**Somerset GP Board**

**Recommendations to Somerset CCG on General Practice at Scale**

**1.0 Introduction**

SGPB has produced this short paper as a contribution to the proposed review of primary care services in the county.

**2.0 Synopsis**.

SGPB recommend that any proposed models of primary care in Somerset should be reviewed against eight change principles recognised as being important for primary care sustainability, patient care and experience. Working in units above individual practice size offers potential benefits, but transition needs to be provider-led, flexible, evidence-driven and properly resourced.

**3.0 Background**.

Somerset general practice undertakes something like 3 million patient consultations a year so although it is often taken as a given part of the health system, small changes in its capacity and effectiveness will have a major impact on both the health of the population and the ability of other providers to function effectively. General practice needs to be regarded as the bedrock of the NHS, its ‘front line’ and not a sector that can either be disregarded or just expected to absorb all the work that other providers do not think they should be doing. General practice contributes directly to both the supply of NHS services close to the patient and to the management of patient demand for NHS services, unlike any other organ of the NHS.

**4.0 GP Forward View Transformation Funding**

The CCG is required to identify £3 per patient of transformation funding between April 2017 and March 2019 to be spent on projects directed at larger scale GP working and practice resilience. For Somerset this amounts to about £1.68m in total. SGPB believes that this money should be spent in a co-ordinated way and directed towards the project or projects that have the best chance of effecting real change.

**5.0 Strengths of General Practice Based Primary Care**

Almost everyone in England is registered with a general practice provider, and the registered list and lifelong medical record are an ideal starting place for building a comprehensive primary care service. Beyond this, whilst the traditional system of a GP principal based service may be unsustainable, it also offers some distinct benefits:

* One doctor co-ordinates all aspects of an individual’s care.
* The same GP is aware of everything about a patient and can sometimes put disparate information together to make a new diagnosis.
* The GP often has a longitudinal knowledge of the patient and their family.
* GPs are skilled at gauging and bearing clinical risk.
* GPs have the authority and status to act as effective advocates for patients.
* The working culture of general practice partners, which is to stay until all the work is done, may be bad for their health but it helps keep an overburdened service more or less afloat (the ‘Partner Premium’.

**6.0 Benefits of Working at Scale**

Somerset LMC has previously 1 summarised the advantages of working with a larger patient population as:

* Greater workforce resilience
* Economies of scale in both business and clinical matters
* 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

and in the current climate we should add:

* Stronger recruitment presence
* Potentially a more robust business model

None of these presumes any particular model, and SGPB believes that given the great variation in practices’ characteristics, significantly different locality cultures, patient requirements and the spectrum of GP partner opinions, it would at best be foolhardy to pursue a single solution. We need a menu of options that will best allow individual groups of practices to reach the best local solution.

There is a wide acceptance, though little direct evidence, that working in 30,000 to 50, 000 patient units is the most effective size. In theory, such a provider is large enough to be resilient but small enough for everyone to know all the other members of the team. It would therefore seem sensible to set this as the locality size for planning purposes, though not necessarily for primary care providers – practices and others.

**7.0 The Local Context**

As a rural county with no centre of population of more than 65,000, some of the models proposed in urban areas are unlikely to work here. In the most thinly populated areas there is no practical alternative to having a number of fairly widely scattered small “delivery points”, particularly given our ageing population and poor public transport links.

For a variety of reasons, Somerset practices are unlikely to generate from their own resources the kind of dramatic system shift that has been seen in a few places elsewhere in England. SGPB believes that any local scheme likely to work will need to be either externally supported, or slowly paced and incremental. Unless there is a dramatic change in Department of Health thinking, the longer we leave things the way they are, the harder it will be to change them. The familiar triad of a shrinking GP partner workforce, static or declining resources and a growing workload already means that primary care leaders have little time for development work as the day job is just too demanding: It is difficult to build a new structure for primary care with bricks that are crumbling away.

**8.0 Corporate Models**

Particularly whilst GPs and other primary care clinicians are in such short supply and so expensive, it is unlikely that any commercial provider will rush to move into Somerset as the margin on providing general practice services using employed staff is probably not sufficient to justify the investment costs and the risk. We are aware of no existing large GP-led and local provider organisations that are likely to enter the market, which leaves us with just local NHS Foundation Trusts as possible host organisations. Symphony Healthcare Services has a growing portfolio of practices, but by taking on a number of weaker practices at the beginning (saving the Somerset health system from the dangerous consequences of practice collapses at the cost to itself of absorbing loss-making or marginally profitable contracts) it may now need to be less flexible in the offers it makes to practices. Taunton and Somerset and Somerset Partnership, with one practice each, have yet to decide how to position themselves in relation to primary care.

Although there seems to be a long term presumption that STPs will evolve into Accountable Care Systems there are very considerable challenges involved, and the track record of big NHS organisational change is not encouraging 2. The Foundation Trusts will naturally be focussing on aligning their own activities before they spend much time on primary care. Furthermore, the CCG’s clinical services review, now not due to report until the end of August 2019, will inevitably lead to a planning blight until its publication.

