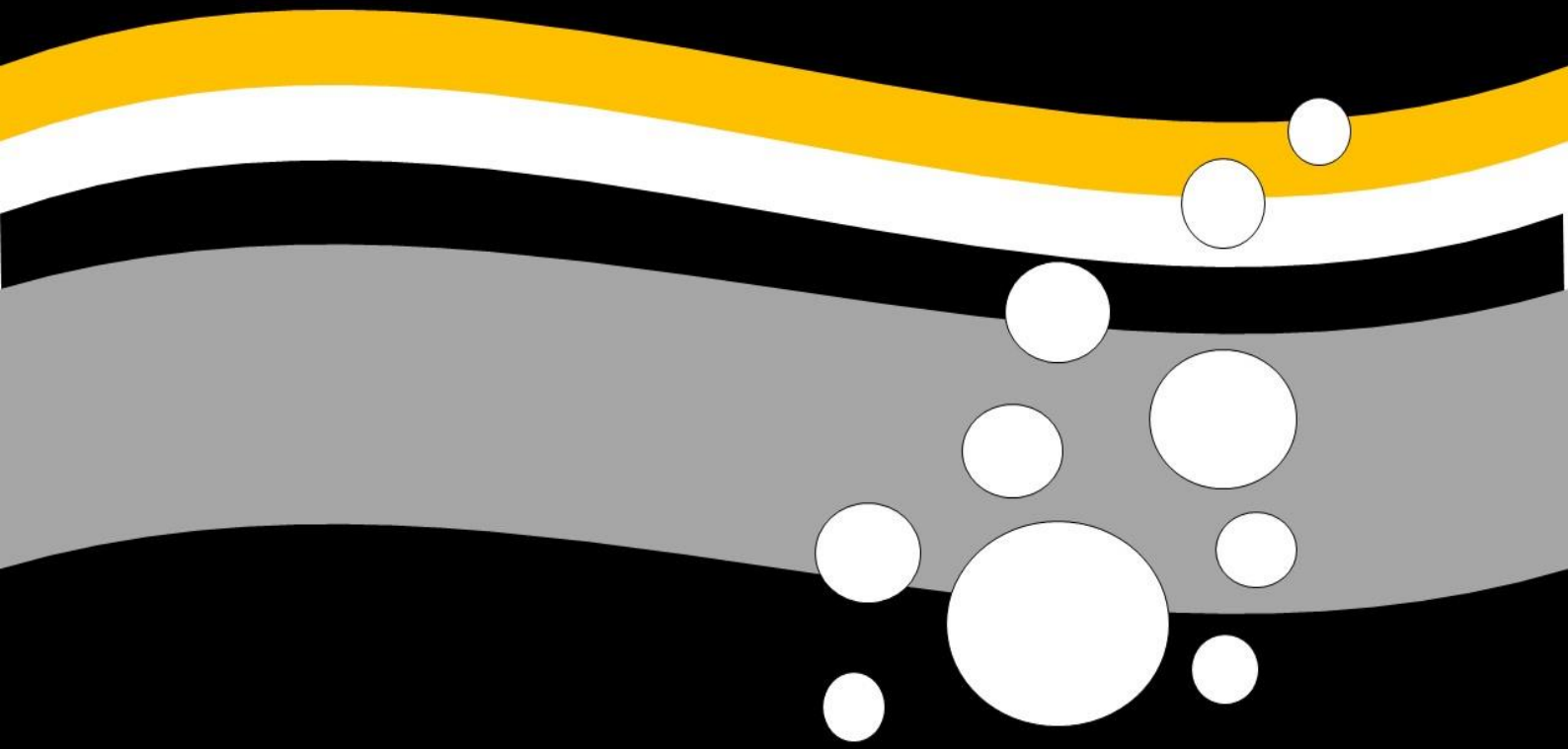
THE FUTURE OF GENERAL PRACTICE

Real Life Case Studies of Innovation and New Ways of Working

By Ben Gowland and Ian Keeber



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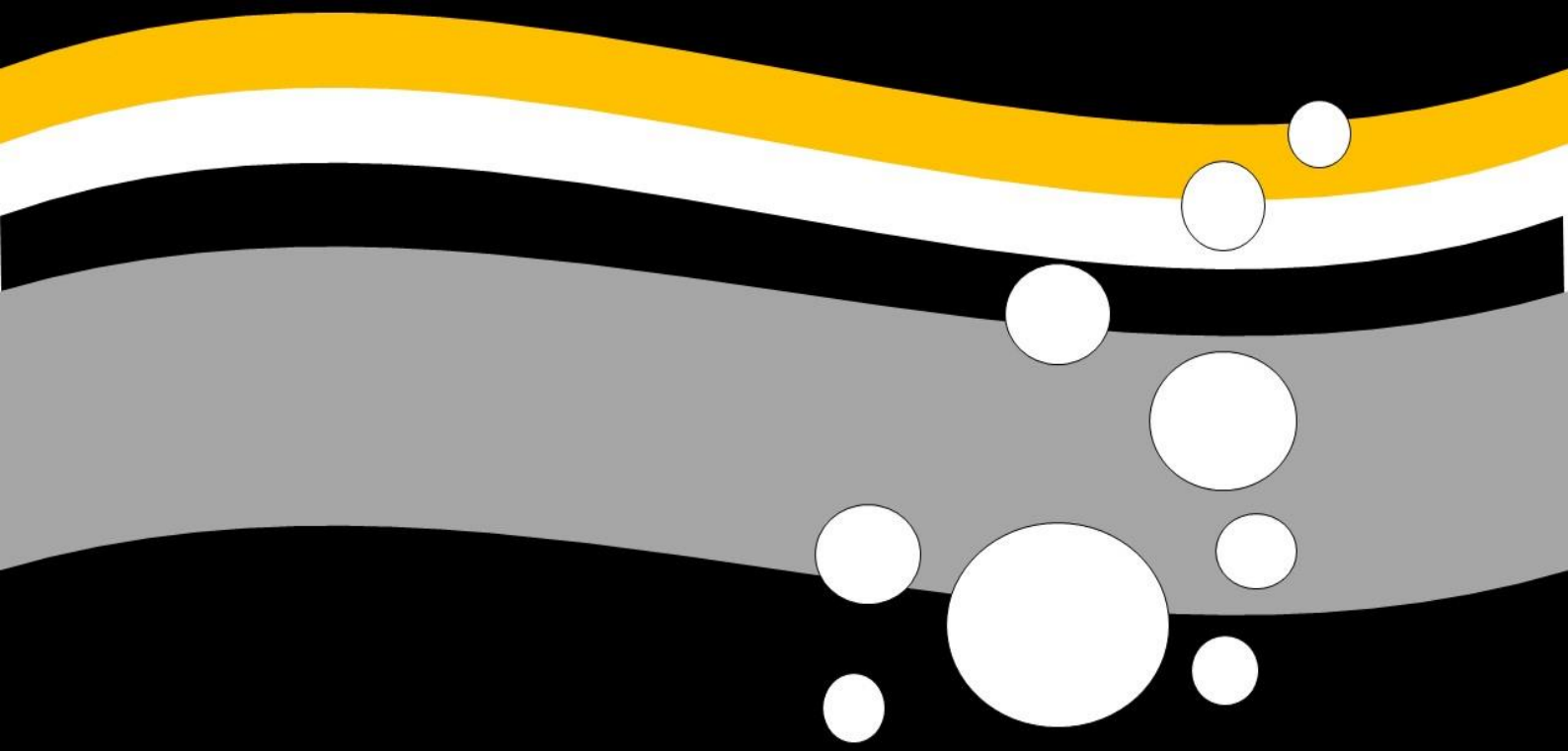

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FOREWORD

By Ben Gowland, Director and Principal Consultant - Ockham Healthcare

What is really going on in general practice?

That was the question to which I wanted the answer when I left my previous role as Chief Executive of the local Clinical Commissioning Group. I had heard the noise coming out of General Practice, and I wanted to understand what it was all about.

To find out, I visited a number of GPs I knew. First, I went to the surgery of Dr Tom Evans, a GP in Northamptonshire. He is bright, motivated and extremely popular with both colleagues and patients. I asked him what his life as a GP was like.

What I heard was alarming. Tom's day starts at 6.30 in the morning. He personally undertakes as many as 150 telephone calls a day with his patients, as well as seeing many face to face. He alone has the responsibility for the practice. Once the doors close to patients at 6.30pm he gets on with the growing bureaucracy that now comes with running a practice. He gets home after 10pm most nights.

Most of us might imagine the financial rewards for this hard work would cushion any pressures he felt. But then he told me about how the practice was doing as a business. The surgery had been crippled by expensive locum fees for doctors because, despite advertising five times, they could not recruit to the vacancy they had. Ultimately he paid exorbitant fees to a recruitment agency to secure someone. The surgery was, in Tom's words, "*maxed out with the bank*", and he was having to see his bank manager every two weeks. This meant he had to pay himself less, just to keep the surgery going.

But maybe Tom was a one-off. Maybe his situation was unique. I couldn't imagine many would put up with that kind of continual pressure.

It turned out I was half right. While Tom may have been unusual in his optimism in the face of adversity, his situation was not. I visited another Northamptonshire GP, Dr Rick Byrne. Rick told me frankly he had had enough. At 57 he had made the difficult decision to retire on his next birthday. It was clear from speaking to him the pressure of dealing with the ever-growing workload was taking

its toll. And he is not alone; over a third of GPs now describe their current workload as "*unmanageable*".

> ***…The crisis in general practice is real…these case studies have made the biggest difference to general practice…***

The crisis in general practice is real. GP Practices like Tom's and Rick's need help. I had found the problems. Now I needed to find the answers. I wanted to find out how these challenges had been met in practice in different places across the country.

What I discovered was incredible. I found individuals, practices and whole systems of care prepared to share openly how they have overcome their own specific set of challenges. Rarely did they seem to understand the magnitude of what they had achieved, but they all wanted to do what they could to make it easier for others about to tread the same path. In this book we have tried to capture their stories. This book is a collection of case studies that have made the biggest difference to general practice. It aims to share the opportunities they found, the difficulties they encountered, and the lessons they learned. GP practices like Tom's and Rick's need help to make changes to meet their own challenges, and learning from the experience of others is a great place to start.

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ABOUT THIS BOOK

This book has been designed to enable you to find the most relevant case studies for you. The case studies are organised into four sections:

1. Introducing new roles (pages 15 – 34)
2. Operating at scale (pages 35 – 56)
3. New models of care (pages 57 – 83)
4. CCGs and General Practice (pages 85 – 104)

These areas offer the greatest opportunity for general practice to transform itself and meet the challenges it is facing. The case studies that have made the biggest difference all sit in one of these four areas.

In addition to the details of the individual case studies we have included analysis of each of these four areas, and established transferable lessons to help you apply the learning locally.

Whilst some may choose to, the book is not designed to be read from cover-to-cover. For time-poor practices we have made it as simple as possible to find the case studies most relevant to you, and access the transferable lessons easily and quickly.

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INTRODUCTION

THE CHALLENGE OF MAKING CHANGE HAPPEN IN GENERAL PRACTICE

Making change happen in general practice is not easy. Little has really changed in general practice since the inception of the NHS in 1948. But for a profession that recognises it is in crisis, change is now essential.

There are no golden bullets. But those looking for solutions can start in two places to ensure the actions they take have the highest chance of success: start with the problem you are trying to solve; and learn from what others have done.

Start with the Problem

Many practices now identify the growth in workload as the single biggest challenge they are facing as a practice. For many it has reached unmanageable levels. It forms an inevitable context for any innovation in general practice.

General practice conducts 90% of patient contacts in the NHS. There have been dramatic demographic changes in recent years, with the population ageing and growing. A 2015 BMA document[i] states, "*GPs and practices are under unprecedented pressure. There are about 340 million consultations annually in general practice in England, an increase of 40 million per year from five years ago. This represents the single greatest rise in volume of care within any sector of the NHS.*"

Waiting times are going up, and as they do pressure on GP practices builds. The RCGP identified on 67m occasions in 2015 patients waited more than a week for an appointment with their GP or nurse. In 2014-15, 27% of patients reported it was not easy to get through to the GP practice on the telephone, compared with 19% in 2011-12[ii].

In a 2015 BMA survey 71% of GPs identified workload as the top factor negatively impacting on a career in general practice, and 93% said their workload has negatively impacted on the quality of care given to patients.

The extent of the rise in workload, coupled with the recruitment challenge general practice is facing, means even for those practices who have optimised their internal systems more transformational change is required. Demand is going to continue to rise.

Our analysis, based on the changes that have had a significant impact, is there are three main transformational options available to GP practices. These are not mutually exclusive, and indeed where implemented together are often found to be supportive of each other. These options are to:

- Introduce new roles to general practice and move to more multidisciplinary working
- Operate at greater scale by working in partnership with other practices
- Build supportive and effective partnerships with other organisations across the local health and social care system, and develop new models of care

Consequently, we have grouped the case studies within this book around each of these areas. In addition, while many GP practices find themselves alone in tackling their challenges, there are examples of places where changes led by CCGs have been extremely helpful. We have therefore included a fourth area of CCG enabled change.

Transformational change is required in order for general practice to emerge from the crisis it is in, and for GPs to once again to be able to cope with their workload. The case studies show change is possible, it can make a genuine difference, and it is often within the gift of practices themselves to make it happen.

Learning from Others

In our case studies it was not just the change itself that was important. Often more important was the way the change was carried out. In none of our case studies were attempts made to force general practice to change. A different approach was adopted.

The approaches used had common characteristics. We consistently found local leadership that inspired those working in general practice to believe change for the better was possible. The group interest of general practice, and its ability to serve its local populations, was consistently set as the priority, as a means of stimulating followership. Change started with and built on the values, ideals and needs of general practice. And there was a focus on innovation, on doing things differently and doing different things, rather than the execution of someone else's plan that no-one believed would work.

> ***…locally-led change, focussed on listening, collaboration and leading by example, can make a difference …***

At Our Health Partnership (*Case Study 6; page 38*), the new "super-practice" formed from 32 previously existing practices in Birmingham, the member practices were inspired by the vision presented to them and committed to the new model. They dissolved their old partnerships and created a new one. It is working because the organisation has created trust between the leadership and the members, because its primary focus is on the needs of the members, and because it is striving to deliver on its promise that the benefits of operating together at scale will outweigh the loss of independence and start-up costs. It is general practice changing itself.

This does not mean super practices are the "answer" to general practice. But it does mean locally-led change, focussed on listening, collaboration and leading by example, can make a difference.

The way out of the current crisis is not by starting with the answer. Imposing change on general practice will make things worse. But sharing new ideas and new ways of working, actions that have worked in other areas, and enabling and empowering GP practices to transform themselves, is the most likely route through today's challenges.

We don't underestimate the challenge of making change happen in general practice. This guide will not make it easy, but may make it easier. We have used real life case studies, examples of what different places up and down the country have actually done, to demonstrate the options open to practices, and provides practical tips for implementing these changes in your own practice or area. We hope it helps.

SECTION ONE:

INTRODUCING NEW ROLES

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INTRODUCING NEW ROLES - CASE STUDIES

CASE STUDY 1: Solutions from Sussex – Creating a GP practice team of paramedics

SUMMARY

- **Newton's practice in Haywards Heath has employed a team of 3 paramedics which has transformed the way the practice manages on the day demand**
- **The team can effectively triage all on-the-day demand and relieve duty doctors from seeing a significant proportion of urgent patients**

INTRODUCTION

Charmi Rogers began her career working in patient transport before progressing to become a paramedic and ultimately a Paramedic Practitioner. As part of her practitioner course she undertook an eight week placement at Newton's Practice, a large GP surgery in Haywards Heath, West Sussex. Once qualified the same practice offered Charmi a job.

PARAMEDIC PRACTITIONER

A Paramedic Practitioner is a paramedic with extended skills. The additional qualification comes via a two year Bachelor of Science course resulting in a degree in Healthcare Practice. The Practitioner specialises in in-depth patient assessment, minor health issues and minor injuries and works under patient group directives for the supply of prescription-only medicines. They work autonomously, within their scope of practice.

WHAT DOES THE PARAMEDIC PRACTITIONER DO?

Charmi began her placement assessing patients alongside the practice's nurse practitioner or duty doctor. She also undertook telephone triage and then, once established, was given clinics of her own, seeing patients with minor health problems (e.g. ears, coughs, sore throats).

Over time Charmi has developed a small team of paramedics who now triage all patients who ring the practice looking for appointments on-the-day. The paramedic team then make a decision on whether the patient needs a GP appointment, whether they can be seen in the paramedics own urgent care clinic or whether the issue can be dealt with over the phone. They have access to input from the duty doctor. The paramedic team also undertake home visits.

The paramedic practitioners also work alongside the practice's Care Co-ordinator and are able to support the practice in keeping frail people in their homes. This includes telephone support for recently discharged patients and enabling longer appointment times for patients who are over-75.

IMPACT OF THE ROLE

The GPs in the practice feel the Paramedic Practitioner is now an indispensable part of the practice team, so much so that they employed two further, part-time, paramedics to support Charmi's role. This ensures there are always two paramedics on duty.

The impact on the duty doctors and nurse practitioners has been considerable with on-the-day demand not such a big issue in the practice as it is elsewhere. This is as a result of the paramedic team relieving pressure by dealing with all urgent calls and seeing all of the minor health issues and the "worried well".

The opportunity to develop in general practice and to practice autonomously has also had an impact on the practitioners themselves,

building confidence, retaining skills and giving additional career options for paramedics outside of the traditional ambulance service route.

LESSONS LEARNED AND OTHER ISSUES

The practice team needs to be forward thinking and welcoming of new roles in order to create an environment where the practitioner can develop their skills and make an effective contribution. They need a clear vision of how they wish their urgent care to be run. This also requires a recognition that the paramedic who is shifting from ambulance work will be moving from a very different environment. Careful consideration of the role, of induction and continuous development is essential.

As with all practices the quantity of telephone calls (particularly during the winter months) is considerable – the practitioner is often dealing with 70-80 a day. This makes it difficult to balance this demand with the need to run clinics.

Because paramedics operating in general practice is relatively new, gaining indemnity insurance is still a potential issue and requires practitioners to “shop around”.

CASE STUDY 2: Pharmacy to the fore – Pharmacists (and pharmacy partners!) in GP practices

Insights from Ravi Sharma and Karen Acott, both pharmacy partners in GP practices.

Karen Acott became the first pharmacy partner in general practice in 2004 and is now Chairman of an 82-practice GP federation in Devon. Ravi Sharma is a leading national figure in the development of the role of pharmacists within GP practices.

Both believe employing pharmacists in GP surgeries should be central to a practice's business model; recognising both the pressures placed on practices (including on-the-day demand and difficulties with GP recruitment) and a relative over-supply of pharmacists. They believe a career for pharmacists in general practice is the future.

Practices should begin, Ravi says, by developing a business case which addresses the areas where pharmacists can reduce pressure on GPs, improve access and quality of care, bring in additional revenue and make savings for the practice and the wider NHS. Karen adds practices need to clearly define what outcomes they want to deliver and view the addition of a pharmacist to the practice as introducing a different skill set – rather than simply plugging a gap.

Primary care pharmacists can take on a large workload from GPs including:

- repeat prescribing
- home visits
- on-the-day appointments
- dealing with clinical mail
- managing QOF
- managing prescribing incentive schemes
- helping with CQC work
- and mentoring junior staff (pharmacists, nurses and medical students)

The benefits of employing a primary care pharmacist in a practice include:

- an increase in QOF revenue
- clinics run by pharmacists including those for patients with long term conditions
- patients called in for reviews
- the promotion of self-care
- additional services (and income streams) taken on by a pharmacist that the practice couldn't take on due to lack of capacity

In Ravi's experience the pharmacist pays for itself and the model he has developed is running effectively in 20 practices. Karen adds practices should see employing a pharmacist as an investment for the future; as part of an overall future staffing strategy including succession planning.

Pre-requisites for employing a primary care pharmacist in general practice include:

- An open culture which is willing to recognise all skills and talents
- Freedom for the pharmacist to make a clinical contribution
- Education for staff and patients about the role of the pharmacist
- A collaborative approach to delivering clinical services
- Sufficient time, training and support to ensure the pharmacist can appropriately develop their scope of practice, including becoming an independent prescriber wherever possible

Ravi was involved in the pilot scheme commissioned by NHS England to provide clinical pharmacists in general practice, which was formalised in the GP Forward View.

