GENERAL PRACTICE FORWARD VIEW (GPFV)
New Contractual Models & Examples of Working at Scale

THURSDAY 26 OCTOBER 2017

INTRODUCTION

This was a citywide event funded by NHS England (NHSE).

With a packed hall David Savage commenced proceedings and introduced the speakers. All presentations can be accessed via the *Facts & Information* page of the LMC's website: http://www.sheffield-lmc.org.uk/page1.aspx?p=19&t=1.

PRESENTATIONS

GPC: National Perspective / Update

Richard Vautrey, Chair of General Practitioners Committee (GPC) UK and GPC England started by recognising general practice as the cornerstone of a successful NHS and the model of the registered list remained paramount. He highlighted some of the main pressures facing general practice now and in the future, relating to funding and workforce.

- GP funding fallen from over 11% of NHS budget to 7.4% last year. Even by 2021 the current proposals only raise funding to 8.4% of overall NHS budget.
- GMS provides £142.63 per registered payment. APMS costs £224.03 (av).
- GPFV investment into general practice will fall to zero in 3 years.
- List closures are increasing as practices become unviable.
- A survey of GP registrars in London revealed 4% wanted to become partners, 47% wanted a salaried post and 37% wanted a locum post.

Richard then discussed GPC views on working at scale models, such as Accountable Care Systems (ACS), Accountable Care Partnerships (ACP) and Multi-speciality Community Providers (MCP). He encouraged Partners and practices to maintain General Medical Services (GMS) / Personal Medical Services (PMS) as a foundation to build upon. He encouraged practices to consider whether risk sharing is involved in new contractual models, because risk-sharing agreements are fraught with difficulty when there is little "cash" in the system. Engaging with different models is voluntary for practices and all models are equally acceptable, although Richard re-iterated the dangers of relinquishing a GMS/PMS contract and the likelihood that it would be impossible to return.

Bury GP Federation

Martin Clayton, Chief Executive of Bury GP Federation, presented the experiences of developing a federation of practices covering 220,000 patients. Bury started looking at the federation process in 2011, prior to publication of the Five Year Forward View (FYFV) and GPFV. It was set up to create one voice to deal with commissioners.

- It was set up as a company limited by shares.
- It is based on practice lists and the GMS contract.
- The Articles have been amended regularly to reflect the demands of practices and of the changing nature of the health care system (generally every 6-8 months).
- There are non-competitive clauses, meaning the Federation will contract on behalf of the practices.
- Practices are asked whether they want to deliver contracted services, and if not these will be offered to other practices in the Federation.
- The Articles include a clause that allows other practices to eject a practice if it is not engaging appropriately with the Federation.
- Communication with shareholders is key, but shareholders must allow the Board freedom to work on their behalf.

Primary Care Home (PCH): Larwood Health Partnership

Stephen Kell introduced the work at the Larwood Surgery in Bassetlaw. PCH is based on a list size of 30-50,000 patients and was developed by The National Association of Primary Care following a Kings Fund report in 2009. Larwood Surgery decided to create their PCH and encouraged other parties, eg District Nurses (DNs) and 3rd sector organisations to join them.

There was an initial suspicion, so Larwood hosted several workshops to encourage face-to-face meetings. Gradually several organisations adopted the project and Larwood embarked on a building programme ($^2/_3$ funded by partners) to create in-house space for DNs and 3rd sector organisations and allow quicker and more directed signposting. Larwood now:

- Have monthly Board meetings with other providers and commissioners.
- Have a Memorandum of Understanding (MoU) with Care Homes to do regular visits and reduce urgent calls.
- Employ paramedics to cover urgent visits.
- Use AskmyGP telephone triage service.

Wakefield Connecting Care Multispecialty Community Provider (MCP) Vanguard

Martin Smith and Greg Connor then presented their work on the MCP Vanguard in Wakefield. The process of collaboration started before the FYFV publication. The model was initially trialled in West Wakefield Health and Wellbeing Ltd; a federation of 6 general practices trying to connect care hubs and:

- Redesign care around the health of the population, irrespective of existing institutional arrangements.
- Focus on prevention.
- Improve health and wellbeing.
- Reduce avoidable hospital admissions and elective activity.
- Unlock more efficient ways of delivering care.

In April 2017 the project was extended to the whole of Wakefield and management was taken over by Wakefield Clinical Commissioning Group (CCG). The model also incorporated a Care Home Vanguard, creating multi-disciplinary teams (MDTs) and using new holistic tools for assessing care needs. The MCP Vanguard is creating a virtual MCP agreement with a plan to develop a partially integrated model in 18 months' time. Greg highlighted some of the good and less successful schemes:

- Training of Registrars was very important.
- Continuity of care was important and achievable.
- Developed their own system of triage without 111.
- Developed a bank of staff held in a "virtual practice" for deployment across the MCP.
- Concerns about several organisations with deficits being tied together.
- Tiny amounts of resilience funding.
- Physio first was not very successful so trying on-line booking.

The most important point was to evaluate and see if you are making a change then develop successful services further.

Sheffield CCG: Local Perspective/Update

Katrina Cleary, Programme Director of Primary Care, Sheffield CCG then gave an update on Sheffield CCG's moves towards working at scale. The CCG contract on a citywide basis, but recognise there are different demands from diverse populations across the city so flexibility is required.

There is a question of whether a citywide contract should be commissioned, with subcontracting to practices or neighbourhoods.

- The neighbourhood model is not necessarily all about contracts but is considering culture changes in primary care provision.
- Neighbourhoods are already providing different models, eg the Virtual ward, but all are at different levels of development.
- The CCG is planning a Neighbourhood maturity self-assessment tool.
- The CCG is planning 3 workshops to encourage practices and neighbourhoods to discuss with the CCG what they want to achieve.

Primary Care Sheffield (PCS): Local Perspective/Update

Andy Hilton, Chief Executive of PCS gave an update on the activities of PCS to support core practice activity, provide wrap-around services and leadership engagement at an ACP level. Andy then went on to:

- Highlight the work PCS had done on Clinical Assessment Service, Education Support (CASES) to flag up areas where services could be redesigned.
- Discuss whether in Sheffield a PCH model was appropriate for neighbourhoods.
- Discuss shared functions between PCS and Sheffield CCG, and how some of the CCG's functions may be more appropriate for PCS to deliver.
- Present the idea of the CCG avoiding contracting individually with neighbourhoods, but delegating this through PCS.

DR A BRADLEY
Vice Chair