**9.0 Traditional Models**

A previous LMC analysis 3 of the choices for joint working between practices noted the lack of evidence of long term benefit for almost all of the alternatives. In particular, low level co-operation, up to and including sharing some elements of back office functions, does not appear to lead to significant savings or service improvements over and above those to be had from doing the same things efficiently at individual practice level. There is a strong argument that the priority should be to increase the efficiency and effectiveness of existing providers before we consider structural integration at a higher level.

At the other end of the scale, multi-site practices have made gains, but these are most marked where a number of small or single handed practices operating in a very traditional way have been brought together and have adopted a common set of processes and protocols. The majority of Somerset practices now have three or more partners and they are generally already reasonably well organised and so would be unlikely to see such benefits. Formal merger and other forms of profit sharing collaboration must also overcome the significant differences between practices in premises arrangements, clinical service configuration, partner workload, resource efficiency, and, most important, partner drawings. However, solutions to all such challenges can be found, and North Somerset has seen four successful mergers in the recent past which overcame these difficulties with the help of a local expert.

We suspect that the best path for many practices will be to find an intermediate level of collaboration that will release efficiency savings (that should benefit both contractors and the local health economy) whilst standing back, at least initially, from formal merger. GPs sometimes assume that collaboration will be easy, but that is rarely the case and the process is complicated and can easily fail, often because of a lack of skill and experience amongst the participants in managing change this complex.

In all the current circumstances SGPB believes that any large scale working scheme needs to meet the following principles :

**9.1. Values Based**

Most hurdles in the way of collaborative working can be overcome with time and effort, but it is very hard to meld together practices that have wide differences of culture and philosophy. The very first step must therefore be for the partners and other key staff to make sure that they can create and subscribe to a shared vision of the underlying principles of the joint venture. This will not be easy where potential participants hold very different views, but we believe it is achievable. Cultural alignment amongst the participants is the first key goal and expert help in achieving this quickly and safely is likely to be essential

**9.2. Iterative and Incremental**

Given that time and resources are so short, work needs to be undertaken in bite-sized pieces and as efficiently as possible. Each stage should have an explicit, objective and measurable benefit.

**9.3. Properly supported**

Whilst practices will need to be convinced at the outset that participating is in their ultimate best interests and that they should therefore invest resources in taking part they will need to be offered a framework so that the work can proceed apace, along proven lines, and without duplication. The minimum requirement will be:

* Enough regular input from an experienced change manager to support the process.
* Project training for practice leaders.
* A proven scheme plan with timelines and explicit work programmes for each stage.
* Supporting contract, legal, accountancy and other documentation. (Some of this is already available through the LMC Practice Support Unit).
* Help with staff and patient engagement.

**9.4. Well evidenced**

We don’t have time to spare to re-invent the wheel or to wander into blind alleys. Any scheme that is to be actively promoted should be come with some evidence of practicality and benefit and it is likely to need piloting, even if the majority of practices become fast followers.

**9.5. Realistic**

Whilst the scheme will need to align with the current health policy of the government of the day, whatever is proposed needs to be achievable and durable. It should be designed to meet the real health needs of the population and constructed so that if capacity is limited the most urgent are met first.

**9.6. Forward Looking**

There will be a strong temptation to build a scheme that addresses the immediate perceived challenges of general practice but it must also anticipate how the architecture of healthcare organisation is likely to change over the next three to five years and how primary care medical services will need to integrate into this. Models should be tested against likely future scenarios.

**9.7. Inclusive**

Although general practice is the largest element of primary health care, the contributions of the other contractor professions, notably pharmacy and of a wide range of health and social care service providers are also essential. A model that recognises this from the outset and embraces the opportunity to include local system flexibility and team building based on joint working rather than employer or contract, should add greatly to the potential impact of a scheme.

**9.8. Consistent but Adaptable**

It would clearly be sensible to have the same or at least similar models for collaboration for the whole county. A consistent approach would be quicker and probably cheaper to implement, and it would also make vertical integration easier in the long term. However, the way in which clinical teams are constructed and the configuration of patient services will need to be adaptable to meet the needs of both some very rural areas and our relatively small urban centres.

**10.0 The Starting Point**

In common with much of the NHS, general practice is struggling to contend with the triple challenges of rising demand, falling (relative) resourcing and skilled workforce vacancies. Somerset also has to deal with a thinly scattered population and sometimes challenging geography, and having too few natural GP and practice managers with both the skill and the time – as well as the business flair – to implement change. In some places the fabric of general practice is so thin that enforcing change might just rip it apart, so whatever we do needs to be designed with this in mind. Although GPs still earn well, providing services using a salaried workforce is only marginally profitable at best, so relying on the market to produce the desired effect would be foolhardy - unless, of course, all the commissioners want is a telephone-led service for acute illness. That means the transition to a locality model needs to be managed, presumably using a mixture of incentives and penalties, and closely supported by the right staff/expert team dedicated to this task

**11.0 Where should the new boundary between general practice and other NHS services lie?**

Ideally, of course, there should not be one at all, at least from the patient perspective, but true integration is clearly some way off. One of the workload challenges for general practice has been the accretion of all sorts of additional roles on top of core GMS/PMS work. If joined –up services are to be provided in localities, this could be an opportunity to look differently at who does what.