He believes there is greater scope for the integration of community pharmacists and practice pharmacists which should be underpinned by full access to medical notes. He believes this could relieve pressure on general practice if community pharmacy could take on some of a GP's work in prevention, screening for long term conditions, public health etc. Karen sees hope that the Primary Care Home model will identify new roles for community pharmacists as major players in system integration.

A Guide for GPs considering employing a practice pharmacist produced by the RCGP and PCPA can be found at http://pcpa.org.uk/assets/documents/gp_guide.pdf.

CASE STUDY 3: Hands-on in Hampshire – in practice physiotherapy assessment

SUMMARY

- **A "first contact" extended role physiotherapist in general practice provided assessment and triage for musculo-skeletal patients without the need for GP referral**
- **As a result GP workload reduced, patients received more appropriate treatment more quickly and there was a reduction in onward referrals, diagnostic tests and prescriptions**

INTRODUCTION

Neil Langridge is a Consultant Physiotherapist working in general practice in South Hampshire. As part of a local "Vanguard" Neil was approached by a local lead GP to develop a first contact musculo-skeletal practitioner model within his practice. In effect this involved moving the extended practice community physiotherapy role Neil was already undertaking into a GP practice. A "first contact" physiotherapy role is one where a patient sees Neil directly without needing a GP referral. Neil remains employed by the Community Trust and is funded by Vanguard monies.

WHAT DOES THE ROLE ENTAIL?

Neil does not provide direct therapeutic physiotherapy and rehabilitation. His role is to offer a musculo-skeletal assessment and triage process similar to the common orthopaedic triage model - but operating in primary care.

Referrals to Neil can result in a number of outcomes, the most prevalent of which is where he offers advice and guidance to patients. Neil can also provide corticosteroid injections or a range of radiological referrals. He can also refer onward to services such as physiotherapy, podiatry and orthopaedics as appropriate.

In fact, Neil's referral rates to other services are quite low. He uses a number of strategies to allow patients to self-manage including information sheets and referrals to approved websites.

Neil sees 12 patients a session in one long session and is currently looking at introducing a further three sessions.

THE IMPACT OF THE ROLE

Neil's role has led to a reduction in the GP workload and a clearer understanding of the allocation of work between GPs and the physiotherapist. Over eight months he has seen 300 patients and many of these patients would previously have seen a GP (not all, as some patients inevitably do see a GP first before they are referred to Neil). He sees a number of patients he feels don't need to see him, let alone a GP.

Patients are now receiving a timely, appropriate specialist assessment. Frequently in the past they would have to undergo a range of different assessments which could often lead to them embarking on inappropriate pathways. Demand for Neil's service is strong and growing. A wait for Neil may be a week but most patients are prepared to wait knowing that to see a GP and then be referred to Neil in the community might take up to six weeks.

In time Neil believes he will be able to record a reduction in referrals to other services (in particular orthopaedics), a reduction in unnecessary diagnostic tests, less prescriptions and a greater demand for local

leisure centre activities and rehabilitation programmes.

There has been a "community medicine" element to the role with patients spreading the news about the self-management tools, and Neil has noticed an increase in the number of patients who self-refer because of the experiences of a family member or friend.

He believes his success comes partly from the fact he has 20 minute slots with patients and can focus on the single presenting issue.

Neil has developed a new-found respect for GP referrals. As a physiotherapist he received referrals which seemed lacking in detail, but having assessed patients in primary care with complex co-morbidities he says he now understands why that might be!

LESSONS LEARNT

Neil is an extended scope practitioner but this is not essential to the role. In the county there are other physiotherapists without the extended role who are able to make triage decisions with support from extended scope practitioners. It is a question of using the skills which are available with a view to developing the extended role over time. However, he warns against training too many extended scope practitioners and suggests a range of skills are needed as the largest demand amongst these patients is for advice and guidance only.

Neil is not currently an independent prescriber but training for physiotherapists is available. However, if patients need changed medication Neil e-mails the duty doctor and a prescription is left out for the patient. Neil is able to advise patients on more effective use of the limited range of medications which most musculo-skeletal patients require.

Neil has discovered that, in the main, patients will self-triage and refer themselves appropriately to him once they know the service exists.

Neil advises developing these roles in partnership with the local community trust rather than separately. Physiotherapists are unlikely to move *en masse* into isolated roles in general practice and will want to retain their role in the community services team as it provides them with professional clinical support.

Any practice who is considering working more closely with a physiotherapist should contact their local physiotherapy management team or approach the Chartered Society of Physiotherapy (their website is available at http://www.csp.org.uk/).

THE FUTURE

The increase in Neil's clinics from one to four (as part of the Vanguard model) will include a session in the new Primary Care Centre, a collaboration between local GP practices and the local community hospital. All GP practices in the area will be able to refer patients into this additional practice and access Neil's service.

Neil sees a greater role in future for physiotherapists in general practice with a small group of practices sharing the limited resource, supported by improved technology. Some areas have difficulty in recruiting physiotherapists but work is currently being undertaken in Southampton to assess whether the population of private physiotherapists might undertake some clinics in GP practices.

A further sum of money is being made available to South Hampshire by Health Education England to run additional clinics for a year to allow HEE to assess the competences and training needed to roll-out the Consultant Physiotherapist role across the country.

CASE STUDY 4: Developments in Devon – creating a duty team of a pharmacist, a paramedic and an ANP

SUMMARY

- **Employing other professionals in a practice with problems recruiting GPs has had a major impact on on-the-day demand and has led to one third of all patients being seen by a pharmacist, paramedic or advanced nurse practitioner rather than a GP**

INTRODUCTION

The Beacon Medical Group was formed in April 2014 from the merger of three South Devon practices. The organisation has 33,000 patients and 20 partners. Although the GP recruitment crisis has come later to this part of the country the pressures felt across primary care are becoming more prevalent.

The Beacon Medical Group has been successful in recruiting a duty team in one surgery consisting of a pharmacist, a paramedic and an Advanced Nurse Practitioner (ANP). This team has reduced demand on the duty GP by over one third and eliminated the need for 11 sessions of salaried GP.

PRACTICAL STEPS

Employing a pharmacist

Because of the struggle to recruit salaried GPs and the increase in on-the-day demand the partners at Beacon Medical Group were open to alternatives. In 2014 they had accessed part of the Prime Minister's Challenge Fund (PMCF) for improving GP access and appointed a part-time pharmacist in October of that year.

Despite some reservations from partners the pharmacist quickly established himself as an invaluable member of the team and, even though the PMCF funding ended, was appointed full time by the Group in May 2015.

The pharmacist runs his own clinics, delivers in-house training in practice meetings, has helped introduce electronic prescribing, tidied up repeat prescribing, and conducts quality audits and medicines optimisation work.

The practice believes he has more than paid for himself with additional income earnt and quality improvement delivered. Medicines optimisation income partially funds his salary but he and his team are able to offer more appointments more quickly than a salaried doctor could at the same cost.

Employing a paramedic

The success of the pharmacist appointment and the inability to fill salaried doctor sessions led to further consideration of a complementary role to join the team.

One of the GPs had met a local paramedic employed by the local Ambulance trust, after the paramedic had seen two of the GP's patients. He was impressed with the way he had safely managed a difficult clinical/domestic situation. He was struck by his enthusiasm, and by the way he worked within his boundaries, appropriately dispensing medication through a patient group directive.

The practice ended up using the funding for the salaried GP sessions to employ the paramedic in July 2015. He now sees on-the-day patients in surgery, takes telephone calls for urgent problems and carries out urgent home visits. He is also resuscitation officer and a lecturer at the local university advanced paramedic course which leads to placements for students in the practice in return. His role is still developing.

Employing an Advanced Nurse Practitioner

To complete the team and balance the skill set, the Group recruited an ANP to have a more clinically based member to support the others. The ANP has a different skill set including the rapid assessment of patients as well as clinical skills in the areas of women's health, contraception and diabetes. These skills are complementary to the minor injury/illness skill set of the paramedic and the medicines, long term conditions and minor illness skill set of the pharmacist.

BENEFITS OF THIS APPROACH

This new duty team has had a major impact in on-the-day demand and has reduced the need for eleven salaried GP sessions (about 8% of the overall GP sessions for the Group).

Over one third of patients in that surgery are now being seen by the other clinical specialists.

The team are also meeting unmet need by providing increased access to urgent advice and assessments e.g. for contraception.

The duty team are reducing the acute burden of work for the GPs and the Group hopes this will lead to the opportunity for GPs to spend longer with the patients with more complex needs.

LESSONS LEARNT

There is a need to be open minded and less protectionist about having allied health professional roles in primary care.

The GP who led on the formation of this team recognised appointing these roles required a "*leap of faith*". In order to demonstrate his own faith in the team he moved his base to work at the site where the team was established.

Employing a pharmacist was seen as a "*quick win*" (either part- or full-time, for an individual practice or shared between practices) because the role paid for itself.

Picking the right person was fundamental to the success of the team i.e. motivated, enthusiastic, team players and good communicators; and those comfortable in managing risk in primary care and prepared to learn and develop in the role.

The Group found it was very important to support the team into their new roles, running joint clinics with GPs initially, offering protected learning time, feedback and a development plan based on a training needs assessment.

CASE STUDY 5: Chesterfield Challenge - 4 ANPs, a pharmacist and a CPN in one practice

SUMMARY

- **A GP practice in Chesterfield that lost ten GPs has successfully employed 4 ANPs, a pharmacist and a CPN to provide patient care previously provided by GPs**
- **In doing so they have improved patient access, patient satisfaction and staff morale**

INTRODUCTION

Blue Dykes and Grassmoor Surgeries in Chesterfield provide GP services to populations of 10,000 and 1,700 respectively. Deprivation is higher than average, with high unemployment. The surgeries serve a large number of elderly people. Incidence of chronic disease and depression is high.

Despite the loss of ten GPs over the last two years, the practice has managed to improve access, staff morale and patient satisfaction by employing alternative specialists.

WHAT PROBLEM IS BEING SOLVED?

Two years earlier the practice had nine GP partners (full- and part-time) and four salaried GPs. Following retirements and resignations they were left with just two partners and one salaried GP and a reliance on locums and agencies. Staff morale inevitably suffered and patient satisfaction dropped. Poor access was often cited as the main issue in patient complaints. The two remaining partners were working unsustainable hours and, although they had some success in recruiting, they couldn't retain GPs because of the resultant pressures.

WHAT APPROACH DID THEY TAKE?

After 6 months of fruitless recruitment the GP Partners met with the practice manager and agreed to look at a more radical alternative. They decided to appoint an Advanced Nurse Practitioner (ANP). The practice manager had experience of a drop-in centre staffed by ANPs and both remaining GP Partners had worked with ANPs in the out-of-hours service.

They employed their first ANP and found the role fitted in very well so began looking for more. They now have four ANPS. When the success of this model became clear they identified other areas where clinical specialists other than GPs might be able to see appropriate patients. They have gone on to recruit a pharmacist (who leads on all medicines matters) and a Community Psychiatric Nurse (CPN).

PRACTICAL STEPS

The ANPs, the pharmacist and the CPN all run their own clinics. The ANPs see most patients apart from young babies and some patients with gynaecological problems. The CPN sees all patients with mental health issues (GPs had previously recognised they were seeing an increasing number of patients with depression in each clinic).

Three out of the four ANPs are prescribers. They can refer, order and review tests and undertake telephone appointments. They also carry out around 70% of the home visits. The GPs visit palliative care patients and undertake the more complex home visits.

The ANPs now see more patients than the GPs.

The pharmacist has taken the lead on anything to do with medicines and runs her own clinics.

In parallel with these changes the practice also increased the administration team

because of the rising administrative burden on GPs. They now have specific prescription clerks ensuring continuity, and a "letter triage team" who filter all post coming into the practice and ensure GPs only have to deal with the mail they need to see.

Previously communication in the practice had been on a "need to know" basis and dominated by regular partner meetings. They now have business meetings twice a month with a representative from all groups including ANPs, practice nurses, the CPN and the administration staff. They find this approach ensures all new ideas can be made to work for all members of the practice team.

Training for the new ANPs was undertaken by the GPs and the more experienced ANP including a minimum two weeks induction working alongside the GPs. On any given day the GP on duty will leave some short empty slots so they can be available to the ANPs if necessary.

The administration staff quickly became experienced in understanding how the different clinics are run and therefore when a patient calls in they can easily match the patient to the appropriate clinic.

BENEFITS OF THIS APPROACH

Access has approved. They are now able to offer 2 week advance appointments, next day appointments and a "pool" system each day. This is something like a "sit and wait" model but with given times. The clinicians on duty (GP, ANP or CPN) decide who is most appropriate to see which patient from the "pool".

As well as creating more sustainable working patterns for the GPs and interesting career development for the other specialists, life has improved for the administration staff who are no longer abused on a daily basis as they had been six months earlier. Patient feedback has also improved.

The CQC made very favourable comments about the model on a recent visit and the practice reputation has improved immeasurably with partners and the CCG.

LESSONS LEARNED

Recruitment to the new roles needs to take place over a period of time rather than all at once. The GPs could not have coped with teaching all four ANPs at the same time.

Many patients were initially wary of seeing "a nurse" so the surgery now refers to ANPs as Clinical Practitioners to distinguish them from practice nurses. Once patients have met the new practitioners they invariably request future appointments with them.

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INTRODUCING NEW ROLES - ANALYSIS

BACKGROUND AND CONTEXT

There is currently a GP workforce crisis. At least 8% of all GP jobs are now vacant nationally, and according to the 2016 BMA GP survey 46% of practices report they have GPs who are planning to retire or leave the NHS.

The Government has promised 5,000 more GPs by 2020. However, 1 in 3 GP training posts remain unfilled, and applications for GP training posts were 6.2% lower in 2015 than they were in 2014, despite a focus on general practice. The RCGP estimates an additional 10,000 GPs need to be recruited and trained to accommodate the workload shift from secondary care.

Even if the recruitment of additional trainee GPs is successful, the impact will not be felt in the near future. As a result, GP practices up and down the country are looking for alternative solutions to bridge these gaps, to make working lives in general practice more sustainable and to protect the delivery of high quality patient care.

INTRODUCING NEW ROLES TO GENERAL PRACTICE

In their report[iii] the Primary Care Workforce Commission identified the introduction of new roles as a potential solution. They said,

"There are many opportunities to change practice skill mix and staff roles. These changes can help address workload issues, improve the patient experience and sometimes deliver savings…There are particular opportunities for different staff to manage minor illness, to work with patients in the management of their long-term physical and mental conditions, to undertake medicines optimisation, and to care for children and young families."

Many practices have successfully filled gaps in GP recruitment by reviewing their skill mix and employing other healthcare professionals. This broader skill mix has seen the employment of, amongst others:

- Pharmacists
- Physiotherapists
- Paramedics
- Nurse Practitioners
- Healthcare Assistants
- Physician Associates
- Community Psychiatric Nurses
- Social Workers

By recruiting these other disciplines (and by using existing staff differently) practices have been able to dramatically impact on GP workload and improve access for patients. The roles and responsibilities other healthcare professionals have taken on include:

- Running their own clinics
- Dealing with telephone appointments
- Taking on visits
- Developing and running new services
- Pursuing opportunities to maximise income

NEW ROLES ARE TO ENABLE CHANGE, NOT REPLACE GPS

There has, however, been resistance to the introduction of these new roles. This is generally based on a misunderstanding that the purpose of these roles in general practice is to replace GPs.

GP practices need to be able to recruit GPs to fill the vacancies they have, and to avoid the financial burden of dependence on high cost locums. But practices with a full establishment of GPs still have a workload that is becoming increasingly unmanageable, and are also facing financial challenges as income has fallen and costs risen over recent years. They cannot afford more GPs beyond those they have funding for.

There is a narrative that says, "*We can't find the extra 5,000 GPs we need, so we need to consider other roles*". The GP Forward View puts the development of new clinical roles alongside renewed efforts to attract and retain more GPs. The Primary Care Workforce Commission report makes the case for individual professions being involved in general practice almost on a case-by-case basis.

> ***…the pressure on practices is essentially one of unmanageable workload on a daily basis…***

As a result, the message some GPs have heard is that somehow lesser trained, lower paid clinical professionals can carry out the work of a GP. And, rightly, they react to it. But this is not why new clinical roles are needed in general practice.

The pressure on practices is essentially one of unmanageable workload on a daily basis. The staff, clinical and non-clinical, cannot cope with the work that is presenting. This feels like not enough appointments to the receptionist trying to calm down vociferously angry patients, knowing they do

not have a single slot to offer them. It feels like not enough GPs to the doctors working 13, 14, 15 hour days just to keep up. All the time the message is "…*the workload is not manageable*".

This is key. If the workload has risen, and capacity (in the form of the number of GPs) cannot be increased to meet this demand, something has to change.

> ***…the question is not "can other clinical specialities carry out the role of a GP…***

The GP practices most on top of this are the ones who have changed the way they tackle the growing demand. Some practices, like our case study from Newtons Practice in Haywards Heath (*Case Study 1; page 18*), have introduced a whole team of paramedics to manage presenting demand in a different way. Some practices, like our case study from Beacon Medical Group in Plymouth (*Case Study 4; page 24*), have brought in multi-disciplinary teams of advanced nurse practitioners, paramedics and pharmacists. They have created an in-house "urgent care centre" to manage the telephone triage and act as the front line for the practice.

The question is not, "*Can other clinical specialties carry out the role of a GP*?". The aim is not to ask under-trained or under-qualified staff to take on a role that requires the skills and training of a GP. Rather, the questions are:

- *How can we meet the challenge the new profile of demand presents for our practice?*
- *How can we re-shape the way demand is managed, using the skills, experience and expertise of other staff groups that are uniquely placed to do this?*
- *How can we make best use of the GP time we do have, while still meeting the needs of our population?*

If the aim is simply to replace "missing" GPs with other staff groups, then attempts to introduce these staff groups to general practice may well negatively impact upon the service practices can offer. But if the aim is to redesign the model of general practice to better meet the shifting pattern of demand, then new roles can have a transformative effect on everyone working in a GP practice, and for the patients they serve.

INTRODUCING NEW ROLES: 10 PRACTICAL STEPS FOR GP PRACTICES

The following steps are a synthesis of lessons from our case study practices:

1. Be open minded about the use of other professions and prepare your practice for their integration into the team. If necessary, change practice meetings and communications systems to welcome new members. For instance, open partner meetings to individuals or representatives from the new professions.

2. Start from the person and their "fit" with the existing team rather than necessarily focussing on a particular profession. Most of our case study practices were opportunistic in approaching an individual who they knew or had worked with in the past, irrespective of whether they were a pharmacist, paramedic or ANP. All said choosing the right personal qualities was as vital as the right clinical competencies. They looked for good communicators, enthusiastic team players, individuals with a desire to develop the new roles and those comfortable in managing risk in primary care. One of our case studies found it easier to "sell" the concept of these new ways of working to reluctant partners because the individual was already well known and demonstrably complemented the existing team.

3. It may be necessary to take a "leap of faith" in appointing an allied health professional, and a lead GP should be identified to oversee their integration, including providing induction, training and clinical support. One of our GPs, for instance, moved his base to a different practice to oversee the development of a new team as a demonstration of his commitment. The return on investment may not be immediate but all of our case studies felt the new posts paid for themselves in improved access, additional income, improved quality of care and/or a more sustainable workload for GPs.

4. Look for roles which complement the existing team and then determine the availability of each (e.g. there is currently a relative over-provision of trained pharmacists). As each team member joins, continue to build the team around these skills. For instance, Beacon Medical Group (*Case Study 4; page 24*) first employed a pharmacist (with long term condition management skills), then a paramedic (with minor injury skills), and then set out to find an Advanced Nurse Practitioner who could complement these skill-sets with the rapid assessment of patients.

5. Determine very carefully what the practice is trying to achieve and use this in recruitment. Competition for allied health professionals is increasing and practices able to describe a clear and compelling reason why a new recruit would want to join them are more attractive than those simply "wanting to survive" or "filling some sessions left by a vacancy".

