable practice set-up, good relationships between practices, effective working between the LMC and CCG and many creative and energetic innovators amongst local GPs.

The Current Position

At present all existing Somerset practices are continuing to provide core GMS/PMS services and a variable range of supplementary contracts. However, a number are under pressure. Generally speaking, larger practices with some workforce flexibility are better able to cope with the shortage of GP partner applicants, and smaller two or three partner practices are potentially more vulnerable as they typically generate lower profits - and failure to recruit or replace even one clinician soon becomes a critical pressure. However, few practices are prepared to be categorical that they can continue to provide current levels of service indefinitely.

Short Term Risks

As profitability falls and recruitment of both partners and salaried GPs remains hard, there is a growing risk that some practices will terminate their NHS contracts. NHS England must then – officially at least - either seek to disperse the list or procure a new provider. The presumption is that such a procurement will be on a relatively short term APMS contract, so each lost GMS/PMS contract weakens the position of traditional partnership practices. However, it is not clear that running an isolated rural or semi-rural practice with a small list is going to be attractive to a commercial provider, which means that re-procuring in such locations could either be very expensive or just not possible. If NHS England then decides to assign patients to nearby practices (if there are any) who may already themselves be under pressure, the latter may seek to close their lists, or conceivably the GPs remaining in a locality may find themselves consolidating into one or two practices, leaving some areas without GP services at all. We cover some ways of avoiding such catastrophic scenarios in part 2 of this paper.

The Problem of Property

Ownership of the practice premises has traditionally been regarded as the best arrangement for a partnership, but the relative increase over time in the capital value of premises compared to GP profits, means there is now a complicated set of factors that have made GP property ownership appear as more of a burden than an asset, including:

- Indebtedness of young doctors at the start of their careers.
- Rising value of property generally, including GP premises, making it more costly to buy in.
- Lack of confidence in the future - GPs no longer seeing GMS as a contract in perpetuity, which in turn decreases the perceived value of premises as a long-term income stream once the business loan is paid off and the notional rent starts to become profit.
- The perceived risk that the market price will become lower than the valuation.
- Cost and risk of undertaking a premises development, particularly if the GPs have a vision beyond that which the NHS will reimburse, leaving them at risk on the additional space.

Historically, of course, all of these are outweighed by the increase in value of property over time, and many professional advisers still believe this to be the case, provided that property owners are prepared to commit for the long term.

Possible Solutions

The LMC still believes that the partnership model for general practice has significant benefits, notably in providing continuity of personal care very efficiently whilst being flexible and adaptable to changing NHS circumstances. The direct relationship between work done and income means partners are personally focused on delivering contract requirements.

But faced with an unsustainable workload (even before the potential parties of government started generating unachievable expectations in their manoeuvring for votes) individual practices – in theory – had two choices: either reduce what they do, or find more people to do it. In practice neither are long term options. Although some contracts may only be marginally profitable, reducing the range of work undertaken tends to reduce income whilst fixed costs remain largely the same, so the exercise becomes self-defeating. And whilst there are opportunities for changing the skill mix in general practice, trained practice nurses are in even more short supply than GPs, and the new training requirements for HCAs means that they are no longer a quick way of redistributing work. Introducing more clinical professionals, notably pharmacists, mental health workers and physiotherapists would be a logical development, if they can be recruited in sufficient numbers.

Apart from reducing activity or increasing the workforce there is a third option: increasing the value of services by redesigning them. Practices are often good at spotting small opportunities to do this, e.g. touch screens reducing the need for a "booking-in" receptionist, but few in their own right have the senior management skill or capacity to take a strategic approach to the whole business, looking at where the value lies for the patient and the profitability for the provider.

Working at a Larger Scale

There is therefore a growing consensus that the best way forward is for practices to work together in larger units. The potential benefits are fairly obvious:

- Greater workforce resilience
- Economies of scale
- Better use of specialist skills
- More management capacity
- Potential to provide wider range of contracts/services
- Greater influence on other NHS commissioners and providers
- Synergy of development and planning ideas
- Better use of premises and resources
- Ability to move to new contractual or organisational structures

The options for fully integrated working are currently limited by the nature of the GMS and PMS contracts, though some loosening of these is anticipated. (*Five Year Forward View Business Plan 2015-16)*. This is probably essential for rapid and widespread change. In the meantime the choices seem to be:

1. ***Sharing Support Services***

   A simple and logical first step is for a group of practices to share some "back office" services. There is little evidence that this of itself generates significant savings as outsourcing, or purchasing through the LMCs Buying Group (or Somerset Primary Healthcare) may be equally cost effective, but it can be a good way of getting practices to start thinking together and converging their internal systems and processes. It may also make it easier for practices to work together on specific supplementary contracts such as additional opening, admission prevention, complex care or intermediate services. The presumption here is that practices wish to maintain continuity of their patient-facing services and concentrate the energy of the team on realising its vision of patient care – and especially for a small practice with limited resources that may be best achieved by sharing or divesting as many other activities as possible.