The move towards amalgamation of the three FTs in the county, and the relative ease of piloting any new structure in one or more of the FT-run practices means that we are no long constrained by traditional boundaries and various possibilities for making service delivery more effective and balancing workload can be considered:

*Option 1*

*The GP practice(s) take over responsibility for providing all community based services* in their locality. This has the advantage of bringing everything under one roof, streamlining clinical and management accountability, allowing rapid local decision making and movement of resources and making it easier for the whole team to be part of the local community. On the other hand, not all staff will want to be GP employees, practice clusters may lack the skills and experience to manage other professional groups, service provision will become fragmented (and, to some extent, arbitrary), and specialist services will become much harder to sustain.

*Option 2*

*Staff continue in their current employment arrangements, but are seconded to GP locality management.*  This offers staff security of employment and guarantees their terms of service but probably will not allow the flexibility of deployment that may be needed whilst cutting off team members from their usual peer group and usual employment support. However, it may be a useful transitional step to a more permanent solution

*Option 3*

*No change.*  Unless there is a clear argument for altering the team structure, then doing nothing in an option, especially given the opportunity cost and the fragile state of the various services.

*Option 4*

*Existing practice staff are transferred to an existing provider.*  The distinction between the roles of, say, practice nurses and district nurses is often arbitrary and illogical. Both teams could potentially be strengthened by joint working.

*Option 5*

*Practices are absorbed by a Foundation Trust.*  This has, of course, already been taking place – notably with Symphony Healthcare Services taking over a growing number of practices, but there has been little evidence to date of functional integration of services.

*Option 6*

*A completely new organisation is formed.*  Over the long term, it seems unlikely that any existing provider is really configured correctly to deliver mid 21st Century healthcare. The capacity of hospital trusts to absorb resources is legendary (for example, hospital spend is now 47.6% of the NHS drug budget and is currently rising at 12.1% a year, whilst primary care costs have gone up 0.6% in the same period4) and no provider is really ready for the necessary shift away from medical interventions to self care and preventative lifestyle changes. It seems sensible to start planning our journey to a sustainable future service from now, even if several stages will be needed.

**12.0 The Need for a Mixed Economy of Primary Care Providers**

It should be abundantly clear that changing the shape of general practice and other primary care services needs to be done very carefully. With the system having very little resilience left and running flat out, the job is asking to changing the wheels of a 1948 racing car in the middle of a Grand Prix – and without coming into the pits. That, of course, is the easy part – we then need to completely rebuild it into a modern Formula 1 car.

Some change is already under way as practices merge or join Symphony, but as the minimum size for long term sustainability gradually increases more practices will find themselves vulnerable. But many of these are well run, profitable, and adequately staffed, and will not want to give up their core contracts. Others will already be large and strong enough to continue as independent contractor partnerships indefinitely. Given the likely mix of GP provider sites we will have, our solution needs to accommodate all the different varieties of viable practice. And just as Somerset is quite unlike the large urban centres upon which health organisation design is usually based, different areas of the county will have significantly different needs and best solutions.

We need at this point to take note of the importance of continuity of care. Although often disregarded by ministers and the DH who are more concerned by the more obvious political risks of perceived poor access to services, the most ill patients value continuity of care very highly, GPs often regard it as the bedrock of their vocation and an essential contributor to job satisfaction, and there is evidence 6 that patients who regularly see the same GP are less likely to be admitted to hospital inappropriately. Continuity needs to be built into large scale solutions, for example by organising front line clinicians into teams small enough for all the clinicians to know all the patients with significant long term conditions

**14.0 A Possible Model**

Given all the foregoing requirements and constraints, there is one nationally accepted model that we think aligns best with the principles enumerated in paragraph 9, the NAPC “Primary Care Home”. Using the practice list as the essential first building block, this model encourages a flexible approach built on meeting mutual goals, and it does not set out any particular prescribed path. There is now much evidence from the 200+ pilot sites in England to help collaborative groups design their own local process whilst ensuring that these are compatible with the bigger picture across the county. We believe that groups will need to be co-ordinated, supported ,and resourced – most particularly with expert time - and this would be an appropriate use of central resources, including an element of the Transformation Fund. It is essential that this support is planned and provided for long enough to see the work through. We cannot afford to start this programme only to let it fizzle out as resources are diverted to some bright shiny new political initiative. If that is not understood from the beginning, it will be better not to start at all.

V1.5 31.05.18