6. Focus on retention. All of our case studies recognised recruitment does not stop once the individual is in post and retaining staff once they are recruited is just as important. All have made concerted efforts to ensure their practice is a great place to work by creating new posts that are flexible, well-supported and developed, are an integral part of the team and are closely tailored to the skills and needs of the individuals. Our case study practices report

> ***…it is vital to assess the training needs of the new appointees and implement a personal development plan…***

these factors are more important to retention than the basic elements of employment like salary and annual leave.

7. Don't overburden the existing team by employing a number of new roles all at once. Our case study GPs found it better to stagger new appointments so they could invest sufficient time in induction before welcoming the next individual.

8. As many of these roles are fairly new to primary care, it is vital to assess the training needs of the new appointees and implement a personal development plan. Our case study practices, for instance, found it useful to have some clear agreements with their allied health professionals around scope of practice. Some initially ran joint clinics with their GPs and the other professionals, offered protected learning time and/or kept some free slots each day so GPs could offer mentoring or advice.

9. Consider working more closely with other practices, e.g. in federations, as this can make the introduction of new roles easier. Larger groups or organisations are better able to accommodate flexible working needs, and can tailor roles to suit the needs of individuals. Smaller practices can find it difficult to create the funding necessary to trial new roles in the practice. Working with other practices means these costs can be shared and the risk minimised.

10. Collaborate with other organisations. Partnerships with other organisations can provide staff from a range of different roles that can support general practice, for example extended scope physiotherapists or community psychiatric nurses from the local community trust, or paramedics from the local ambulance trust. In our case study from South Hampshire (*Case Study 3; page 22*), Southern Health provided the extended scope physiotherapists to work in general practice. Partnerships with these organisations can enable attractive new roles, or development opportunities, for existing staff to be put in place.

There are also many other resources available[iv][v][vi][vii] that offer GP practices advice on the introduction of new roles.

3 TOP TIPS TO SUPPORT THE RECRUITMENT OF GPS

While introducing new roles can transform a GP practice, they do not negate the need for GPs. National work is underway to increase the supply of GPs[viii]. But for individual GP practices today, there are no easy answers to the challenges of GP recruitment. We gleaned some lessons from those we spoke to about the approaches to GP recruitment they had found most useful. These are listed below.

1. **Change your approach**. If the current approach of advertising for a GP is not working, explore different avenues. Continually trying the same thing over and over is unlikely to be successful. Adopting a different approach can set your practice apart. In an environment where there is a shortage of GPs it is important to be one step ahead. Trying different strategies to tackle the GP recruitment crisis can provide hope to staff who are overwhelmed by the current situation. Focus on the unique aspects of your practice and what makes your practice attractive, or consider 2 or 3 below.

2. **Work in partnership with other GP practices**. By working together practices can offer more flexible or part-time GP roles built around the needs of the interested GP, offer dedicated training and professional development, or create more attractive specialist posts. Combining rotas can enable leave to be covered more effectively, vacancies to be managed, and the prospect of working in the practice considerably more attractive. Larger federations are even considering the development of their own in-house pools of salaried doctors who can flex across different practices.

3. **Look at joint appointments with other organisations**. Working in partnership with other NHS organisations can help produce new or exciting roles which are attractive to GPs, for instance by working in tandem with secondary care to develop joint roles in delivering specialist services for GPs looking to specialise in a specific area, or developing a new joint GP role with the local community trust.

Our case study on local locum GP Chambers (*Case Study 16; page 94*) is also important in this context, as while it does not help GP recruitment to an individual practice, it helps with the availability of GPs to a given area, and both improves the quality and supply of locum GPs while keeping their cost under control.

SECTION TWO:

OPERATING AT SCALE

6

OPERATING AT SCALE – CASE STUDIES

CASE STUDY 6: Big in Birmingham – Our Health Partnership use scale to strengthen general practice

SUMMARY

- **Our Health Partnership (OHP) is a super-partnership of 32 practices with 150 partners, covering a population of 280,000**
- **Each practice retains its individual contracts, its own profits, and its own property and pays a fee which funds a central team of support**
- **Economies of scale include single HR, accounting, purchasing and legal support functions shared by the practices**
- **A local pool of salaried doctors is replacing ad hoc locum cover offering a substantive career option with full benefits and the opportunity to try out different practices**
- **The partnership is run by a Board of 7 elected GPs (accountable to the 150 partners) with a CEO, Finance Director and Operations Director**

INTRODUCTION

Our Health Partnership is a partnership of 32 practices in Birmingham with 150 partners. The 32 practices agreed to dissolve their existing partnerships and sign up to a new super-partnership that covers a population of nearly 280,000. Our Health Partnership (OHP) was established on 1st November 2015.

WHAT PROBLEM IS BEING SOLVED

Why a Super Partnership?

The aim of the new organisation is primarily to strengthen existing general practice. Locally most practices believe scale is necessary to strengthen and preserve the existing model of general practice. The majority of the early discussions focussed on overcoming misgivings about GP partners giving up enough control to be able to participate in the benefits, without passing total control to the new organisation.

As a result the model has been designed by the GPs to enable the existing partnerships to thrive with support from a central team, and so is still able to support the model of existing general practice. Each practice retains its individual contracts, its own profits, and its own property. By paying a fee (based on population size) it is able to participate in the benefits of the model at scale.

BENEFITS OF THIS APPROACH

What are the benefits of operating at scale?

OHP has identified a number of specific areas where the benefits of operating at scale can be delivered:

- Single accounting function across all member practices
- Single purchasing across all member practices
- Single legal support across all member practices
- Development of a pool of salaried doctors to replace ad hoc locum cover. Locums cost twice the amount of salaried doctors, with a combined spend across the practices of over £2M per year. A new pool of salaried doctors will be developed as a career option, offering substantive employment with study leave, career options, including allowing newly qualified doctors to test different local practices.
- Single HR function, including payroll, across all practices or across clusters of practices

- Single set of policies and procedures enabling regulatory requirements to be met, plus support with quality issues and preparation for CQC visits

What other benefits are there?

OHP also believes the new model will prepare general practice for the future, because:

- It provides a platform for local general practice to develop a multispecialty community provider (MCP), one of the new models of care, if it wishes to do so in the future
- It creates a voice for local general practice as a provider around the system leadership table, for when issues such as the development of the local Sustainability and Transformation Plan (STP) and the use of winter pressure funding are being discussed
- It enables local general practice to bid for and provide a wider range of services in the future if it chooses to do so
- It allows the organisation to have a stronger voice working with commercial partners in, for instance, introducing technology

PRACTICAL STEPS

How was it developed and how does it work?

The CCG played an important role in the early stages of development by facilitating meetings for practices to explore what could be achieved by operating at greater scale, and thinking through how it might work in practice. It came from a view the CCG held that larger groupings of GP practices are the way forward, but the CCG did not try to impose a model onto practices.

The partnership is, according to CEO Mark Newbold, underpinned by a *"…strong belief in locally autonomous, partner-based general practice."* The organisation is not a federation, it is a single legal partnership. However, the same partners that led and ran the previous 32 practices are still doing so, and thus contributing to a sense of continuity and local control.

The practices retain their own contracts (although these are held in trust by OHP) and practice numbers but bank accounts have been merged. This allows each practice to operate as individual profit centres and keeps the day-to-day decision making in the hands of partners and in accordance with the needs of local patients. Contract related returns, like QOF, still take place in individual practices.

OHP is run by a Board of 7 elected managing partners (GPs) supported by 3 officers: a CEO; Finance Director; and Operations Director. The officers are accountable to the elected partners. This Board is accountable to the 150 partners across the organisation, and OHP is exploring options for how this accountability can be exercised in practice (e.g. with a Board of Governors, akin to the Foundation Trust model).

Practices pay a membership fee (or levy) of £2 per patient, to fund the central functions. However, prior to the first year, practices were paying, on average, £1 per patient on accountancy fees. These fees are now included in the levy and so, in effect the "new" payment is therefore closer to £1 per patient. The procurement contract agreed by OHP with an external partner is expected to return another 20p-30p per patient in benefit, bringing the actual costs of the levy down to around 80p per patient. It is hoped over time the savings generated by the central team will be sufficient to cover all costs and that a fee will no longer be required.

Practices can choose to leave at any time, and specific arrangements for this have been worked out prior to practices signing.

Although there were, for instance, 32 practice managers on the day the partnership formed, clusters of practices are working together to look at the options of sharing some of these central functions.

KEY LESSONS

- Start by focussing on the potential benefits of operating at scale, and design a structure that can enable these to be implemented. Calculate the specific financial benefits that can be generated, e.g. the reduction in agency expenditure across all practices.
- However, don't try and sell the advantages of partnership purely on the financial benefits
- Spend time ensuring concerns about practices losing individual autonomy are addressed in an inclusive manner
- Ensure the model, in particular the governance, is developed collectively, to foster a sense of ownership across all practices
- Get the fundamentals in place quickly
- Leave issues, such as the development of new models of care and bidding for new contracts, as secondary to the prime goal of strengthening and supporting the existing model of general practice
- In order to obtain some of the economies of scale around shared functions – size *is* important. Smaller, locality based partnerships probably won't be able to afford high quality centralised functions.

CASE STUDY 7: Scale in St Austell – Merging the GP practices across a whole town

SUMMARY

- All of the GP practices in St Austell were brought together by the failure of one large local practice
- They merged and took the opportunity to radically reorganise the way GP services were delivered by splitting the provision of acute care from planned care
- They have set up an Acute Care Hub; GP-led but staffed by a multi-disciplinary team
- Working at scale has enabled them to ease their GP recruitment problems, create new and satisfying roles and begin providing more services by working as more equal partners with other organisations in the healthcare system

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INTRODUCTION

The St Austell Healthcare Group in Cornwall is a single GP practice formed from the merger of the town's previous four practices.

In August 2014 the largest of these four practices with 9,000 patients relinquished their GMS contract following a period of instability. The practice had been failing for some time and this had resulted in a large migration of patients to the other three practices causing them significant problems (one of the other three practices had grown from 5,000 to 9,000 patients in three years).

Once the practice had given its notice the remaining three practices met with NHS England and agreed to take on an APMS contract to try to stabilise and run the failing practice for a period of 12 months. However, after just a few months and following a damning CQC inspection it became clear recruitment to this practice was impossible (there were only 1 or 2 WTE equivalent GPs for 9,000 patients) and the deeper, underlying issues made it clear the practice was no longer a viable business.

WHAT APPROACH DID THEY TAKE?

Along with NHS England the remaining practices put together a plan to merge all of the practices in the town including the failing practice.

NHS England wrote to all of the patients of the failing practice to consult on whether they supported the merger, or whether they wanted the services put out to tender through a procurement process and to keep the surgery as it was. The vast majority of respondents were in favour of the merger.

The decision to merge rather than operate as a less formal federation was taken for two main reasons. First, because geographically, unlike most of Cornwall, St. Austell is an urban and densely populated area, it felt right to offer a single practice service. Second, the lessons from the failed surgery demonstrated just how fragile smaller practices potentially were.

The partners felt merging would deliver economies of scale that made business sense, while greater co-ordination of services made sense to patient care. It seemed ridiculous to them that whenever they visited a given nursing home they would meet colleagues from other practices in the town duplicating the same work.

AN ACUTE CARE HUB TO HELP MANAGE DEMAND

Once the merger was complete the new practice went straight into a radical redesign of the way GP services were delivered. They closed the failed practice, refurbished it and

opened it two months later as an on-call centre, which they call their Acute Care Hub. All of their calls are handled by the Hub which is open Monday-Friday 8am-8pm. They see all of their patients needing to be seen the same day at the Hub and all of their pre-planned care is seen at the other three surgeries.

The hub is staffed by a wide ranging, multidisciplinary team. Across the day there are 3 minor illness nurses who are triaging and seeing patients with minor illness. They also have an ANP who is an Emergency Care Practitioner who meets the demand by offering a flexible number of appointments and is also available to go and carry out emergency visits as needed. There is also a pharmacist who has revolutionised the efficiency and safety of their prescribing.

They also plan to run a pilot with a mental health worker who will be a member of the Community Mental Health Team seconded to the Hub to deal with any psychiatric crises that arise on the day.

Three GPs rotate through the Hub with one, in particular, providing a more sustained leadership presence. Each GP is in the Hub at least 3 times a week.

The practice consulted widely before implementing the change and used their active Patient Participation Group to engage with the local population - including explaining the concepts in the aisles of their local supermarkets!

They also employed a PR company to ensure the key messages were delivered locally.

WHAT HAVE BEEN THE BENEFITS?

The benefits of merging have included solving their recruitment problems. At the time of the merger the practices had 9 whole-time equivalents for 33,000 patients. One WTE GP taking sick leave would easily destabilise an individual practice. Since the merger they have been able to successfully recruit 3 doctors, 2 minor illness nurses, 2 nurse practitioners and a pharmacist.

They have been able to create specialist administration roles which are more attractive and relieve GPs of some of their work. The pharmacist now oversees a specialised prescription handling team and under his guidance the team is becoming expert at managing prescribing and prescriptions.

Their specialist call handlers are getting more experienced at dealing with callers and sign posting people to the right places. They have been surprised at the number of people in their organisation who have blossomed in the new environment, once given the opportunity to shine. Moving all the call handling to one site generated financial as well as operational efficiencies.

Access and waiting times have improved. The number of appointments they are able to offer has risen. The GPs feel the safety of the care they deliver has improved. The surgeries that deal with the more complex, pre-planned care have been able to lengthen their appointments to twelve and a half minutes and have been able to reduce their opening hours to 8.30am to 5.30pm.

They feel as a single entity they are better able to communicate with other care providers and integrate some services better. The merger has allowed them to begin looking at providing a wider range of services in conjunction with other partners. They are about to launch an ophthalmology service with glaucoma follow-up and macular degeneration injections. Patients with glaucoma who are mainly old and frail currently have to travel 15 miles to Truro and walk a long way from the car park to a busy Eye Department. In future they will be able to access this care locally.

WHAT LESSONS DID THEY LEARN?

In retrospect they would like to have been more proactive with the failing practice and feel they could probably have avoided some of the "chaos that ensued". They would advise any area with a failing practice to approach their neighbouring practices to see whether they can help.

Any change needs ongoing leadership, ongoing governance and ongoing appraisal of whether it is working or not.

Problems with recruiting GPs forced the practice to think outside of the box and look at alternatives. They continue to identify gaps and consider whether they could be filled by another more easily available role such as a nurse practitioner or pharmacist. They have been amazed at the potential for both administrative and clinical staff to take work away from GPs. Investing time and energy into upskilling them has reaped great rewards for the GP team.

Becoming less busy has had its downside for the non-acute sites with them occasionally feeling "like ghost towns at times".

They reflect that a "session" in general practice is a meaningless concept, because it means different things in different practices. They created a template as to what constitutes a GP partner session.

A key challenge with any merger is how to level up financially across the practices, in particular if there is a wide range in drawings between the different practices. They advise an open-book approach and a commitment to equity are key starting points for meeting this challenge. They recognise they had an advantage as they had one practice without partners (the one returning its list) which they were able to use to fill some of the gaps.

CASE STUDY 8: Prospering in Portsmouth - Portsdown Group Practice realises the benefits of mergers

SUMMARY

- A large practice formed through mergers has achieved greater financial stability, recruitment and retention and had a positive impact on population health by working at scale
- The mergers are successful because they are driven by a core set of values and a shared desire to improve population health
- The focus in each merger has been on a common culture and outcomes and not on the mechanics of merging

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INTRODUCTION

Portsdown Group practice in Portsmouth is a large GP practice which has merged with others in recent years (primarily single-handed and financially challenged practices) to become a fifteen partner practice on six sites covering a population of 40,000.

They have energetically pursued a policy of expansion and are continuing to grow, aiming to double in size again over the next few years. Their focus is first and foremost on what is best for patient care in their area. They believe working at increasing scale brings significant benefits for patients, practice staff and the health economy as a whole.

BENEFITS OF WORKING AT SCALE

Impact on population health

As a larger practice they have been able to change their focus from the more day-to-day pressures and think more widely at a population level.

Being larger has enabled the practice to develop chronic disease management clinics with small teams of dedicated nurses rather than, as happened in the smaller practices, one nurse trying to do it all. Size also means the practice has been able to put more time into developing enhanced services and other schemes. They are looking to work with community teams and district nurses to risk stratify and manage patients as a wider team and employ a wider range of other professionals (pharmacists, physiotherapists etc.). The partners are not spending all of their time "fighting fires" and have more time to invest in leading those schemes.

Their size means they are able to develop a stronger voice across the local health economy and can work with external agencies more effectively to help them deal with, for instance, high levels of social problems such as substance abuse.

They have also found their size has been attractive to other commercial organisations who are looking for innovative and enthusiastic practices with a large cohort of patients to pilot developments such as telehealth.

Financial stability

As a larger practice they are able to share resources, back room functions and management. Although they have six sites, each with its own identity, they share staff around the sites and have a centralised management team. They are working to reduce the number of physical sites to gain further financial advantage but recognise the need to maintain local services. The changes they have been able to implement have been undertaken within existing resources; being larger has given them greater leverage and access to more capital.

Recruitment and retention

They have found being larger is attractive to new and existing staff because it offers job security, flexibility and work-life balance and the ability to develop specialist skills. For example, one partner works a day a week in the local day hospital whilst another has an ultrasound machine and scans one day a week. Other partners have developed interests in cardiology, diabetes and respiratory illness.

Because the six sites have their own cultures and demographics (see later) medical staff are not routinely rotated. However, partners do swap sites on a regular basis as part of their continuing development.

Having a pool of salaried GPs means it is easier to cover absences and has drastically reduced the need for locums.

Developing specialist skills

Previously, the practice ran a range of chronic disease management clinics staffed by experienced and well trained nurses (e.g. diabetes, heart disease, and respiratory disease). Since becoming larger, specialist GPs have added a layer of skill and supervision to that staffing. This has, for instance, seen the respiratory specialist GP reduce the rate of referral to secondary care by 50% in one year, as well as reducing the admission rate and prescribing rate. The specialists not only offer support for the nurses but also provide an in-house cross-referral service for other GPs.

MANAGING MERGERS

They believe for an organisation to be successful it needs to have one culture and one set of values. This is why they have chosen mergers over looser federations.

The key focus for each of their mergers has been their core values; what they want for their patients. Practices who do not have similar aspirations and aims are deemed unsuitable for merger. Although there are traditional differences between practices around culture, workload and income, they have found these do not get in the way of merging when the shared focus is on the changes that will benefit patients.

Honest discussions between all parties identifies the tensions as well as the benefits of merging, e.g. the perceived loss of independence versus the benefits of working at scale. They avoid dwelling on the mechanics of merging and on the impact on individuals, and instead focus on how being bigger will create more and better services for patients, improved financial viability and the speed with which they can react to changes in the NHS.

For the first six to twelve months of a merger they do not interfere with merged practices and allow them to continue as before, whilst listening and learning, working together and cross-fertilising ideas. They encourage the merging practice to recognise that maintaining the status quo is not an option and new ways of working will more quickly help them achieve their aspirations.

As the practice has grown it has assimilated the existing cultures from merging practices and worked with them. But they believe they have now reached a point where any future merging practices will have to “sign up” to a single value base.

7

OPERATING AT SCALE - ANALYSIS

BACKGROUND AND CONTEXT

The current pressures on general practice, in particular the rise in costs and workload alongside a fall in income, has meant for many the traditional model of general practice has become unsustainable. As a result, there has been a growing trend in recent years[ix] of GP practices working together in an attempt to use economies of scale to reduce costs, and to increase profitability by delivering new services.

In its report[x] the BMA advocated general practice working at scale and stated:

> *"The independent contractor status model needs to evolve. A collaborative care model – which involves larger practices employing bigger teams which can, in turn, work together in networks, as well as with other local health and social care providers – reflects the core principle of GP-led primary healthcare which doctors and patients wish to see retained."*

Operating at scale moved into even sharper focus in 2015 when the government announced it would be offering a new voluntary contract for general practice from 2017. This new multispecialty community provider (MCP) contract is only available for GP practices or groups of GP practices that cover a population of 30,000 or more.