2. Takeovers & Mergers

The difference between a merger and takeover is subtle, but the route by which a smaller practice is combined with a larger one is well trodden, and there are options for the way in which continuing contracts can be held, depending on the views of the parties (NHS England and the practices). Although separate contracts maybe retained, it is generally easier to combine them into a single one, although this can be a challenge if PMS and GMS strands are to be combined as the notional GMS global sum and calculated PMS baseline may still be quite far apart. It is certainly possible for different elements of a larger practice to retain their separate identities so far as patients are concerned, whilst formally combining all other activity. The biggest stumbling blocks are likely to be differences in the profitability of the two businesses, and the ownership and leasing of practice premises. Sometimes the different working philosophy of practices that are otherwise compatible makes a merger impractical, but often practices will have been formed in the past due to an historical partnership dispute between GPs who are long gone, and there is really no reason they should not now be re-combined.

3. Super-Practice

Although the configuration varies, the typical pattern is that one of two large well organised practices combine and then absorb a number of smaller one or two handed practices. Generally the practices are geographically close together and in urban or suburban areas. Apart from general economies of scale, the greatest benefit seems to be in introducing modern processes and working practices to clusters of fairly old fashioned and under-managed practices. Given that most Somerset practices are now well managed, there may not be the same benefits to be gained in the county, particularly in rural areas. It may also be difficult to maintain a balance between collective organisations and locally responsive services, especially where practices have clearly defined identities - efficient shared working practices may seem to some to de-personalise care. Initially such a merger may be costly, with each party needing separate professional advice, and changing long established working practices is challenging, especially when the running costs per patient can vary greatly between practices. However, once combined a super-practice will have considerable financial and organisational leverage, and will be in a strong position to bid for other NHS contracts locally. Participants need to commit financially, and ensuring that property and leases are acquired equitably may be challenging. But in localities with a shared strategic vision and a willingness to adopt a more corporate style of practice, this option should certainly be able to create a sustainable organisation.

4. Commercial Acquisition or Co-operation

Whilst GMS and PMS contracts can still only be held by GP-led partnerships, there are models under which the running of practice business can be transferred by agreement to a commercial provider. There are clearly operational advantages in bringing in expertise from a large primary care provider, but there are three significant concerns. First, commercial providers do not have a good track record of continuity in providing GP services. Several have come and gone in recent years. Secondly, once in a commercial relationship the practice will have to generate profits for shareholders, which may be difficult to reconcile with GPs' wishes to provide comprehensive services for patients, sometimes outside their contract obligations. Finally, the current pricing or primary care contracts make it difficult for any provider relying on relatively costly employed GP to offer a full service and still generate a commercial return. Buying in management products or expertise from a commercial company whilst the practice remains autonomous, would, of course, be a different matter.

5. NHS Integration

The future foreseen by the Five Year Forward View is for either horizontal or vertical integration of primary care with other NHS providers, with almost any model apparently open for consideration. Early discussions through the Symphony project on vertical integration showed that whilst there is some enthusiasm in general practice for exploring what the path to shared working might look like, there are complex technical hurdles to be overcome, not least the completely different funding formulae for general practice and secondary care providers. From a purely business perspective practices may also be cautious about the longer term risks of joining small but profitable primary care businesses with large but over-spent secondary care providers. Formal integration also limits the flexibility that practices traditionally have in delivering their contracts, but on the other hand would back the practice with the considerable financial and management resources of a large organisation, for whom the deployment of, say, a small number of trained staff would be a small matter. The Yeovil Vanguard project should

allow all this to be considered carefully, so we think it unlikely practices will wish to go down this route outside that funded development project. The essential requirement for practices is to have a clear vision of what they want from a project, and to be clear just what the benefits for practices, staff and patients will be. There are obvious risks in giving up a core GMS or PMS contract with its assured income stream for something new and untested, though this may present a unique opportunity to refocus GP time and effort on real clinical work.