HOW GP PRACTICES CAN OPERATE AT SCALE

The initial energy in the move to operating at scale came with the development of GP Federations. This is where groups of GP practices work together to form a new entity separate from their existing practices. Often these were established as a vehicle for practices to be able to bid for new contracts and to work together to manage the shift of activity from secondary to primary care.

In recent years there has been a new trend with the development of very large practices, which have become known as "super practices". These practices are formed from mergers of multiple practices and cover very large populations, e.g. our case study of Our Health Partnership or OHP (*Case Study 6; page 38*) in Birmingham which was formed from 32 GP practices who dissolved their partnerships

to form a new partnership covering 280,000 patients. Some federations are now considering merging their member practices into a larger partnership, e.g. the Suffolk GP Federation[xi].

12 BENEFITS OF WORKING AT SCALE

Our case studies identified the following benefits of working at scale:

1. Recruitment and retention is easier

Greater scale allows individual practices to be part of arrangements which can dramatically increase the attractiveness of posts within the practice through access to pooled funding and a wider range of practice environments.

Size gives freedom to create posts which are more flexible, offering greater work-life balance. For instance, a number of our case study partnerships were able to offer more part-time posts for salaried GPs. OHP (*Case Study 6; page 38*) is developing a pool of salaried doctors to reduce the need to use locum cover and to create a new career option involving rotating newly qualified doctors across a range of different practices.

Offering more flexibility and choice through scale has also seen some partnerships able to offer more specialist roles to GPs, for instance a GP from our case study in Portsmouth (*Case Study 8; page 44*) was able to obtain an ultrasound scanner and now spends one day a week scanning.

Size gives partnerships the freedom (and funding) to expand the practice team to include other professions (e.g. pharmacists, paramedics etc.) in single practice or shared roles. This in turn relieves the GP workload, and even allows GPs to focus on longer appointments for those patients where their skills are more relevant.

2. Income is improved

All of our case studies reported greater scale provides greater head-room to pursue other opportunities. Where individual GPs are not simply working to survive they have the freedom to pursue new and enhanced services and partnerships with others, including non-NHS work. For instance, Portsdown Group practice (*Case Study 8; page 44*) found as it grew it became attractive to commercial organisations needing access to robust practices with large cohorts of patients, for example to trial a variety of telehealth initiatives. They were also able to introduce new members of the team with specialist skills to increase income.

> ***…greater scale provides greater head-room to pursue other opportunities…***

3. Profitability is improved through economies of scale

OHP believes the development of a pool of salaried doctors to reduce reliance on locums will be able to eat into a combined locum spend across the practices of £2m a year (with salaried doctors being significantly cheaper than locums). They have already been able to realise significant savings in adopting single functions across their practices, in particular by moving to a single accounting system.

Merging practices are also able to consider estate rationalisation where they are operating across multiple sites, where this is appropriate for local populations. Other larger scale organisations are better able to optimise the use of their estate by, for instance, focusing certain specialisms on particular sites. Our case study at St Austell (*Case Study 7; page 41*) converted one of its sites into an acute care hub, which significantly reduced the pressure on the other sites.

4. Strength in numbers

An underlying theme of our discussions with larger scale practices and federations has been the increased feeling of confidence and control that comes with managing one's own destiny. Many of our case studies felt being part of something bigger gave them a better chance of survival in a potentially hostile world and that they were genuinely able to drive change rather than have change "done to them".

5. Headroom to develop wider partnerships

Where GPs are relieved from day-to-day fire-fighting they have found the headroom to develop wider partnerships with other organisations such as the local community provider and secondary care. Our case study from Beacon Medical Group (*Case Study 12; page 68*) demonstrates how a merged practice of 33,000 patients was able to find the time to develop a mutually respectful and strategically useful relationship with local community pharmacies. The relationship, built over regular meetings with both independent and large multiple pharmacies, has resulted in a new focus on health outcomes (rather than competition between them) which has, for instance, led to a greater uptake in flu vaccinations.

> ***…scale gives practices freedom to pursue new models of working, enhanced services and pathways all of which support the management of growing demand…***

6. Managing demand is easier

Scale gives practices freedom to pursue new models of working, enhanced services and new pathways, all of which support the management of growing demand. Examples include:

- Becoming large enough to begin offering chronic disease management clinics staffed by dedicated teams of nurses, where previously one nurse in each practice was expected to take on all clinics.
- The ability to introduce new roles, which has a knock-on effect on GP workload and improved on-the-day access. At Beacon Medical Group the merged practice employed a pharmacist, paramedic and ANP, and reduced the number of patients needing to see a GP by one third. As well as reducing the need for 11 salaried GP sessions this also meant GPs could start to see less patients but for longer.
- Greater access to capital and spending power, which presents opportunities to adopt and share new technologies such as an online triage system, which for example enabled St Austell Healthcare to record a fall of 100 face-to-face appointments per week.

7. A stronger voice for general practice is created

All of our case studies gave examples of how size has meant the voice of general practice could be heard more clearly in interactions with larger organisations. Dr Jonathan Cope from Beacon Medical Group talked about the confidence and strength that came with the knowledge he represented not just himself in discussions with the community trust but 20 partners and 33,000 patients.

This stronger voice in system leadership unlocks the ability to bid for and provide more services in the future if the larger organisation chooses to. And it has, quite literally, paid dividends for some, e.g. the ability to access a share of winter pressure funding.

8. Practices are prepared better for the new models of care

Strengthened general practice with a confident and mature organisational voice is in a much better position to begin developing new models of care such as multi-specialty community providers (MCPs) or Primary and Acute Services (PACS). In South Hampshire (*Case Study 9; page 60*) three strong federations are now working with 16 other NHS, local government and voluntary sector organisations to develop Primary Care Access Centres to improve access and create a single extended primary care team to better manage whole population health.

…strengthened general practice with a confident and mature organisational voice is in a much better position to begin developing new models of care…

9. Meeting the challenge of regulation and inspection is easier

Working more closely with other practices can often lead to the development of a single set of policies and procedures which, in turn, makes it easier to meet regulatory requirements and underpins support in preparation for CQC visits. Super-practices have been able to reduce the number of CQC inspections to one for the newly formed practice, as opposed to each of its members being inspected individually.

10. Access to the new MCP contract is possible

The framework for the new MCP contract indicates it will only be available to practices or groups of practices covering a population size of at least 30,000. Whilst the specific terms of the new contract are not yet known, it may be that future opportunities for, and investment in, general practice are channelled via this route.

11. Better able to meet the needs of the local population

Larger practices are able to offer a wider range of services, and tailor these to the needs of the local population. This can include activities such as social prescribing, and developing strong relationships with the local voluntary sector, to enable more holistic care to be provided.

12. 7-day Working

Clinical Commissioning Groups have been charged to ensure pre-bookable appointments are available outside of the core hours of 8.30am to 6.30pm Monday to Friday, and funding to support this has been announced within the GP Forward View. However, the guidance now states this can be delivered via a federation or super practice. As such operating at scale offers member practices the opportunity to meet the requirement for 7-day working[xii], and access the funding that accompanies it, without each surgery having to offer the appointments.

Cautionary Note: Operating at Scale does not automatically deliver these benefits

With so many benefits available, to most outside observers the problems facing general practice seem quite straightforward. The nearly 8,000 small businesses, many of whom are finding their current business model unsustainable, need to consolidate into a smaller number of larger organisations. The "answer" is operating at scale.

But it is not that straightforward. Reports have emerged recently about a federation in Doncaster going into administration after running into financial difficulties. Not only did operating at scale in this instance fail to provide the answer to the current pressures for this set of practices, but it also cost them as much as £20,000 each to find this out.

Operating at scale can help practices. But it is not a solution in itself. It creates the potential for the benefits we have described above to be delivered. But these benefits are not automatic. They are not delivered simply because the practice is now operating at a greater scale. If two or three practices merge or form a federation these benefits will not necessarily follow.

This is because the journey is often not straightforward. As one GP put it,

"(These changes) have the potential to help the practice but if they are introduced badly they could also make things worse… Working as a group could definitely improve things if developed well, but could also drain effort and resources without giving enough benefits in return[xiii]".

Ultimately it is the way the change is made that is important. Not the practical, legal governance issues (these are straightforward enough), but the engagement of hearts and minds, the development of a shared set of values, the building of trust, and the setting of common goals that will determine success or otherwise for those parties deciding to get bigger together.

The GP practices involved must ensure they have the capability to change the scale at which they operate. They need the expertise to ensure the benefits of getting bigger outweigh the effort and resources required to get there.

> ***…many practices are stuck in a vicious circle of increasing workload and worsening finances…***

Our case studies show it is possible. But many practices are stuck in a vicious circle of increasing workload and worsening finances, and haven't the capacity for a discussion about whether to make a change, let alone to implement anything significant.

Simply deciding to operate at scale on its own will not be enough. This is only the start of the process. Practices need to find a way to create the headroom to change the way they operate, help with the process of identifying and making these changes, and resources to make these changes happen.

OPERATING AT SCALE: 10 PRACTICAL STEPS FOR GP PRACTICES

1. Ensure the right motivation

The challenges facing general practice signal to even the most recalcitrant of practices something has to change. As a result, some choose to join or create a local federation. But the mind-set is sometimes *"...if the new federation can create an additional source of income for the practices, and provide some form of respite from the current pressures, this will allow the practices to continue on pretty much as they are at present*".

These practices agree to join a federation on the basis of what the federation will do for them (provide extra income, support recruitment etc.), rather than on the basis of what the practice will do for the federation. Joining is really a defensive manoeuver, to avoid the need for change within the practice, and the decision often does not involve any ceding of sovereignty or decision making to the larger group.

Whilst the additional funding each additional practice provides helps enable a new federation to be established, allowing practices to join who have no intention of changing is storing up problems for the future. To deliver many of the benefits of operating at scale, the at-scale organisation needs to influence the way core general practice is carried out. It needs to be able to set and adhere to minimum standards, and to consistently apply change across every member practice. If it can't do this, its ability to deliver value back to the member practices will be compromised, and the risk of the resources and effort being put in outweighing the benefits that can be delivered becomes much higher.

Some places are doing the hard yards of change. They agree common standards across all practices, and put processes in place to ensure they are maintained. They actively tackle individuals that cannot, for whatever reason, be part of the new system. They meet inter-practice funding discrepancies head on, and don't leave issues festering beneath the surface. It is hard work, and it takes time, but it can be done.

2. Start by understanding what the practices want

Working at scale has considerable benefits for the new entity and for the local population. But a clear, consistent focus on each of the individual practices involved is needed. Many of the practices embarking on this journey do so because of the support scale offers to their individual practices in tackling the problems they face today and in preparing them for a more challenged future. Agreeing and explicitly stating at the outset the problems operating at scale is trying to tackle is important. It will help two things. It will prevent the process of working together becoming the end in itself (rather than a means to an end). And it will mean when challenges are encountered, for example disagreements between practices about specific governance arrangements, there is a point of reference practices can collectively use to guide the decision making (i.e. which option best helps us solve the problems we are seeking to address).

3. Let form follow function

> ***…do not begin by focusing on the legal form…focus on the problems you are trying to solve…***

Do not begin by focusing on the legal form the venture will take. Focus on the problems you are trying to solve, and then later work out (with support if necessary) the best legal form. Building trust between the member practices as quickly as possible is a critical early focus, as this is what will

determine how ambitious the joint working initiative can be. Some commentators have suggested where there is no history of GP practices working together, then time working as a looser alliance (like a federation) is required first to build the trust, and that models which bring practices more closely together (like a super-practice) should only be attempted once that trust is in place[xiv].

There are a number of guides that are particularly helpful with some of the governance issues that practices can access. For example, the BMA has produced a document, "Collaborative GP Networks: Guidance for GPs on the basic legal structures"[xv], and the London-wide LMCs group has produced, "Collaborative Provider Models: a handbook for general practice"[xvi].

4. Identify Great Leaders

Any at scale organisation requires strong leadership. Committees that meet weekly or less frequently will not be able to carry out the leadership function. The way individual leaders behave will establish the culture of the new organisation and the way the organisation does things, so putting in place leaders who do things the way you want them done is really important.

Identifying an individual already working within the practices is ideal. This is because they will understand the way the practices operate, the history, and the local context. In our case study from Yeovil (*Case Study 10; page 63*) the GP practices worked together and in partnership with the hospital primarily as a result of the leadership provided by Dr Berge Balian. As an ex-LMC chair he was trusted by the local GPs, and was able to help create trust between the practices and the local hospital.

However sometimes this is not possible. This may be because the level of trust has not yet been established and there are concerns the practice from which the leader comes will unfairly benefit, or because the skill set required does not exist within the practices. In the Our Health Partnership case study (*Case Study 6; page 38*) the challenge of running a corporate venture at the scale of 32 practices required an executive experienced in managing large organisations, and as a result they brought in Mark Newbold as Managing Director, an ex-hospital Chief Executive.

5. Create a compelling vision

> ***…one of the most important early actions for a new venture is to outline a vision for the future…***

Even with the problems clearly stated as the driver for working together, operating at scale will not automatically provide the solution. One of the most important early actions for a new venture is to outline a vision for the future, how working together will tackle the problems presented. All of our case studies started from a key uniting vision. Our Health Partnership state they will,

"*Build on the partnership model of local general practice to create the conditions where our GPs can deliver the highest quality, sustainable healthcare to our patients in their communities. We will build resilience and resources to support an environment where GPs are financially viable, respected and highly skilled. We will use our profits to ensure sustainability and we will create value beyond the Partnership*."[xvii]

6. Create effective channels of communication

Initial enthusiasm for working together can quickly dissipate if an initial frenzy of communication is followed by none. Practices can quickly become disenchanted with the new arrangements and problems can quickly grow. As a result, it is important for practices to agree upfront the level of communication that will take place – the frequency of the meetings, the nature of the updates, as

well as setting clear expectations as to which decisions can be taken by the central team and which require wider involvement.

7. Be upfront about the commitment needed from each practice

Successful at scale organisations have established two-way membership agreements. The member practices make an upfront commitment to the at-scale organisation, and the central team make a commitment to the member practices. This may include commitments to certain behaviours, as well as things such as involvement in decision making and any funding requirements. Key to success is clarity as to what will happen if those commitments are not kept, e.g. if member practices do not play their part, or the leadership fails to deliver on its promises.

8. Be realistic about returns on initial investment

> ***…realistic expectations are required as to how quickly returns can be delivered…***

Setting up any venture is difficult. Making it profitable quickly is even more difficult. Realistic expectations are required as to how quickly returns can be delivered to member practices. There will inevitably be a lead in time while the new organisation establishes itself. Our Health Partnership in its business case for its second year (and first full year of operation) is aiming to return the cost of the levy back to its member practices in benefits, and not promising anything more. It also has clear plans as to how it will achieve this. Promising too much too quickly will lead to disillusionment and engagement problems when promises cannot be kept.

9. Focus on a small number of priorities to begin with (the quick wins)

However, it is also important the new venture can demonstrate some benefit to its member practices as quickly as possible. Identifying a small number of "quick wins", and working hard to publicise them as widely as possible, is critical to establishing early momentum. Where possible it is best to focus on areas within the control of the organisation, such as spreading innovations between practices, rather than areas such as winning new contracts where the decision making is outside of the organisation's control.

10. Make sure you have the expertise and support you need

Support to enable practices to work at greater scale can come from a number of sources and practices. CCGs are often highly supportive of the development of partnerships and federations. Our case study partnerships discovered a wealth of support was available from inception (for example the CCG facilitating initial discussions between practices) through to the CCG shifting services and resources once the partnership was established. Different types of support, e.g. legal, financial and procurement are likely also to be required as the organisation develops.

THE PARTICULAR CHALLENGE FACING GP FEDERATIONS

In a recent BMA survey 43% of GP practices reported they are part of a federation. A few years ago federations were seen as the great hope for general practice, but if so many practices are now part of federations, why does general practice remain in such trouble? Were federations never the solution, or has something prevented them fulfilling their perceived potential?

Three things have changed in the last few years which have altered the fundamental role of federations, making the challenge they face considerably greater.

First, the vast majority of federations were originally set up primarily to protect local general practice from the threat of new private sector entrants, and to generate additional income for the member practices through the establishment of new services. Practices were not joining federations to change the way they operated, but rather saw them as a potential additional income stream.

Second, the problems of core general practice turned into a full blown crisis. Persistent underfunding, growth in demand and recruitment problems combined to turn a once secure profession into one that has left many practices teetering on the brink. For federations this has required a fundamental shift in focus. Federations are now needed not to provide a bit of additional income to practices, but to generate a sustainable model of general practice going forward.

Third, the publication of the 5 Year Forward View signalled a shift away from a focus on competition to a new focus on integration. The role of federations as competitors in the out of hospital "market" has all but disappeared. Instead, the introduction of the new models of care means the job of the federation is to partner, not compete, with the other players in the local healthcare systems.

Combined, these three changes mean the challenge for a new federation today is completely different to the challenge a new federation faced five years ago. A different relationship is required between the member practices and the federation. Member practices now need to trust the federation and be prepared to act differently as a result of what the federation asks. Practices must be prepared to cede a level of sovereignty to the federation that was unnecessary 5 years ago.

Federations have to agree how general practice can work differently with the community trust, the acute trust or any of the other local players, to achieve common local goals. Federation leaders have to be able to deliver the changes they agree with their member practices. They also need to ensure the necessary investment in general practice is delivered via local Sustainability and Transformation Plans (STPs) to enable the agreed changes to be delivered.

The opportunities for operating at scale within a federation are potentially greater than they were a few years ago. But the challenge for existing federations to realise them is considerable, as it requires a fundamental transformation of their role, their relationships, and how they operate.

SECTION THREE:

NEW MODELS OF CARE

8

NEW MODELS OF CARE – CASE STUDIES

CASE STUDY 9: Whole System in Hampshire - Developing a Multispecialty Community Provider model

SUMMARY

- **27 practices in three federations covering 220,000 patients are engaged in a partnership with health and social care organisations to develop a new Multispecialty Community Provider (MCP) model**
- **The model includes new ways of dealing with on-the-day demand including Primary Care Access Centres, a single extended primary care team and moving more specialist support into the community**

INTRODUCTION

27 GP practices covering a population of 220,000 worked with the Southern Health NHS Foundation Trust to develop a vanguard Multispecialty Community Provider (MCP) across South Hampshire.

The initial focus was on three early adopter GP localities covering South West New Forest, Gosport and East Hampshire. As it developed, the MCP covered a larger and larger population, with plans to ultimately cover a population of 1m. The MCP also involves 16 other local NHS, local government and voluntary sector organisations.

WHAT PROBLEMS ARE BEING SOLVED?

GPs in South Hampshire are struggling with increasing on-the-day demand, recruitment difficulties, financial pressures and the changing demands of patients.

The three populations involved cover a rural area with an aging demographic (South West New Forest), an urban population with high levels of deprivation and significant pressure on local GPs (Gosport) and an aging population in a semi-rural area with difficult transport links (East Hampshire).

WHAT APPROACH ARE THEY TAKING?

The MCP has three main thrusts:

A) New models of delivering primary care including primary care operating at scale to improve access (via Primary Care Access Centres – see below) and also small groups of practices working together to sub-specialise

B) A single extended primary care team e.g. community care teams (both physical and mental health) in each locality, integrated with teams in primary care to look after whole populations rather than historical cohorts

C) "Delayering" i.e. taking out layers of hierarchy in the NHS and moving more specialist support into the primary care team. For instance, they are gathering very localised information about the top three health problems facing a community where the biggest health gain can be achieved, and then getting hospital and community specialists to work with general practice in that community to come up with new pathways of care for these patients.

PRACTICAL STEPS

There are three relatively well-established GP federations in South Hampshire: South West New Forest, East Hampshire and Gosport. The vanguard MCP started by working with these and a small group of energetic local GPs who were willing to lead change and help get their colleagues on board.

Local GPs have recognised the status quo is untenable and that there is a need to keep what's best about general practice but to operate at scale and make the best use of the limited specialist and medical resources available in the local community.

The GPs are benefitting from the fact both community and acute providers recognise if general practice "falls over" it will destroy the whole system. The whole health economy is working in partnership and sees it as everyone's responsibility to resolve these problems; the larger trusts are supporting GPs to take time to think outside the box (the GP clinical leaders time is funded at risk) in the hope that together they will come up with new solutions.

PRIMARY CARE ACCESS CENTRES

The first fruit of these new ways of working was the development of Primary Care Access Centres (PCAC) to help deal with increasing on-the-day demand. One in the New Forest is serving a population of around 70,000 and gives the opportunity for local people to access care over an extended period i.e. seven days, 8am-8pm for problems where they don't necessarily need the continuity of seeing their own GP.

Around 40% of patients (those needing on-the-day access) ring their practice, are triaged and are sent to the PCAC. They are also looking at the option of using Web GP (online consultation templates) to appropriately direct patients to the PCAC.

The PCAC is staffed by duty GPs from each of the practices involved plus a wide and varied multidisciplinary team including extended scope physiotherapy practitioners. They are currently piloting extended scope physiotherapists to be the first point of contact for around 20% of patients presenting with problems that are primarily musculoskeletal (See *case study 3, page 19*). This has already demonstrated a single stage appointment reduces the delay and inconvenience for patients across several different clinical pathways.

The PCAC is based in an existing hospital building, co-located with the minor injuries unit, and has access to the common clinical records of all engaged practices.

BENEFITS OF THIS APPROACH

This approach gives patients more straightforward access to a wider range of care. In turn, the GPs in the practices which have a stake in the PCAC are able to give more time to the frail elderly and patients with complex long term conditions. These practices are now looking at moving from ten minute appointments to something more bespoke for each patient's needs. The PCAC also provides access to team and leadership development for GPs. The approach is also reducing hospital activity.

LESSONS LEARNED

Key to the success so far is strong provider primary care with a unified sense of direction and purpose. Local general practice has adopted a strong single voice to make clear and articulate demands on the acute and community providers.

Genuine partnership working has been achieved through a shared focus on outcomes. Keeping the natural GP leaders in each locality front and central in the redesign work has been vital.

Each organisation had to discuss what they were responsible and accountable for, but equally had to recognise boundaries have to be blurred if all partners are not be become unsustainable in the future. With enormous operational pressures on all parties there is inevitably a risk of individual organisations reverting to a more insular focus, but the organic rather than linear approach to developing this integration has built high levels of trust which act as a solid foundation for the future.

CASE STUDY 10: Assimilation in Somerset - Developing a Primary and Acute Care System (PACS) Model

SUMMARY

- **GP practices, the acute hospital and other organisations in Yeovil have joined together to deliver a new primary and acute care system (or PACS)**
- **Some GP practices have integrated with the hospital via Symphony Healthcare Services, a new organisation owned by, but at arm's length from, the acute hospital**
- **The practices are delivering "enhanced Primary Care" which is improving care for patients with chronic complex conditions**

INTRODUCTION

The South Somerset Symphony Programme is one of NHS England's vanguards working to deliver an integrated primary and acute care system (PACS) around Yeovil in Somerset. The programme is a partnership between Yeovil District Hospital NHS Foundation Trust, Somerset CCG, South Somerset Healthcare GP Federation and Somerset County Council.

WHY WAS THE VANGUARD ESTABLISHED?

Dr Berge Balian is a long-standing GP in Yeovil, and two years ago was appointed by Yeovil District Hospital onto its Trust Board as Associate Director for Primary Care. He describes the driver for establishing the vanguard as *"…practices were struggling with their workload… [And]…interactions with the hospital…part of the reason for doing it was to protect primary care by opening up more channels between primary and secondary care…and deal with some of the hassles we have with the hospital and vice versa".*

The acute trust, general practice and other partners are joining together to establish a joint venture which will hold a single budget for the population and target resources to parts of the system where they can make the most difference to patients.

THE VISION

There were early concerns from GPs that closer integration with the acute trust would mean a loss of independence as well as additional workload being passed onto them. For a year to eighteen months considerable work was undertaken with the local practices and the acute trust to establish a shared vision for the future and to develop an understanding that closer integration could be mutually beneficial to all organisations and their patients.

The hospital's vision was to change the way it worked to only provide services appropriate for a hospital setting – even though this would ultimately mean it might shrink in size. The remaining services would be provided elsewhere, primarily in the community.

Prior to this time there had been no mechanism to move resources from one organisation to another (either money or personnel) when services were transferred between secondary and primary care. However, the vanguard PACS model allows this transfer to happen. The vision is that if the acute hospital and GPs work more closely together, rather than create an imposition on general practice, the shift of work into the community will be better for patients and, importantly, be resourced appropriately.

MOVING BEYOND THE ORIGINAL VISION

Although originally a PACS vanguard with the aim of integrating acute and primary care, the Programme Board quickly came to the conclusion they wanted to go further and integrate all health and social care services. The Symphony Programme Board now includes the Head of Adult Social Care, and representatives from the community and mental health provider organisations. The voluntary sector has also been approached. The Board is now effectively taking a population health approach.

SYMPHONY HEALTHCARE SERVICES

A number of local practices became so overwhelmed with their own problems they approached the hospital directly, wanting to formally merge with them. The hospital considered this, but Dr Balian wanted to ensure the valuable GMS/PMS contracts, which are contracts in perpetuity, were protected. As a result, they set up a new organisation, "Symphony Healthcare Services", under a relatively complicated set of governance arrangements which used roles called "nominee GPs" to allow practices to integrate with the hospital but also preserve the existing contracts.

The organisation is at arms-length from the hospital. It has a Board which has been set up to include four elected representatives from local practices including three GPs and one practice manager partner. There are also four members on the Board from Yeovil District Hospital NHS Foundation Trust – and one of these is Dr Balian. This means five of the eight voting members on the Board are from primary care including the Chair and Vice-chair. This membership helped convince the GPs they would be properly represented and that the new organisation would have their interests at heart.

The lead partners of the practices joining Symphony Healthcare Services have a "right to return" to their original contracts in future. Impressed by the hospital's commitment to making this work for general practice, another 6 or 7 practices have expressed an interest in fully integrating with the hospital through Symphony Healthcare Services.

A Participating Practices Group has also been formed for those local practices who choose not to join Symphony Healthcare Services, to ensure they have a voice at the table and that primary care remains at the centre of everything the Symphony Programme Board does.

THE THREE PILLARS OF INTEGRATION

The integration of the practices with the hospital is built on what are described as "three pillars":

- to preserve the individual identity of each practice and its relationship with patients
- to share administrative and back office functions (e.g. CQC registration, HR etc.) across the practices and the hospital
- to redesign the healthcare system, through the enhanced primary care (EPC) model and shifting how care is provided for patients

ENHANCED PRIMARY CARE

EPC is a model to avoid inappropriate admissions for patients with chronic complex health needs. It has led to the appointment of 54 health coaches. These are the first port of call for patients with stable chronic conditions and are available to signpost them to appropriate health or social care services and lifestyle advice. This role in turn frees up GPs to concentrate on the medical needs of the complex patients. At the same the primary care workforce is being expanded e.g. having musculo-skeletal practitioners in GP surgeries, employing pharmacists in practices

and having mental health coaches for low level mental health interventions. The roles are being piloted in all practices in the area, not just those that have joined Symphony Healthcare Services.

LESSONS LEARNED

A programme such as this cannot be done quickly. It takes time to build relationships and trust between the participating organisations, and to develop a shared vision to which all organisations are committed.

Models of care should be redesigned based on the patient. Identifying appropriate patient pathways and ensuring the right thing is done in the right place by the right person helps identify a range of inefficiencies and waste which, when eliminated, provides a better service for patients and can save money.

However, redesigning services does not lead to an immediate return on investment. The Symphony programme has needed pump priming through the vanguard funding, and it expects it to be some time until financial returns are delivered.

More information is available at www.symphonyintegratedhealthcare.com

CASE STUDY 11: Novel in Nottinghamshire – Creating the Primary Care Home

SUMMARY

- **A Primary Care Home pilot in Nottinghamshire is developing a genuine integrated team approach to providing out-of-hospital care from general practice**
- **The pilot aims to deliver better care by breaking down organisational barriers, creating a more attractive environment for staff and creating greater efficiencies for the practice, providers and commissioners**

INTRODUCTION

In 2015, fifteen "rapid test sites" across England were chosen by the NAPC and NHS Confederation to develop and test a new enhanced primary care approach - in line with the ambitions of the Five Year Forward View. The new approach was called The Primary Care Home. The Primary Care Home is defined (by the NAPC) as *"…a form of multispecialty community provider (MCP) model. Its key features are:*

- *provision of care to a defined, registered population of between 30,000 and 50,000;*
- *aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards*
- *an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and*
- *a combined focus on personalisation of care with improvements in population health outcomes"*

Hubs that serve populations of 30-50,000 have now been established as the essential building blocks of an MCP. One of the fifteen rapid test sites chosen was the Larwood and Bawtry Primary Care Home in Nottinghamshire.

WHAT PROBLEM/S IS THE PILOT TRYING TO RESOLVE?

The Larwood and Bawtry Primary Care Home pilot set out to address a lack of collaboration between local providers of out-of-hospital services which meant care for patients was not very well coordinated. The aim was to build a genuinely integrated team that could address the potential gap in care between shrinking hospital services and the services GPs provide e.g. the nursing home population, people with mental health problems, and people with intermediate care needs in the community.

The team being developed is working beyond contracts and organisational walls and includes general practice, community services, the voluntary sector, social care and secondary care. According to one of the lead GPs the aim is to provide *"…a much better holistic service for our patients whilst also delivering a number of key objectives for us as a practice*."

WHAT ARE THE AIMS OF THE PRIMARY CARE HOME PILOT?

The pilot is working to deliver three main aims:

1. Better patient outcomes through integrated working
2. Creating a team environment that people want to work in

3. Providing more efficient care by reducing waste and bureaucracy

WHAT DOES THIS MEAN IN PRACTICE?

One thing the Larwood practice (13 partners and 32,000 patients) has done is employ a pharmacist for three days a week as Head of Prescribing and mentor her though a prescribing course. The pharmacist oversees all prescribing processes and quality indicators and is delivering efficiencies by closer working with district nurses and other partners across the pilot. Prescribing expenditure has fallen by £230,000 with no effect on quality. This has been achieved through, amongst other things, the pharmacist reviewing nursing home prescribing and reviewing special medications.

The practice recognises the value of new clinical roles now and in the future. It is already planning a team that will enable them to survive in an environment where medical and social needs are becoming more complex and recruitment to more traditional roles is becoming increasingly difficult.

The practice has provided key accommodation in the surgery to community staff not employed by the practice. They have also provided free Wi-Fi and a new telephone system that allows calls to be transferred between the two organisations as well as sharing records and meeting face-to-face more often. They have found this facilitates more joined-up care for patients.

The team now meet across organisational boundaries to discuss what care might look like in the future. One such meeting resulted in a list of twenty things the nurses wanted to do differently and they are working as a single team to implement these. As the lead GP says *"…we are starting to build that team approach…and trying to get to a point where we work as a single team, if not contractually, then for the patient benefit it feels like that."*

A third thing the practice has done is invite the voluntary sector into one of their surgeries to run clinics in a particular area of need, and introduced social care clinics to help reduce waiting times for assessments and to provide quicker support.

THE FUTURE

The practice would like to extend the team to include other agencies such as mental health and housing. The next area of focus will be on reducing waste and bureaucracy e.g. reducing inappropriate referrals, using all the skills they have across the practice, and increasing the range of services they provide within the practice. This includes plans to provide extended dermatology services and orthopaedic services. A consultant orthopaedic surgeon is due to run clinics in the practice and thus provide more rapid access to treatment. The ambition is to develop a musculo-skeletal team including physios in the future – with delegated budgets to support it.

CASE STUDY 12: Building Bridges at Beacon - How a practice developed effective partnerships

SUMMARY

- Beacon Medical Group has been able to develop mutually beneficial partnerships because of its size, its at-risk funding of GP management time and its openness to new ways of working
- The partnerships they have developed have provided support, reduced demand, enhanced quality, increased revenue and profitability, and made the practice more attractive

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INTRODUCTION

The Beacon Medical Group was formed in April 2014 from the merger of three South Devon practices. The organisation has 33,000 patients and 20 partners. They have taken an innovative and collaborative approach to developing external relationships which have impacted on improved services for patients, increased revenue and are beginning to address issues of increasing demand. It has been named as one of the original 15 rapid test sites for the Primary Care Home initiative.

The practice funds a senior partner for four sessions a week of management time. This has been instrumental in ensuring the practice has a strong presence at discussions with partner organisations. The GP partners at the practice have recognised this investment in relationship building will not make a quick financial return but, over time, will bring quality dividends and develop the practice in ways which will be financially worthwhile.

EXAMPLES OF PARTNERSHIP WORKING

With Community Pharmacy

A partnership developed as a result of a strong relationship between the practice and the LPC chair. This led to a regular meeting between the practice and the seven community pharmacists operating within the practice footprint. The meeting provided an opportunity for improved communication and collaboration rather than competition. The practice has taken the opportunity to promote community pharmacy schemes such as Pharmacy First, winter ailments and lost medicines. They are keen to enhance the role of community pharmacy in primary care and have developed joint plans around, for instance, flu vaccinations which has led to a greater uptake of flu vaccines locally.

The relationship built through regular meetings with independent and big multiple pharmacies included frank conversations about commercial viability. A greater understanding of the clinical skills which exist in community pharmacy was established (e.g. the GPs spent time in the pharmacies watching them undertaking medicine usage reviews). In this way they were able to agree acceptable common ground and are now working to increase the role of community pharmacy and move towards a population based contract with real health outcomes, rather than a transactional prescribing one.

Together they are embarking on a joint piece of behavioural research (with Pfizer and Imperial) on how to develop the same levels of patient trust in the clinical skills of community pharmacists as there are in primary care practitioners.

Outcomes have included a better service for patients because of improvements in the education of pharmacy staffing and may soon impact on workload in primary care, if they can continue to increase community pharmacy's role through Pharmacy First and

the minor illness and winter pressure services they offer.

With the Community Provider

Because of the practice's size and scale they have been a strong voice at the table in meetings with most partner organisations. They have regular meetings with the large community provider to discuss what services they could develop and deliver together for mutual benefit.

These meetings led to a new scheme for care home patients. It was acknowledged that care in care homes was not particularly pro-active, e.g. visits only happened when patients were already poorly and prescribing was difficult to review. The practice and the community provider developed a jointly led service whereby a pharmacist and a GP visited selected care homes on a regular and pro-active basis to spot when patients were in danger of becoming ill, review medication, de-prescribe where appropriate and offer education and support for care home staff.

The scheme is funded as a result of a successful bid to the CCG. The community provider employs the pharmacists to provide the care home visits, and clinical assessments, medication reviews and regular GP input comes from the practice.

With Secondary Care

In cooperation with secondary care the practice has developed GPSI-led dermatology and MSK services. A business case to the CCG suggested secondary care activity in those two specialities could be reduced by 30 – 35%. The practice and the CCG shared the service charge for setting this up and agreed any savings would be split 50/50. The actual service reduction in secondary care has been as high as 80% across the board in outpatient, elective and dermatology two-week wait activity.

The two services were developed through a CCG facilitated Clinical Participation Group which brings together primary and secondary care clinicians every two months to discuss service changes, new ideas and concerns. But the successful development of these services was underpinned by long standing relationships developed between secondary care clinicians and very experienced GPSIs.

Despite "taking work" from secondary care, the relationships stayed positive because this clinical respect led secondary care clinicians to have confidence in the work done in primary care. It was also helped because secondary care was struggling with a lack of capacity due to the nationwide recruitment crisis in dermatology.

As primary care has become more confident and more efficient at dealing with these two cohorts of patients the actual increase of workload for them has not been equal to the full reduction seen in secondary care. They are able to get real time feedback in primary care, unlike the ponderous system in secondary care, which leads to much quicker triage. The GPSIs have undertaken in-house education using their own patients, e.g. on long term management of skin conditions or lesion recognition, in order to upskill all clinicians (rather than operate an internal referral system). This allows all GPs to identify serious conditions more quickly and refer on, and deal with the less serious things better themselves.

LESSONS LEARNT

The strength that comes from size and scale underpins all of these relationships. The lead GP found senior management in the larger organisations were keen to engage with him because he represented 20 partners and 33,000 patients.

A shared vision, common goals and common threats helped relationships form. The local health economy is financially challenged and the secondary care hospital has been hit by increasing demand. There is a collective recognition that new ways of working are

essential and more collaboration and co-operation is the only solution if the whole system is to survive.

Useful management relationships can grow out of existing strong clinical relationships. Bringing a strong clinical voice to the table was essential in being heard. Freeing up the senior partner with four sessions of management time was vital, along with the recognition there would be no immediate financial return on this investment. All 20 partners understand developing relationships takes time, and are confident the practice will develop in all sorts of useful ways which will eventually be financially worthwhile.

Effective partnerships lead to more. Other partners like Pfizer and Imperial and the Warwick Business School are keen to work with the practice in research because of the cooperative approach they have taken, and other organisations are beginning to approach the practice with commercial opportunities.

CASE STUDY 13: Growth in Gateshead – working with patients to introduce social prescribing

SUMMARY

- **A growing practice with a strong focus on patient outcomes took the opportunity to develop patient partnerships which handed greater ownership of how the practice is run to patients**
- **They have been able to offer a wider range of more social alternatives to exclusively clinical interventions ("social prescribing")**
- **They have introduced these schemes with minimal financial input and are beginning to see some reduced demand on the clinicians, a more patient-centred practice, greater public support and increasingly motivated staff**

INTRODUCTION

Oxford Terrace and Rawling Road Medical practice is in the centre of Gateshead, one of the fourth most deprived areas in England. There is a high population of people with more than two long-term conditions and complex care needs. There are a high number of refugees and asylum seekers using the practice. The practice provides support into eight nursing homes, and as a result cares for a patient cohort with a very high prevalence of dementia.

SOCIAL PRESCRIBING

The RCGP describes social prescribing thus "*…social prescribing aims to expand the options available in a primary care consultation. This expansion is in the direction of strong choices — options that make available new life opportunities that can add meaning, form new relationships, or give the patient a chance to take responsibility or be creative. Usually these services need to be available locally and often within the voluntary, community, and social enterprise sector ("third sector").*"

THE PRACTICE STORY

The practice was involved in the national pilot for Quality Accounts in general practice which helped them develop a strategic direction for the next 5 years, including:

- how they would better manage their complex cohort of patients
- how they would address issues of recruitment
- how they would grow as an organisation to be able to manage demand

They set out to develop a culture of "continuous quality improvement" and were particularly keen to ensure the patient remained at the centre of everything they did. Along with many practices they faced recruitment, workforce and premises challenges.

With the practice based in an end terrace in Gateshead there were no opportunities for premises development. Instead they took out service agreements with the commissioners on eight care homes, and the GPs began to undertake house calls and ward rounds in these care homes. They worked with the CCG and community services providers to develop some older people specialist nurses to work with the care homes but be based in the practice. This was driven by a recognition that patients from care homes had unusually high

levels of admissions with conditions which could be prevented (e.g. UTIs). In developing these roles they were able to reduce attendances and admissions by 12% in the first year and 14% in the second year.

When they first took on the care homes they broke even financially, but as the initiative developed and they started to reduce admissions and streamline pathways they've been able to generate funds to reinvest into frontline services to develop new roles.

The practice also began to take services out to patients by winning the contract to provide substance misuse services across Gateshead. GPs from the practice now provide 5 sessions a week into the service.

THE MERGER AND PATIENT ENGAGEMENT

Driven by a need to address the lack of appropriate premises they began conversations with a neighbouring practice that was struggling, but had an under-utilised, purpose-built building. Despite considerable differences between the practices in size and culture, the discussions focused on what the practices had in common (a focus on quality, the desire to manage more care closer to home). Good, regular communication and a robust HR process which engaged staff at every stage meant they managed to resolve their differences and bring the two practices together.

Key to the merger and the development of the practice was the engagement of patients and the local population. During the merger process the practice undertook a highly praised public consultation focussed on the likely quality outcomes and found themselves with an engaged and enthused practice population. Capitalising on this, they began to recruit patients as active volunteers within the practice and directly involved patients in developing services including the redesign of the baby clinic. It quickly became clear the volunteers had skills and a level of commitment which could be used to develop a range of additional non-clinical services which could be made available to the local community through the practice at minimal cost.