6. Coalescence and Joint Ventures

Horizontal integration with other practices seems more immediately attractive and might establish the foundation for a more stable integrated care approach. The LMC is in discussion with our legal and accountancy advisers about procuring generic advice for all localities to use, which can be tailored to specific needs, but the key to this option is planning, planning and planning – and using proper change management to agree and follow that plan. This does not necessarily require a formal joint venture agreement, but signing some sort of document does concentrate the mind and demonstrate commitment.

Integration can also be achieved by a series of distinct and individually manageable steps. This might look something like this:

- Start discussions on the adoption of common management procedures, processes and structures, including accounting. Set up a clinical reference group.
- Start to share some specialist skills – e.g. Long Term Condition Specialist Nurses - between practices.
- Agree on some financial and cost brackets, target staffing and skill requirements, and sharing of executive management skills.
- Write and adopt a formal Memorandum of Understanding and Shared Services Agreement.
- Agree a core management structure and provision (or combined outsourcing) of shared services such as payroll, HR and procurement.
- Agree shared contracts & target pay scales for staff, benchmark and agree variance for NHS targets such as prescribing costs and referral rates.
- Bring in expert help to look at premises ownership, leases and anticipated 20 year needs, start to consider how notional costs and rental will be allocated.
- Undertake a clinical staffing review, including profiling existing clinicians, looking at skill mix opportunities, employment and time allocation of salaried GPs, locum requirements.
- Consider the possible role of clinical sub-contracting.
- Ensure that systems and legals are ready for any advantageous switch to a new contract vehicle if and when this becomes available.

The objective of this is to bring practices progressively closer together so that by this stage as much of their business structures are integrated, leaving just the patient facing clinical services identifiably “belonging” to the individual practices, which each will for the time being retain their individual contracts.

This GP consortium would be in a good position to negotiate with NHS provider trusts – both community and acute – over possible next stages of integration. One important benefit for practices of this would be access to capital if this was needed to, say, buy out individual practice leases, develop new premises, or fund the infrastructure cost of new services.

7. Establishing a New Service Company

The logical consequence of a functionally merged organisation is that it becomes structurally merged as well, but this is not a necessity, and in the context of general practice it may not be the best move. As only partnerships can hold GMS or PMS contracts these partnerships would have to continue as shareholders or members of the company, which would incur additional costs without necessarily adding value. A company may find it easier to raise capital - once it has a track record - but this would need to be a service rather than a clinical provider or additional complications would ensue such as Information Governance requirements and CQC registration, and whatever its function VAT liability could be incurred if the company is trading with other separate entities. Given that Somerset already has Somerset Primary Healthcare Limited as a flexible vehicle for contracting at levels above the practice, this seems to be an unnecessary complication.

2. Dealing with a Workforce Crisis or a Non-Viable Practice

Responding to a serious problem in the practice takes time, resources and opportunity – and sometimes we may have none of these. Although integration is some form is likely to be the medium term route towards sustainability, practices may cease to be viable very suddenly, and this is a risk you should assess now. A hardworking and moderately profitable practice of three partners may seem stable, but if one retires and cannot be replaced and a second GP has a serious accident or prolonged illness the one remaining GP may find herself unable to replace partners, recruit salaried doctors, or afford locums. This will quickly drive the practice into the red, and, more importantly, it may simply be unable to provide core services.

1. Plan in advance

The LMC strongly advises all practices to have a business plan that considers such possibilities, and that each partnership should agree a procedure in advance for handling them. At the very least consider how you will deal with a short term problem: remember that even if you cannot meet all the terms of your contract, it is better to provide an emergency service than nothing at all. For example, can you have a reciprocal arrangement with a neighbour for emergencies only cover? Is there any sort of co-operative arrangement you could build in your federation to deal with uneven demand patterns between practices? And have you though about the possibility of co-operating to run a separate "urgent" care pathway to make duty days in the practice less hellish? Have you a procedure for stripping out all unnecessary activity, including outside commitments, to concentrate on essential services?

2. Obtain advice early

If you suspect that the practice may be vulnerable, do not wait until disaster strikes – get help as soon as you can. Obvious sources of help include the Area Team of NHS England who will try hard to ensure that the practice can continue as it is not in their interests to have practices fail, but it has the ultimate responsibility for ensuring a service is provided for your patients if it cannot. You should certainly contact the LMC, and accountancy advice is likely to be essential. Depending on the circumstances, a variety of other organisations may be able to help.