INITIATIVES TO SUPPORT SOCIAL PRESCRIBING

By the time the merger was complete the practice had recruited 39 volunteers. These have been engaged in a number of innovative and surprising ways, including an initiative which began when the practice manager was hospitalised just prior to Christmas.

How Christmas Dinner Can Galvanize a Community

The practice Manager was so moved by what she had seen in hospital, in particular the plight of lonely patients over the Christmas period, that she asked her body of volunteers to help organise a Christmas lunch for the following year. Rather than addressing some of the complex issues in the practice in a mechanistic way, the organisation of the Christmas lunch became the focus for galvanizing community resources. The practice set out to identify frail, lonely and vulnerable people. Those who would be completely alone and unsupported on Christmas Day acted as proxy for the people most in need of the practice's help. They organised a health fair, launching some work they were developing around dementia care and, talking to the attendees at that event, identified a group of people who would be on their own at Christmas.

Instead of having a flu clinic they organised a "Flu Fair" and invited all the local self-help groups. This identified more isolated people. Finally, the GPs and other professionals (including the third sector) suggested further people who might be on their own at Christmas.

The Christmas lunch was cooked on the day by people with enduring mental health problems who came to the practice via a local charity. The volunteer patients did all of the organising. Local supermarkets provided free food. The practice staff did the waitressing.

On Christmas Day 26 people turned up to lunch. The practice was surprised both by the number and by the fact not all of the attendees were frail or elderly. In her own words the practice manager Sheinaz Stansfield relates:

> *"We had refugees and asylum seekers who in their own countries would have had fantastic, magnificent lives but because they'd come [to England] they'd got nothing and they would have been on their own on Christmas Day. We had [a child] of 18 months old…and then we had an 83-year-old woman who normally would have been on her own… the 26 people who came along to Christmas dinner last year are now working with us this year to organise Christmas dinner for other people."*

Other Initiatives

The Christmas dinner is only one example. Other initiatives include:

- Instead of organising a patient forum to launch their long term condition strategy the practice took the innovative step of organising a tea dance. The regular patient forum meeting would have attracted around a dozen patients but the tea dance was attended by over 250. The local university took care of the formal consultation part of the event – but GPs, nurses and the practice manager danced with patients and demonstrated, in the words of the practice manager, *"… you can come and talk to us because we're …just normal, everyday people and we're here to work with you to improve the services that we provide and we want to hear from you what the system might look like*".
- The patients with mental health problems who cooked Christmas lunch have continued to work with the practice to develop a range of self-help groups including a women's "knit and natter group", an arts and craft group and a walking group.
- Two men with substance misuse problems run the practice's Facebook page.
- A tea for veterans is planned for Armistice Day – with the same aim of identifying and engaging with vulnerable members of the community.
- An ex-smoking cessation counsellor now works as a volunteer for the practice, going out into schools running health promotion sessions. They use the engagement of the children to, in turn, engage their parents and grandparents.
- The practice volunteers have taken the lead on the patient survey by organising events, choosing the questions and writing the action plan. The practice believes this is delivering a more meaningful survey and resultant plan, and they estimate it has saved them £4k.
- A patient's husband writes the practice newsletter.

PRACTICAL MATTERS

The practice has developed this level of engagement without additional finance and the practice staff have been stimulated and motivated by the level of expertise and knowledge the patients bring with them.

The practice manager has responded to suggestions this work falls outside of her remit:

"Often people say, "Sheinaz, this isn't your job as a practice manager." Actually this is absolutely my job as a practice manager. For CQC we have to evidence that we're actually engaging with the whole practice population and what better way to do it than this. I could be holding patient forums. I could be having patient surveys. I could be ticking the boxes. That adds no value to anything that I do and adds no value to the practice…by involving patients who have lots and lots of skills …they are the ambassadors for the practice really."

The work consumes about 2 hours of the practice manager's time each fortnight and the practice gives up a meeting room to the volunteers when they need it and provides free tea and coffee. All volunteers have been CRB checked and signed confidentiality agreements.

As a result of this work GPs in the practice are also changing their clinical practice, for instance instead of prescribing antidepressants they will prescribe the walking group or the knit and natter group.

9

NEW MODELS OF CARE - ANALYSIS

BACKGROUND AND CONTEXT

Since the inception of the NHS the range of activities provided in general practice has increased. It now plays an increasingly important role in coordinating care provided in other settings. As a result, the relationships general practice has with other organisations are more important than ever.

GP practices are relatively small organisations compared to other healthcare providers. They employ relatively few staff, and have lacked both the time and the capacity to create or develop strong relationships across the system. Practices are in the most part physically separate from other organisations, and their contractual independence from the wider NHS means they have little or no obligation to spend time building external relationships.

> ***…GP support for the independent contractor model has, for the first time in its history, started to wane…***

Historically, where relationships have developed, they have generally been in the context of education or the development of new services, and have stopped short of practices' core contract for the provision of general medical services.

RECENT CHANGES AND THE FIVE YEAR FORWARD VIEW

In recent years the pressures of workload, recruitment and finances have meant GP support for the independent contractor model has, for the first time in its history, started to wane. The role of partner in a GP practice has become less and less attractive. A small but increasing number of practices are now looking to other organisations to take on overall responsibility for the practice, allowing them to become salaried employees. For example, in Chesterfield four practices have handed over responsibility to the local hospital, who now run them through the Royal Primary Care banner[xviii].

In 2014 NHS England and partner national organisations released the "Five Year Forward View". This document set out what it termed "*new models of care*". These models have been put forward to

address what it describes as the "*barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care"*.

There are two new models of care based on general practice:

"*One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the* ***Multispecialty Community Provider***"

"*A further new option will be the integrated hospital and primary care provider -* ***Primary and Acute Care Systems*** *- combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too"* (5YFV, p4).

These two models of care, the Multispecialty Community Provider (MCP) and the Primary and Acute Care System (PACS), are based on GP registered lists. They require general practice to expand its existing model to incorporate larger multidisciplinary teams and provide a broader range of specialist and generalist care. NHS England has produced a guide to explain the new models of care, entitled "New Care Models: Vanguards – developing a blueprint for the future of NHS and care services"[xix]. Further detail of the contractual framework for MCPs has also been published[xx].

> ***…partnerships can improve outcomes for patients and provide support for tackling the problems individual practices are facing…***

A further model known as the "Primary Care Home" has developed since the publication of the Five Year Forward View. This model focusses on populations between 30,000 and 50,000, and looks to bring together clinical and financial drivers across organisations. It aims to integrate the workforce, with a strong focus on partnerships across primary, secondary and social care. These hubs of 30-50,000 are now seen as the core building blocks of the developing MCP model.

The introduction of these models, the changing needs of patients, as well as the challenges general practice is experiencing at present, mean the potential value of working in partnership has dramatically increased. Now the effort and commitment involved in creating new partnerships is much more likely to be worth the benefits achieved than at any time in the past.

The Royal College of GPs in 2016 produced its own document, "The Future of GP Collaborative Working"[xxi], to highlight different examples of GPs taking the initiative in developing collaborative working arrangements.

5 BENEFITS OF BUILDING SUPPORTIVE PARTNERSHIPS

Listed below are 5 benefits building supportive partnerships can generate for GP practices.

1. Meet Changing Patient Needs

Supportive partnerships can enable GP practices to meet the new demand profile as patients become older and more demanding of primary care services. In our case study of the Primary Care Home in Larwood and Bawtry (*Case Study 11; page 66*) the GP practices started by identifying the skills and relationships they required to meet these needs and have taken steps to integrate with community teams, as well as introduced new roles to their team.

2. Tackle Recruitment Problems

Many practices are struggling to recruit GPs. Partnerships can help tackle this issue directly by creating new, more attractive roles for GPs across organisational boundaries, e.g. the Livingston Experiment where a new town established all its GP roles working across primary and secondary care[xxii]. Partnerships with other organisations can also help introduce new roles into general practice. For example, the MCP in West Wakefield has led to extended scope physiotherapists working in all of the local practices, through its Physiotherapy First initiative[xxiii].

3. Better Manage demand

Demand for general practice continues to rise. Developing new partnerships is one way by which practices have been able to meet this demand. In the MCP in Southern Hampshire (*Case Study 9; page 60)* the GP practices and community trust have worked together to create Primary Care Access Centres, in which the on the day demand from a group of practices is seen in one location. These Centres are staffed by duty doctors from each of the practices working alongside a range of skilled professionals from the community trust.

4. Deliver Financial Benefits

Partnerships create opportunities to deliver financial benefits in three ways. The first is where new joint services are developed that are commissioned locally, e.g. the joint care home visiting service established between Beacon Medical Group and the local community provider (*Case Study 12; page 68*). The second is where financial efficiencies can be developed through practices accessing the back office infrastructure of a larger organisation, e.g. the practices joining Symphony Healthcare Services in Yeovil directly access all of the hospital's back office support (*Case Study 10; page 63*). The third is much of the new investment in general practice is likely to be through the development of new models of care, for example through the new MCP contract.

5. Prepare for the Future

There are many challenges ahead for general practice, including continuing financial austerity, the introduction of the new models of care, the drive for increased access to general practice and ongoing cuts to social care services. Some practices are seeking more security within such a changeable environment. Others want general practice to be at the forefront of any new changes, rather than being recipients of them. Either way, developing strong partnerships enables practices to better meet the challenges ahead.

BUILDING SUPPORTIVE PARTNERSHIPS: 6 PRACTICAL STEPS FOR GP PRACTICES

There are a range of organisations GP practices can consider developing partnerships with. Building effective partnerships does not have to result in mergers or new legal entities. These are only one mechanism for enabling the maximum benefit of a partnership to be delivered. The nature of the relationship developed will depend on the circumstances of the individual practice and the goals of the specific relationship being created.

Below we have outlined a number of organisations for a practice to consider, and the types of support each can provide. The starting point for the practice is generally to identify what problem they are looking for a potential partnership to solve, and to identify the organisations most able to help achieve that goal. At the end of this chapter we have also included some "top tips" on developing new partnerships.

1. Community Trusts

One of the most obvious places for GP practices to start when thinking about collaboration is with the community teams working in their area. The findings of a Department of Health sponsored report, "Moving Services out of hospital: Joining up general practice and community services?" (2014)[xxiv] included the headline advice that, "*Good multidisciplinary team working depends crucially on communication. Initiatives to improve community-based care should be allowed to develop from the bottom up, building upon successful local collaborations, rather than imposing a model from above*".

> ***…the starting point for a practice is generally to identify what problem they are looking for a potential partnership to solve…***

Our case study from Southern Hampshire (*Case Study 9; page 60*) outlines how the community trust and local practices were able to work together to find new ways of dealing with the demand they were collectively experiencing.

2. Acute Trusts

Partnerships with acute hospitals potentially provide access to a range of well-developed back office functions, and create an opportunity for work being transferred from secondary to primary care to be accompanied by resources. However, there is not a strong track record of collaboration between general practice and acute trusts. This was explored by the Kings Fund, in their publication "Acute Hospitals and Integrated Care" (2015) p22-26[xxv]. They said,

"*An important message from our research was that there is often no alternative to building relationships on a practice-by-practice basis, and many of the acute hospitals involved in our research have invested considerable resources in doing so. For example, senior hospital leaders in Yeovil and Airedale reported spending a significant amount of time visiting local practices and attempting to strengthen relationships, including a "closing the gap" programme in Airedale which aims to bring primary and hospital-based care closer together. GP provider groups or federations represent one level at which an acute hospital provider could build a relationship with general practice. However, these are still at an early stage of development in many areas of the country, and where they do exist it is not always clear that they are sufficiently cohesive to represent local practices and have leverage over them. A lesson from our case study sites was that while the presence of a local federation may be helpful, it does not necessarily remove the need for practice-by-practice engagement.*"

For practices to lead the development of the relationship with an acute trust, they most likely will need to group together first because of the disparity in size and resources. Our case study from Yeovil (*Case Study 10; page 63*), however, shows equal partnerships can be developed between general practice and acute trusts, in this instance within a developing PACS model. There is also an increasingly common phenomenon whereby individual practices are approaching their local hospital looking to be taken over, e.g. in Chesterfield and in Wolverhampton, as an exit mechanism from the current pressures they are facing.

> ***…for practices to lead the development of the relationship with the acute trust, they most likely will need to group together first…***

3. Community Pharmacy

While competition between community pharmacies and GP practices has acted as an obstacle to collaborative relationships in recent years, the new enthusiasm for employing pharmacists directly in GP practices has opened up the opportunity for re-building some of these bridges. The Royal Pharmaceutical Society drew out many of the opportunities in its 2014 publication, "Pharmacists and GP surgeries"[xxvi]. They reference the Community Pharmacy Future project, a collaboration between Boots UK, the Co-operative Pharmacy, Lloyds Pharmacy and Rowlands Pharmacy that looked at a deeper role for community pharmacy in the management of long term conditions. The project included three schemes: a "four or more medicines" support service in Wigan for patients over 65 taking four or more medicines; a chronic obstructive pulmonary disease (COPD) support service in the Wirral; and a COPD case finding service also in the Wirral designed to identify undiagnosed COPD patients. This service has changed the way of working between professional colleagues. One of the GPs involved in the service said, "*Together, we were able to devise a process from screening patients for COPD all the way through to diagnosis. It was invaluable to have the pharmacy involved as it meant that patients were no longer being lost between the screening and diagnostic stages. The service also benefited the surgery by helping existing patients to manage their condition.*"

Our case study of the Beacon Medical Group in South Devon (*Case Study 12; page 68)* outlines how they built a relationship with community pharmacy locally.

4. Voluntary Sector and Social Prescribing

Collaboration and partnerships with the voluntary sector are a key component of introducing social prescribing, as our case study in Gateshead (*Case Study 13; page 71*) demonstrates. Age Concern produced a report on developing relationships between general practice and the voluntary sector, with specific advice on establishing a social prescribing function[xxvii]. They recognised GP practices would not always be able to keep up to date with the range of services the local voluntary and community sector can offer, and promote a co-ordinated approach by the local voluntary sector. In their view, social prescribing offers a model for effective partnership working, with one organisation taking a lead role in managing the assessment and referral process.

5. Social Care

Many older people are actively supported by both general practice and social care. HSMC published a document in 2013 entitled, "New conversations between old players? The relationship between general practice and social care in an era of clinical commissioning"[xxviii] in which they reviewed the evidence on joint working between the two. They found the factors that may aid more effective joint working include the importance of time and space to build good relationships; trust and

awareness of each other's roles; clear commitment at practice and senior level; shared priorities and outcomes; and appropriate practical and organisational development support.

> ***… developing relationships with other GP practices can help both improve the ability to tackle some of the problems practices are experiencing …***

They suggested more opportunities need to be given for GPs and social workers to understand their respective roles and professional perspectives. This is necessary to develop a reciprocal acceptance of their differing practice, financial and performance contexts, and needs to be supported by a willingness to seek joint solutions to situations in which eligibility rules and organisational procedures issues prevent integrated care being delivered.

6. Other GP practices

Developing relationships with other GP practices can help both improve the ability to tackle some of the problems practices are experiencing, and enable them to partner more effectively with some of these other, larger organisations. This is covered in more detail in Section 2 Operating at Scale (*pages 35 - 56*).

FROM SUPPORTIVE PARTNERSHIPS TO THE NEW MODELS OF CARE

Strong supportive partnerships are the foundation of the new models of care. Aspirations to create an MCP or PACS model without them are most likely doomed to failure. But the new models of care provide further opportunities. They also create a contractual framework that provides the opportunity for practices to develop or be part of new organisational forms that can better deliver some of the other benefits.

However, some practices are concerned these new models of care may represent the takeover of general practice by either the community trust (in the MCP model) or the acute trust (in the PACS model). Each of these is considered below, in relation to two of our case studies.

Multispecialty Community Provider – Southern Hampshire

Plans by Southern Health Foundation Trust to set up a joint venture with a GP practice and employ practice staff[xxix] created consternation in certain sections of general practice. Practices were concerned this might mark a further degradation of the model of independent general practice, and felt the local FT was being "predatory" in the face of the difficulties general practice is currently experiencing.

We spoke to Chris Ash, the Lead Director for the MCP at Southern Health, and found something completely different. Chris and Southern Health fully understood the importance of general practice ("*it does 90% of the work for 10% of the resources*"), the critical role it plays in the local health economy ("*if general practice falls over, the rest of the system falls over*"), and the interdependence that exists between them ("*we can't do this without general practice and general practice can't do this without us*").

It was clear Southern Health were committed to supporting general practice to succeed and in Chris's words, "*truly doing it as a partnership*". Southern Health put money directly into general practice, for example funding GP leadership time. What was striking was other providers in the system were taking responsibility for the development of general practice. Such a clear articulation of the responsibility of providers, and in particular the community and acute trusts, to play their part in the development of general practice is rare, and even rarer is such a willingness to take this on. Where this exists general practice should cultivate and build on it at every opportunity.

Primary and Acute Care System - Yeovil

The reaction of many GPs to reports a number of local practices – initially 3, then 6, and potentially 10 – were joining Symphony Healthcare Services, a company wholly owned by Yeovil hospital, was one of dismay that the traditional model of general practice was being abandoned.

We spoke to Dr Berge Balian, a GP and the Chair of the South Somerset Symphony Programme Board, to find out what was really happening[xxx].

What we discovered was a clear focus on general practice. The plan locally was to develop it to play a leading, sustainable role in the delivery of care, through an enhanced primary care model. General practice and the hospital were working together to tackle the challenges they both faced. Key was providing the mechanism for moving resources, whether money or personnel, from secondary to primary care, in ways that could alleviate pressure on both sides.

Because of the trust that had been built between the hospital and general practice, individual practices overwhelmed with their own problems approached the hospital directly wanting to

formally merge with them. Symphony Healthcare Services was set up to enable this to happen in a way that kept primary care clinicians in charge, and protected the G/PMS contracts. Other practices have since followed.

Partnerships built on trust, developed over time, can enable much more fundamental change to take place than is otherwise possible. Rather than a threat, the PACS model represents an opportunity for practices to create this for themselves locally.

TIPS ON CREATING PARTNERSHIPS

Choosing to enter a Partnership

A partnership is an arrangement between two or more groups, organisations or individuals to work together to achieve common aims. For all the difficulties of working in partnership, they are established because they can add value to both parties. General practice would choose to enter a partnership when:

- All the parties involved have some sort of personal stake in the partnership;
- All the partners are working towards a common aim;
- The partners have a similar ethos or system of beliefs;
- The partners work together over a reasonable period of time;
- There is agreement amongst the partners that a partnership is necessary;
- There is an understanding of the value of what each partner can contribute;
- There is respect and trust between the different partners.

Preparing for Partnership

When setting up any type of partnership, there are some key questions it is helpful to consider. These include:

- What are you trying to achieve, and how will you explain that to others?
- Is your plan viable?
- Is it a long-term or a short- term project?
- Will you need to partner with only one or a number of different organisations?
- What money, resources and time will you have to contribute to the partnership?
- What money, resources and time will your partners have to contribute to the partnership? Are they clear on this?
- What support do you need to make the partnership effective?
- Will there be a lead partner, and if not how will you ensure equality?

How to create and run a good partnership

Partnerships often start with good intentions, but can deteriorate over time. The risk of this can be mitigated by taking the following actions:

- Take time to build the partnership
- Put an effective management structure in place
- Develop a shared aspirational vision of what might be achieved and set a “stretch” mission
- Develop compatible ways of working and be flexible
- Appoint a leader who is respected by all the partners
- Ensure each partner shares their mandates and agendas
- Have open avenues of communication and use a facilitator if necessary
- Ensure the partners never lose sight of the vision and mission
- Make decisions collaboratively and always strive to reach consensus
- Keep the welfare of the beneficiaries at the forefront of the process

SECTION FOUR:

CCGS AND GENERAL PRACTICE

10

CCGS AND GENERAL PRACTICE – CASE STUDIES

CASE STUDY 14: Transformation in Tower Hamlets - How the CCG led the development of general practice

SUMMARY

- GP practices in the borough of Tower Hamlets have been on a 15 year journey of transformation from coming together as a network to the formation of a borough-wide GP provider group
- The transformation has been supported throughout by the commissioner who has provided financial incentives, support in tackling poor performance, effective data and an outcomes based framework but has otherwise given the networks maximum autonomy
- The driver for GPs working successfully at scale has been a clear uniting purpose and a focus on population health, not an abstract concept that scale is a good idea

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INTRODUCTION

Tower Hamlets covers 37 GP practices with a population of 254,000 with high levels of ethnic diversity and deprivation. Around 90 different languages are spoken in the borough and one third of the population is Bangladeshi. People in the borough have a lower life expectancy than anywhere else in England and many people live with a long term condition.

Since 2009 the 37 GP practices have worked in eight commissioning networks covering geographical areas co-terminous with the sub-boundaries of the borough. Each network contains 4 or 5 practices. The networks have worked extremely well, focussing on proactive care and prevention. Outcomes have been particularly good in such areas as delivering NHS health checks, child immunisations, smoking cessation, diabetes and secondary CVD.

The practices have recently formed a Tower Hamlets wide GP community interest company (The GP Care Group) which is already taking on a variety of commissioning roles from the CCG.

TRANSFORMING GENERAL PRACTICE IN TOWER HAMLETS

NHS Tower Hamlets (as a PCT and now CCG) has supported the development of general practice in the borough through a process which has strengthened primary care, unlocked the creativity of GPs and delivered measurable benefits to population health.

The story of this development covers around fifteen years but essentially comprises the following key lessons:

1. HAVE A CLEAR UNITING GOAL

In 2000 2.2% of the borough had type 2 diabetes. This has risen steadily to 7% today. In 2004 the GPs took on full responsibility for managing patients with type 2 diabetes. For many years practices have had access to shared benchmarked data at a population level. This is used by practices to discuss and understand what the data means and what can be done about it.

In 2009, using these data and discussions, GPs had collectively come to the conclusion care for patients with type 2 diabetes was poor, outcomes were not good and providers were overburdened.

It was this concern for inequalities and the unacceptable risks for the local population

that drove the practices firstly to adopt a more person-centred care approach and secondly to look at how working at scale might tackle the poor care being received.

The starting point of the conversation between the commissioner and general practice was about purpose - "what we are here to do". This collective conversation recognised the danger of simply "rearranging the deckchairs on the Titanic" and drove the need for something fundamentally different.

In 2009, driven by this clear uniting goal the 37 practices formed into eight GP commissioning networks comprising four or five practices, each focussed on the same geographical areas as the sub-boundaries of the borough. Through these networks, driven by a single shared aim, they began sharing information to identify patients, sharing the call and recall system and sharing knowledge about what other resources were available to support people with type 2 diabetes, such as those in the voluntary sector, and provided by community services.

2. TACKLE POOR PERFORMANCE

The commissioner undertook a lengthy developmental process with poor performing practices and removed contracts from those that were dysfunctional or incapable of improvement. They recognised working at scale cannot be effective whilst the notion of "bad apples" persists, and although this was a difficult and uncomfortable process for some it was an essential part of the local transformation of general practice.

3. FOCUS ON POPULATION HEALTH

The commissioner imposed the idea of networks being built around geographic proximity because the focus was on population health, not individual GP practices, their alliances or preferences. This would not have been possible without tackling poor performance. Where practices found it difficult to work together the commissioner funded mentoring and team development and, in extremis, professional support in arbitration.

The development of networks and practices working together has been a journey. Although some networks became legal entities others operated on a "gentleman's agreement". However, it was recognised in 2014 in order for GPs to sit equally around the system "table" with the larger organisations there needed to be a single body with a strong voice for general practice.

This led to an agreement to form a Tower Hamlets-wide GP community interest company, called the GP Care Group. Whereas the networks had focussed on long term conditions, this new body is about all of core general practice and was a natural next step after their success in working in units bigger than individual practices.

The formation of the GP Care Group strengthens the GP provider voice at a time when the borough is undergoing massive system redesign. It is an integrated care pilot, has taken on fully delegated co-commissioning and is a multi-speciality community provider (MCP) vanguard site.

The group has already taken on GP education and claims validation, and the CCG is planning to shift IT delivery and other functions over time.

4. DRIVE POPULATION HEALTH WITH FINANCIAL INCENTIVES

Not all practices were comfortable in joining a network but a generous enhanced services income stream was only paid if a practice was part of the network and agreed to share their data.

Investment in general practice was two-fold. There was £1.2m to fund the network management structure, GP time and data searches and £.25m to enable more diabetes care to be provided in general practice (shifted from secondary care). When diabetes

care alone was being run through the network model, the central functions looked expensive but they are now running 31 clinical pathways through the network structure and it delivers a strong return on the investment.

However, the nature of long term conditions and the prevention agenda requires a longer term view than the traditional one or even three year financial cycle. The CCG recognises judgements on whether this model is a success have to be based on improvements in population health first and financial balance second.

The money goes to the network rather than individual practices (70% up front and 30% on performance) and it is up to each network to decide what to do with it, e.g. employ staff centrally, employ locums for an individual practice, share staff, organise patient events etc.

5. CREATE THE INFRASTRUCTURE TO UNLOCK CREATIVITY – THEN HANDS OFF

The commissioner was determined to unlock the creativity and energy that existed in general practice and so made no attempt to be overly directive about what should happen in the networks. They created the boundaries (i.e. the geographic shape of the networks, the financial incentives, and the data sharing) and some high level outcomes but underneath this they allowed the creativity to come from within. This is what they have described as "the magic of the network".

Because of this freedom to innovate, the outcomes have been good. 90% of type 2 diabetes patients now go to their GP, with diabetes specialists coming into networks and practices as consultants rather than delivering direct care. Because the network structure has professionalised the call and recall systems there have also been significant developments in, for instance, delivering NHS health checks, child immunisations, smoking cessation, diabetes and secondary CVD.

6. SUPPORT THE BEST DATA

Sharing benchmarked data at network meetings created clarity on the need for change and helped GPs not to focus on under-performance but on learning from those practices meeting the difficult outcome targets. This is at the heart of the "magic" of the network. Different networks have very different populations and have been able to tailor very specific local solutions.

The data supported the focus on population health by giving practices the ability to see the bigger picture for the whole borough. Whereas most public health data is based on sampling or old surveys and so doesn't have immediacy, the benchmarked data used by the GPs is monthly (they are aiming for daily), and is very specific down to ethnicity, postcode etc. So, for instance, rather than dividing the investment in diabetes in equal portions, as they would have done previously, they can now see there are belts of diabetes in the borough and they focus resources there.

There are challenges here (e.g. in undertaking risk stratification; what is the control group?) and CCGs need to support networks and federations with this.

7. BUILD PARTNERSHIPS

The geographic locality basis has also been useful because it has meant local GPs have been able to build more local and responsive partnerships with individuals and groups within their communities. Different networks have targeted specific communities through public events, working with their community pharmacists, engaging with housing associations etc.

CASE STUDY 15: The Bolton Bounty - Investment in General Practice through a CCG Contract

SUMMARY

- **Bolton CCG developed a new contract for its GPs to provide a guaranteed income per weighted head of population with incentives for the delivery of 19 agreed quality standards**
- **The investment of £3m was returned within the first year and saw a dramatic increase in capacity in primary care, an increase of 60,000 additional appointments, a reduction in waste and expenditure and improvements in a range of care quality measures**

INTRODUCTION

The Bolton Quality Contract was a new contract developed between Bolton CCG and the 50 GP practices in the area from April 2015. The aim was to deliver a mechanism that supported investment in capacity in general practice by providing a guaranteed income per patient with incentives for the delivery of a range of agreed quality standards. £3m was identified to fund the contract.

HOW DID THE CONTRACT ORIGINATE?

The contract was developed for a number of reasons including:

- a desire to develop effective and consistent primary care better able to manage patients in the community
- to support GPs to manage the increasing demand on general practice
- to improve patient satisfaction with access to general practice

The contract was developed in an environment where there were considerable threats to GP income. The team at Bolton CCG were aware of contract development work in Liverpool some years earlier where the CCG had invested its own money in a new, enhanced contract for GPs linked to the achievement of a set of standards. They visited Liverpool in early 2014 and began to work on their own solution.

HOW WAS THE CONTRACT DEVELOPED?

Immediately on their return from Liverpool the CCG invited a representative group of GPs, the LMC and their commissioning leads to a meeting where they explained their ambition to go further than the Liverpool scheme and invest around £3m for the delivery of a set of quality standards. Engagement with GPs began immediately over the principles of the contract and what the standards might be. The Primary Care Team in the CCG visited all the practices to explain the contract and the Board of the CCG committed to introducing the contract in January 2015. Over the following months each practice was required to produce a plan which detailed the investment they would make in staffing to achieve the standards and how they would meet each requirement. All practices signed up and the contract began in April 2015.

WHAT STANDARDS ARE INCLUDED?

The standards fall into three main areas:

1. Those focused on improving care and experience for patients
2. Those focused on requiring practices to deliver enhanced services

3. Those focused on how the practice is run

There were nineteen standards initially (a twentieth has been added at the end of the first year to cover practices' role in integration and care planning for the over-75s).

The biggest set of standards were those around access to general practice which required, for example, an increase in the number of appointments offered across the board, all practices to be open for appointments during the contracted working hours (i.e. no afternoon closures), all practices being able to offer access to a male or female GP, an expectation that all children would be seen and assessed on the same day, and all practices to offer phlebotomy.

There were standards in eighteen other areas including cancer referral, end of life care, sexual health and more.

Achievement of the standards is measured through a range of challenging key performance indicators (KPIs).

HOW WERE THE TARGETS SET?

Setting the standards was easier than agreeing what should be measured! In order to set targets which would reduce variation and level-up performance, learning from the Liverpool experience, the CCG agreed to measure all practices against the 75th percentile rather than the average. This ensures stretch targets for at least three quarters of the practices. This was appropriate for targets such as prescribing but did not work for some of the other standards e.g. getting practices to influence the take-up of bowel screening where factors such as patient ethnicity play a large role. To set a standard for this type of target the CCG grouped practices into peer groups according to the demography.

HOW DOES THE CONTRACT WORK?

The CCG wanted to ensure equity of funding. The pre-existing core contracts for each practice were different and covered a wide range of payment levels. To achieve equity, the proposal was the Bolton Quality Contract would pay the difference between each core contract and £95 per weighted head of population. Effectively, a new level of income was set at £95 per head if practices met the requirements of the contract.

The core contract (PMS or GMS) and the QOF element remain in place but an additional NHS contract has been added which delivers the Bolton quality standards and pays the difference between the core contract and the £95.

Any practices that were already paid over £95 retained their core funding. If, in the future, NHS England were to reduce the core contract for those practices, they were guaranteed by the CCG that their income would not fall below £95 per head, if they met the quality contract.

The £3m investment comes from the CCGs commissioning budget and the CCG calculated that, if all practices met the standards, it would create a return on the investment in the first year. It was agreed if it delivered in year one and effectively funded itself, it would be made recurrent. The return on investment was largely predicted to come from prescribing but also from a reduction in emergency attendances because of the improvements in access.

Practices are paid on the basis of the plan they developed and delivery of the KPIs against each standard. 60% is payable on delivery of the recruitment plan (an increase in capacity) and the achievement of the mandatory standards. The other 40% (effectively performance related) is paid on the extent to which practices meet the KPIs.

Five payments are made. There is one up-front payment and then a payment each quarter. This reflects performance throughout the year but ensures cash-flow in the practices.

THE RESULTS IN YEAR ONE

The £3m investment returned approximately £3m in the first year, a fact of which the CCG is rightly proud and meant they could continue with the contract into the second year (and increase the payment to £102 per weighted head).

In terms of access the CCG has met its target of increasing appointment slots by 60,000 across the year. Responses to the national patient survey regarding access have improved, with the CCG now better than the England average on most standards. On ability to get an appointment the CCG score has risen from 77% to 82.4% - the best in Greater Manchester, as is the Friends and Family Test.

In prescribing there has been a saving of over £2m from increased effectiveness and a reduction in waste.

Screening has also improved, including 125,000 patients (over 50% of the population) undertaking the Audit C questionnaire on alcohol harm and a rise in bowel cancer screening. There have been increases in the care indicators around asthma and heart failure.

The CCG has also been able to measure the staffing capacity across the 50 practices and this has increased as expected (although, in medical staffing, the increases have mainly been in locums and salaried GPs – reflecting the national difficulty in appointing partners).

Many local practices praised the Bolton Quality Contract and were pleased the CCG was actively supporting general practice. The income guarantee and financial security has helped them make longer term investment decisions. Some, however, have not enjoyed being scrutinised quite so relentlessly.

LESSONS LEARNED

The quantity and complexity of KPIs led to a mini “industry” in data collection and, on reflection, the CCG would have limited the number of KPIs.

Some KPIs turned out to be difficult to measure or no longer made sense during the year.

Already having a large number of measures in existence helped in setting the standards.

Working closely and early in the process with the GPs to agree the KPIs was essential. When practices are engaged and energised they will deliver.

The investment in capacity in general practice is essential if the whole local healthcare system is to survive. £3m out of a £370m budget is a relatively small price to pay.

CASE STUDY 16: Leveraging Locums – Establishing a local locum GP chambers

SUMMARY

- **Supporting the development of a local locum GP chambers is a tangible way for CCGs to ease the impact of the GP recruitment crisis on local practices**
- **They keep GPs in the local system, provide an accessible route back for GPs who have left and attract new locums to the area**
- **For local practices they improve the quality of locums, reduce overall expenditure on locums, and make locums easier to find**

INTRODUCTION

Locum GP Chambers are, according to the National Association of Sessional GPs (NASGP) "…*small, independent groups of local self-employed locum GPs all working together through a shared management structure to support NHS GP practices to maintain, and in some cases improve, local GP services*."

Local Locum GP Chambers are organisations made up of and owned by small groups of locum GPs. Each of these GPs contributes a share of their earnings to fund an administrative team that carries out all the bookings, queries, handling of feedback and complaints, invoicing and cancellations for the group. The member GPs operate as a peer support group to each other, and they meet regularly for clinical governance sessions, discussing significant events and generating evidence for NHS appraisal. Typically, they consist of 10-15 locum GPs and cover a specific geographic area of 60-70 practices.

WHAT PROBLEMS ARE THEY TRYING TO SOLVE?

The challenges of GP recruitment and retention are well documented. According to a 2015 Pulse survey, 9% of GP partner positions remain currently unfilled, and almost 1 in 5 of these roles are taking over a year to fill[xxxi]. As many as 49% of GPs report a colleague has left their practice due to retirement or emigration in the last 12 months[xxxii]. According to the same 2015 survey 40% expect a GP at their practice to retire in the next 12 months, and 7% expect one to emigrate. 34% of GPs hope to retire from general practice in the next 5 years[xxxiii].

Between 2009 and 2014, 45.5% of GPs leaving the NHS were under 50 years of age[xxxiv]. Commenting on the Commonwealth Fund GP Survey 2015[xxxv] the Health Foundation reported,

"*There is a clear correlation between those who want to leave general practice and stress levels. In the UK, 29% of GPs plan to leave general practice within five years. Of those planning to leave medicine for a different career, 82% identified their role as extremely stressful. In contrast, of those who plan to stay, 48% identify it as extremely or very stressful*."[xxxvi]

Consequently, the usage of locums is growing. In a recent GPonline Survey of 352 GPs[xxxvii], 55% said the proportion of sessions filled by locums has risen throughout the past year, with this rising to 63% over the past three years.

Practices struggle to find locum cover when they need it. In a BMA survey of 2800 practices[xxxviii]:

- 46% of practices said they have trouble finding locum cover "frequently"
- 40% "occasionally" have issues
- Only one in ten GP practices in England said they did not require locum cover at all

At present there are c17000 GPs who are locums, representing a quarter of the GP workforce. They see 36M patients a year. This number is set to grow further. According to the Kings Fund[xxxix] 44% of trainees plan to locum within a year of qualification. The current workload pressure is also leading many GPs to leave practices and become locums. A poll of 701 locum GPs[xl] revealed 1 in 5 were in partnership or salaried roles a year ago.

In a recent NASGP survey[xli] of over half of all the GPs currently working in a local GP Chambers, 91.5% agreed or strongly agreed they are currently still a GP because of the existence of the local chambers. 81.5% indicated they would have burnt out if it was not for the chambers. Direct comments from GPs who undertook the survey included,

"Given my particular circumstances, joining a chambers allowed me to continue to practice as a GP without being isolated. It is also useful to be able to support and be supported. If I had been able to remain a partner I would have done so. I was fortunately able to take my pension, but had I not I could not afford to remain a partner financially, physically (high BP as a result of stress) or mentally (burnout)."

"I really had burnt out as a partner, and when I read about chambers I looked them up on Google, put the house on the market, and the rest is history!"

"Chambers helps support me and I feel part of a professional team - as well as taking the hassle out of being freelance. I can choose my workload, share problems with colleagues and continue my learning within a peer support group. Being part of a practice these days is higher and higher risk as systems, services and staff become more stressed."

THE BENEFITS OF A LOCAL LOCUM GP CHAMBERS

They keep local GPs in the local system. Local GP Chambers create an opportunity for GPs, who might otherwise leave because of the stress levels in general practice, to continue to practice. They are an option for those GPs who simply want to be able to focus on seeing patients without the pressure of working in a specific GP practice. They also provide peer support, and remove the burden of booking and invoicing that becoming a locum entails.

They offer an accessible route back into general practice. Similarly, there are large numbers of GPs who have already left because of the pressures they were experiencing. Operating as a locum within a chambers allows GPs to take more control over their workload and work-life balance, without the isolation some locum GPs experience. As such, it offers an accessible route back into general practice for those who may consider a return, but are concerned about operating independently as a locum.

They attract locum GPs to your area. Finding a locum is becoming increasingly difficult. Local locum GP chambers establish a group of locum GPs to work consistently in a specific local area. As the chambers grows the availability of locums for local practices improves.

They improve the quality of local locum GPs. Traditionally the quality of locum GPs is variable. However, local locum chambers build in audit, education, peer support and

complaints procedures to enable quality and performance to be monitored and continuously improved. They also make appraisal and revalidation much more straightforward.

They enable locum GPs to be effective quickly in each local practice. Local locum GP chambers develop systems to make it easy for each of their locum GPs to get to know the different ways of working in each practice. One of the biggest challenges facing a locum GP is to become effective quickly within a new environment, and by working with a specific number of local practices the chambers is able to share information and support its members to do just this.

They ensure locum GPs operate as part of the local system. The only system interactions many locum GPs have is with the individual practices they support. A local locum GP chambers provides a contact point between the CCG, the local healthcare system, and the locum GPs. This means where new systems, such as new referral pathways, are introduced, the local locum GPs can be informed and be part of the process of implementation.

They reduce expenditure on locum GPs. Chambers are entirely funded by charging each member a percentage of their income, instead of charging the practice. There is no additional agency fee incurred. Locums from GP Chambers are typically 25%-40% cheaper than those accessed from agencies.

They make finding locums GPs easier for local practices. Chambers provide an easy point of contact (usually one email) that results in a high quality locum attending at a set price. This is in stark contrast to the experience of many practice managers, who can spend hours and even days chasing and negotiating with agency after agency to try to find a locum.

They allow local systems to access the talent and skills of locum GPs. Locum GPs have plenty to offer local systems. They have a unique perspective as they have seen first-hand how many of the different practices within an area operate. They can identify and facilitate the spread of best practice between practices. In many areas locum GPs from local chambers have even taken up leadership positions within the local CCG.

HOW CCGS CAN SUPPORT THE DEVELOPMENT OF LOCAL LOCUM GP CHAMBERS

As a result of these benefits, local locum GP chambers can be very attractive for CCGs. However, establishing them locally is difficult because it lies outside of the direct control of the CCG. It is not as simple as deciding one is needed, and then charging someone within the CCG with setting one up and persuading a few locum GPs to join to get it off the ground.

This is because the chambers will only work if they are owned by the locum GPs themselves. One of the reasons GPs become locum GPs is because they do not want to work for anyone else. Working for a chambers established by the CCG would feel to them like joining an organisation on a zero-hours contract, where it is in the gift of the organisation to decide when and where they will work. This loss of control makes it so unattractive that most locum GPs would not join.