3. Try to give yourself options

Although a GP has no contract responsibility for their patients once he or she leaves a practice, or it is closed down, most GP partners have some hopes about the way in which their patients will be cared for in the future. Even if you expect your current partnership to continue indefinitely, do think about possible options now. In the event of a problem, are there other practices in the locality who might want to take on the contract? Would you consider advertising for new partners with a view to handing the contract to then and then retiring? Is there any other organisation you might approach to take over the practice under the current contract? Any of these might well be better for everyone – the current partners, the patients, the Area Team, the new contractor and general practice as a whole, than NHS England having to re-procure the service or disperse the patient list. Don't forget that so long as there is a GP taking responsibility a lot of work can be delegated to other staff. Some nurse practitioners with prescribing rights can do much of the acute work in general practice, or you might even be able to get an Emergency Care Practitioner to do some visits, a pharmacist the medication reviews, or a physio to see all the musculoskeletal problems.

4. Help! I need short term support!

Even with the best forward planning a practice may find itself in acute difficulty and needing emergency help for a short period whilst a long term solution is found. Particularly at the moment getting immediate locum cover may be very difficult. We have a short list of experienced GPs, mostly semi-retired, who are prepared to be contacted by the LMC or Somerset GP Locums to provide emergency cover for 2-4 weeks in the event of a practice collapse. This may be enough to tide you over the crisis until your plans can be implemented. It is also worth negotiating with the commissioners who are likely to want to use contract flexibility and offer supportive actions on a case by case basis.

5. Just what do you need GPs for?

There are remarkably few things within the contract that absolutely have to be done by a GP. If a nurse practitioner can see acute problems, a physio musculoskeletal complaints, an RMN deal with mental health matters, a pharmacist sort out medication, a practice nurse deal with long term conditions and a HCA do any

tests, that leaves the GP to act as triager and care manager. Intelligent Access/Doctor First models which turn all new appointment requests in to telephone consultations are very effective at streaming demand in to different pathways, and in an emergency they do not need to be highly organised. You need a comprehensive plan and some way of increasing the number non-medical face to face consultations you can offer in the short term, but that may a more realistic option than assuming you will be able to get more GP sessions.

6. Be sure of all your contract and legal obligations

If everything fails and the practice simply cannot continue for either financial or workforce reasons you may have to tell NHS England that you are no longer able provide essential services. Giving up your core NHS contract may be relatively simple, but there are a number of other legal implications. For example, you will probably have to pay staff redundancy if any new provider does not continue to offer services from your premises, there will be contracts of various sorts associated with your premises as a commercial property, the CQC needs to be notified, and you will need to give separate notice on other contracts such as those with the CCG and the local authority.

7. What if a neighbouring practice closes?

If you have concerns about the viability of your practice, but one of your neighbours jumps first, what do you do? This, of course, may not always be a disaster. You may want to increase your patient numbers, recruit skilled staff, or take on any remaining GPs yourself. If the list is dispersed you may be able to maximise the use of your own premises by increasing your numbers, or you may see this as an opportunity to expand the practice as a whole. On the other hand, if none of these apply, you may need to put up the shutters and close your list to protect the service for your current registered patients. It is certainly worth doing some scenario planning for several possibilities so as to avoid any surprises, but the most important thing is to establish a relationship of trust with nearby practices so they will let you know of their intentions before resigning a contract – it is much easier to reach a local solution at that stage than later.

Conclusion

Although there is potentially a bright future for general practice, the current difficult times are likely to last for some time yet. The key to re-establishing the profession as both a sustainable career and an attractive choice for medical graduates is to ensure the workload is tolerable. Whilst work on reducing the flow of un-resourced work into general practice is undertaken by GPC nationally and the LMC locally, and the CCG seeks to establish more efficient care pathways, practices are likely to find that managing their existing workload will be eased by working on a larger scale. And it is worth remembering that nearly all the successful models of large scale primary care are led by GPs – yours could be the next.

Somerset LMC Study Day

Coalition or Competition: General Practice in a 24/7 Society

Taunton Racecourse Thursday 14th May 2015

Confirmed Speakers

Roy Lilley, NHS Writer & Broadcaster, Dr David Geddes, Head of Primary Care Commissioning, NHS England, Dr Richard Vautrey, Deputy Chair, GPC & Sarb Basi, Managing Director, Vitality Partnership

£35.00 per delegate including lunch

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