There are, however, actions CCGs can take:

Publicise the model locally. To start off with CCGs are unlikely to know who the potential GP members of the chambers will be. The aim is to connect those GPs who would like to be part of a local locum GP chambers with the idea of it. Publicising the model and the benefits it can bring will help make that connection.

Identify a leader. In order for the model to take off locally, the CCG will need to use all of its networks and contacts within the GP

community to find a locum GP who wants to lead its development. Dr Mark Sage, a GP locum who set up the West Kent chambers, suggests the place to look would be either, "*the well-established locums in an area, or the more recently qualified doctors, who are looking for a group they can affiliate with*". He suggests Programme Directors on VTS courses are important contacts, as they know the plans of the GPs leaving the course.

Provide support for the leader. The support those who have set up chambers describe as most beneficial is moral support in terms of encouragement and working through any issues which arise. They also mention help with the business case, in particular establishing the level of demand for locums from each of the local practices, so the newly formed chambers can be clear sufficient demand exists for the new business.

HOW CCGS CAN PARTNER WITH LOCAL LOCUM GP CHAMBERS

Once a chambers has been established locally, CCGs can partner with them to put together a programme to offer training and other services to local practices. This programme can include:

Practice Improvement. The chambers can collect regular feedback on each practice from its GP locums and sensitively provide constructive feedback to help practices improve their working relationship with its clinicians. It can also play an active role in identifying local best practice and spreading it to other areas (e.g. appointment systems, DNA policies and procedures etc.)

Backfill to create GP time for CCG business. GPs often cannot attend CCG meetings because no locums are available. Local locum GP chambers can work in partnership with the CCG and use their local workforce intelligence to ensure these meetings are organised at a date and time when backfill can be arranged.

Practice Manager Training. The chambers can put on workshops for practice managers on how to make the best use of locum GPs, including elements such as getting their feedback on your practice, how to make sure locums want to keep working at your practice, avoiding risk and complaints, and spreading best practice.

GP Locum Training. The chambers can provide training for locums to include elements such as high quality referrals, improved prescribing, supporting continuity by writing better notes, being involved in clinical governance, increasing effectiveness as a locum by giving better feedback, engaging with the practice, risk management and clinical handover.

Workforce Planning. Commissioners and the chambers working together proactively can ensure an effective use of the local GP locum workforce to help manage and avoid workforce issues, including holidays, sickness, winter, out of hours and weekends.

Service Provision. As with other GPs, many GP locums have specialist skills e.g. women's health, dermatology etc. As locum GPs these skills are often under-utilised, but within the chambers model these skills can easily be deployed across the CCG when and where they're needed.

Direct locum Involvement in CCGs. CCGs and local locum GP chambers can work together to better involve the dedicated pool of flexible locum GPs so they are more involved with commissioning, especially building on their experience in working in lots of different practices across the patch.

LESSONS LEARNED

- CCGs cannot successfully own chambers. The locums need to maintain ownership otherwise there is a feeling that the GPs could be "at the beck and call" of the CCG

- CCGs can however help publicise the chambers model, identify those who might set up a chambers, and give them support as they establish the chambers locally

- A chambers needs to remain small enough to allow effective peer support, to allow the members to work together easily to analyse significant events and to allow members to share information comfortably

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CCGS AND GENERAL PRACTICE - ANALYSIS

BACKGROUND AND CONTEXT

The current crisis in general practice presents a real challenge for CCGs. CCGs are statutory bodies, whose role is the planning and commissioning of health care services for their local area. At the same time, they are membership organisations of groups of GP practices, but their responsibility to their members can be unclear.

CCGs have always had a duty to improve the quality of primary care, and more recently have taken on an increased role in the direct commissioning of general practice. They consistently have to manage the tension between supporting general practice to be able to play its role in the local healthcare system, and managing the conflict of interest for those GPs on CCG Governing Bodies making decisions to allocate resources or support to local practices[xlii].

> ***…GPs are important to commissioning because they understand the needs of their local population…***

GPs are important to commissioning because they understand the needs of their local population, and are uniquely positioned to ensure money is spent on areas that will deliver the greatest benefit to patients. The challenge for CCGs comes when that money should be spent on general practice itself, and applying the rigour required to ensure this is truly the case, and that accusations self-interested GPs are seeking to line their own pockets can be countered.

The level of involvement of CCGs in the development of primary care has varied. Research by the Kings Fund and the Nuffield Trust[xliii] found, "*For some, GP leadership and influencing one another's clinical practice were already commonplace, but others were wary of undertaking this role. The reasons for this caution were numerous:*

- *not wanting to be seen to be "policing" colleagues*
- *a concern over resources*

- *diverting attention from CCGs' primary purpose*
- *the impact on GP engagement*
- *resistance to doing a job that was seen by some as NHS England's and wanting to wait and see how the relationship with NHS England developed*" p28-29

Whilst the opportunity for CCGs to play a more leading role has grown recently, in many areas these concerns have lingered and prevented any real progress from being made.

Meanwhile, the crisis in general practice has deepened, and action is required. This was the central thrust of the General Practice Forward View (GPFV). This document mandates investment in general practice by CCGs, including a requirement to invest £171M of "*practice transformational support*" from 2017/18 to "*stimulate development of at scale providers for extended access delivery, stimulate implementation of the 10 high impact changes in order to free up GP time to care, and to secure sustainability of general practice to improve in-hours access*". CCGs are also to invest in IT and technology at practice level and spearhead investment in primary care infrastructure.

The mandates contained within the GPFV create an opportunity for CCGs to provide more consistently active support for general practice in future.

SUPPORTING THE DEVELOPMENT OF GENERAL PRACTICE: 5 PRACTICAL STEPS FOR CCGS

Within this challenging context it is not always clear how CCGs can best provide appropriate and effective support for general practice. Based on the experiences within our case studies we have identified five practical actions CCGs can take to support the development of general practice.

1. Introduce a single contract to uplift funding for general practice

The share of overall NHS funding allocated to general practice has consistently declined in recent years. Two of our case studies identified mechanisms for improving the allocation of resources to general practice in ways that also delivered real benefits to the populations they serve.

In Tower Hamlets (*Case Study 14; page 88*) a focus on quality and population health enabled significant investment to be made in local general practice by the CCG. In Bolton (*Case Study 15; page 91)*, the CCG has invested an additional £3m into general practice and provided a guaranteed minimum income per practice. By bringing together the different funding streams for general practice and investing additional resources, the CCG created an uplift of core funding that made a real difference to the problems GP practices were experiencing, while at the same time generating real improvements in the quality of service provision for patients.

> ***…A number of CCGs have taken the principles used by Bolton CCG to create their own version of a local contract…***

A number of CCGs have taken the principles used by Bolton CCG (and Liverpool CCG before them) to create their own version of a local contract.

General practice delivers 90% of patient care in the NHS, and any high performing system requires a high performing general practice. By combining investment with quality improvements CCGs have been able to increase funding to general practice as well as ensure they deliver their duty as commissioners of healthcare services for the local population.

2. Support the introduction of new roles into general practice

As recruitment of GPs becomes increasingly difficult, GP practices are being forced to look at the introduction of new roles, such as advanced nurse practitioners, paramedics, pharmacists, physiotherapists, mental health workers and physician associates.

Indeed, the NHS Alliance report Making Time in General Practice[xliv] found, "*The greatest opportunity for relieving pressure on GPs is by extending and making fuller use of the wider practice team. There is considerable variation across practices with some making extensive use of a broad skill mix while others retain a traditional medical model of general practice... New roles may offer fresh ways of sharing the workload in a way that reduces pressure on GPs and improves the overall quality of care for patients.*" p37

They suggest commissioners can help by supporting and promoting initiatives to share new skills across practices. Some CCGs have gone further than this by developing local general practice workforce strategies that include aspects such as:

- Establishing the local availability of each type of role
- Bringing together into one place the additional funding available to support practices with these different roles

- Creating a local scheme to support the introduction of the roles that will have the greatest impact locally, e.g. extended scope physiotherapists
- Providing information about the availability of local training, e.g. prescribing courses for pharmacists, and information on implementation issues such as indemnity
- Creating local groups whereby clinical staff taking on these new roles can gain support from each other, and share best practice

3. Support the establishment of a local Locum GP Chambers

GP locums make up nearly a quarter of the GP workforce, according to the National Association of Sessional GPs (NASGP). GP practices spend inordinate amounts of time finding GP locums, and often have to pay exorbitant rates. Encouraging the local locum GPs to establish a chambers (*Case Study 16; page 94*) will improve the availability of locum GPs, improve the quality, and reduce the cost. Supporting the establishment of a locum chambers locally is a tangible way in which CCGs can actively support local practices to cope with the shortage of GPs.

> ***…supporting the establishment of a locum chambers is a tangible way in which CCGs can actively support local practices to cope with the shortage of GPs…***

However, the establishment of the chambers ultimately lies outside of the control of the CCG. This is because the chambers will only work if they are owned by the locum GPs themselves. And for them, the CCG-led model is not attractive. GP locum Dr Caroline Chill puts it like this, "*If chambers are controlled by CCGs it makes being a locum less attractive, because it almost becomes a zero-hours contract with the terms and conditions being dictated by the practices using the service*".

CCGs can however facilitate their development, and our case study identifies exactly how CCGs can do this.

4. Help local GP practices explore the opportunities of working at scale

A recent Kings Fund Report[xlv] examined what approaches CCGs had taken to develop general practice. These included, "*Commissioners taking a leading role in supporting the development of new provider models capable of supporting transformation in primary care. CCGs are well placed to lead an active debate locally and to facilitate discussions between providers. If local general practice providers are interested in working more collaboratively or at scale, research suggests that the main barriers (and thus areas where CCGs might provide support) are: getting all parties to sign up to the agreement; understanding what the benefits are for practices; finding the time to lead this change; and uncertainty around choice and competition regulations, organisational development and leadership.*" p33-34

The origins of Our Health Partnership, in our case study of the largest "super-practice" in the country (*Case Study 6; page 38*), came from the CCG providing some facilitation support and opportunities for local GPs to come together to explore the potential of working together at scale to work out what it could mean for them.

In the recent Nuffield Trust report, "Is Bigger Better? Lessons for large scale general practice"[xlvi] there were the following recommendations for CCGs,

- *"Have realistic expectations about the capacity of large-scale general practice organisations to take on extended roles, their ability to develop specialist skills and their capacity to set up*

new services. Involve large-scale organisations, therefore, at a pace that allows them to bid for and, if successful, establish new services without becoming overwhelmed.

- *Facilitate local debate between patients, the public and other stakeholders about how best large-scale general practice organisations can contribute to population health improvement and what other part they might play in the local health economy.*

- *Follow guidance on conflicts of interest, but avoid excluding GPs with an expert knowledge of a specific area of care from service redesign work"* p5

They go on to say,

"*Many CCGs are keen to get these organisations up and running in order to deliver more care in community settings and they are likely to feature prominently in emerging Sustainability and Transformation Plans (STPs). But CCGs may be reluctant to invest money in setting them up due to their current "immaturity" as service delivery organisations, due to conflicts of interest or because some are perceived as private organisations. Other options for helping the organisations to develop include funding initiatives to improve quality; offering "support in kind" (for example seconding CCG staff to the organisation) and stimulating growth through contracts to deliver services*." P87-88

> ***…one of the key challenges is finding the GP leaders with the right skills and experience…***

One of the key challenges is finding the GP leaders with the right skills and experience, as well as the willingness, to lead this type of change in general practice. It is not easy. There will always be scepticism from some, and trust between practices has to be built and developed over time. Many of the GPs who could potentially take on this role are currently working in CCGs. One option for CCGs is to second some of these GPs back to general practice, to lead and support the efforts of local practices to work together.

Secondment from the CCG enables the time of these GP leaders to remain protected. It allows these GPs, who have developed skills in building and maintain partnerships while at the CCG, to develop the new models of care locally from the ground up. A key challenge is ensuring this is received as a genuine offer of support, rather than a CCG attempt to force federations (or the like) on its member practices. Only GPs can really develop general practice, and seconding GP leaders is potentially one of the most powerful actions a CCG can take to accelerate the development of at-scale working.

5. Facilitate the development of partnerships between GP practices and other local providers

Joint working between GP practices and other health providers, such as community trusts, acute trusts and local councils has enabled some GP practices to develop new staffing models, introduce new systems for managing on the day demand, and create innovative approaches to managing estates. Our case study of the joint work between Southern Health and the practices in South Hampshire (*Case Study 9; page 60*) is a good example.

What GP practices lack is an understanding of the enthusiasm of different local organisations for collaborative working, what type of joint work might be attractive, and who, within each organisation, is the best point of contact. CCGs can establish this information and make it easily accessible to practices, and then actively support joint initiatives as they develop.

CCGs can also help shape the development of these partnerships locally by establishing clear links between system transformation plans and planned or actual local initiatives, by clarifying routes for future investment of funding into change efforts and locality developments, and by creating a road map to the future for local practices and partner organisations.

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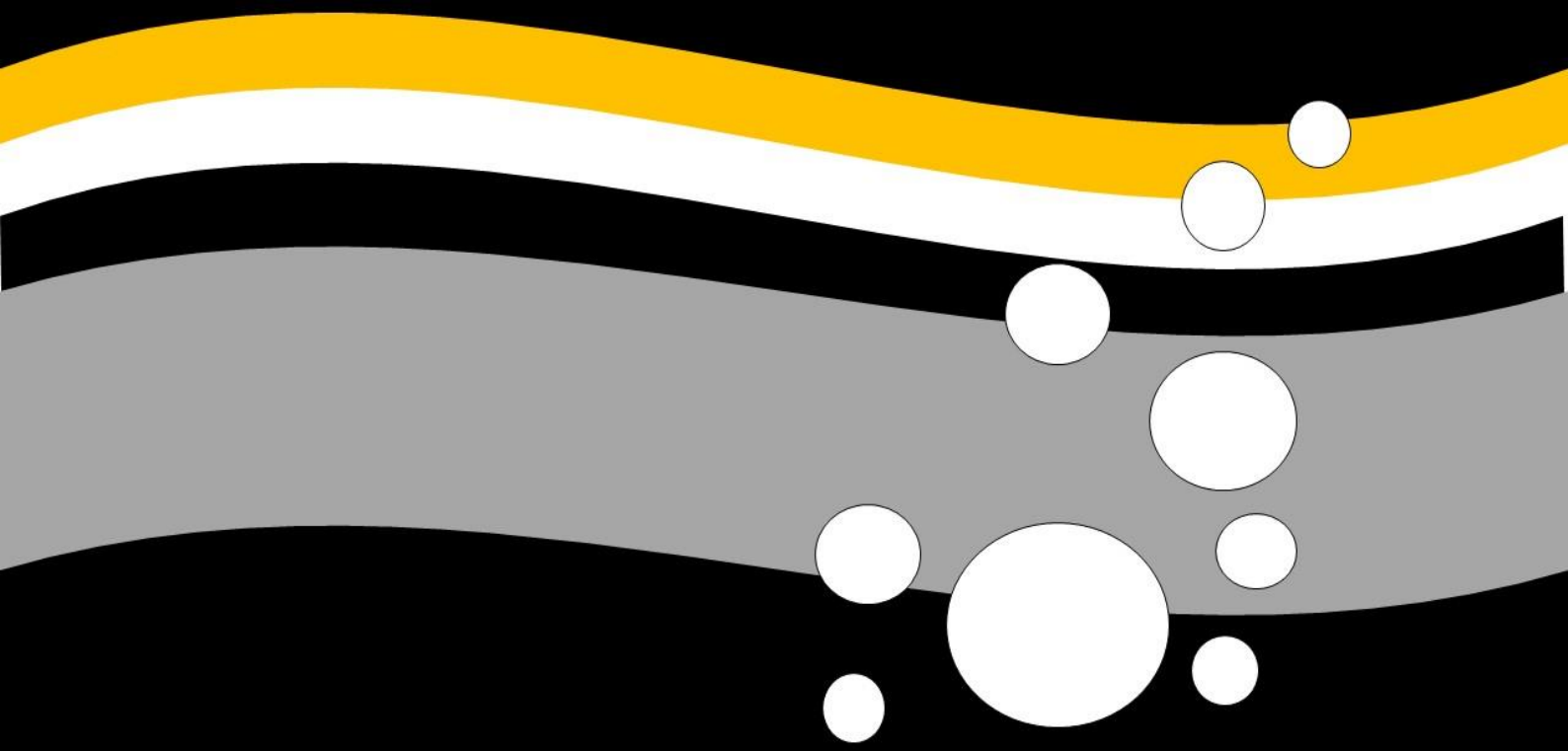

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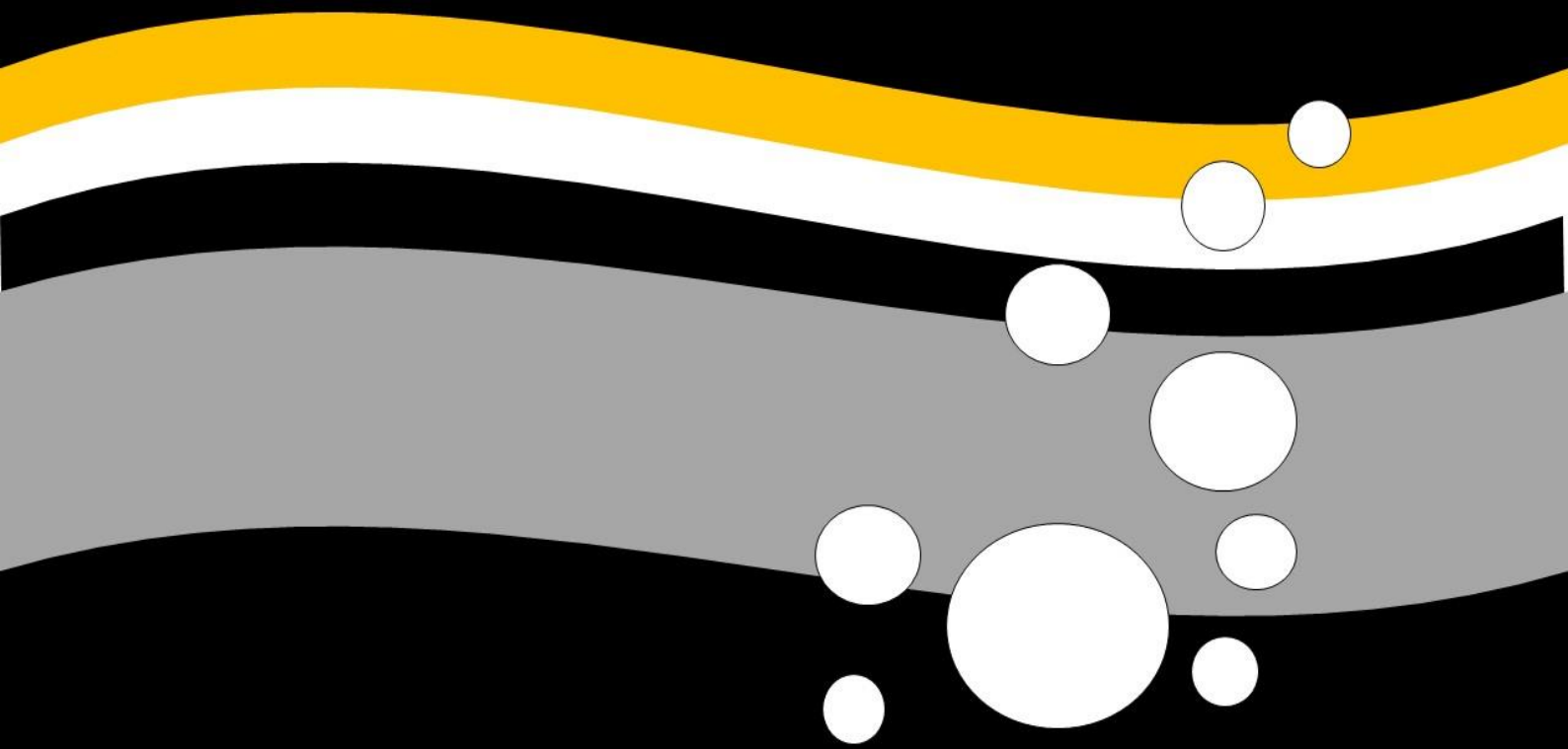

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