Delivering a sustainable future for General Practice

BMA

Richard Vautrey
Chair, BMA GP committee England

Recognition of the problem
NHS Five Year Forward View October 2014

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"General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain"

"Primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care"

Underfunding of healthcare in the UK

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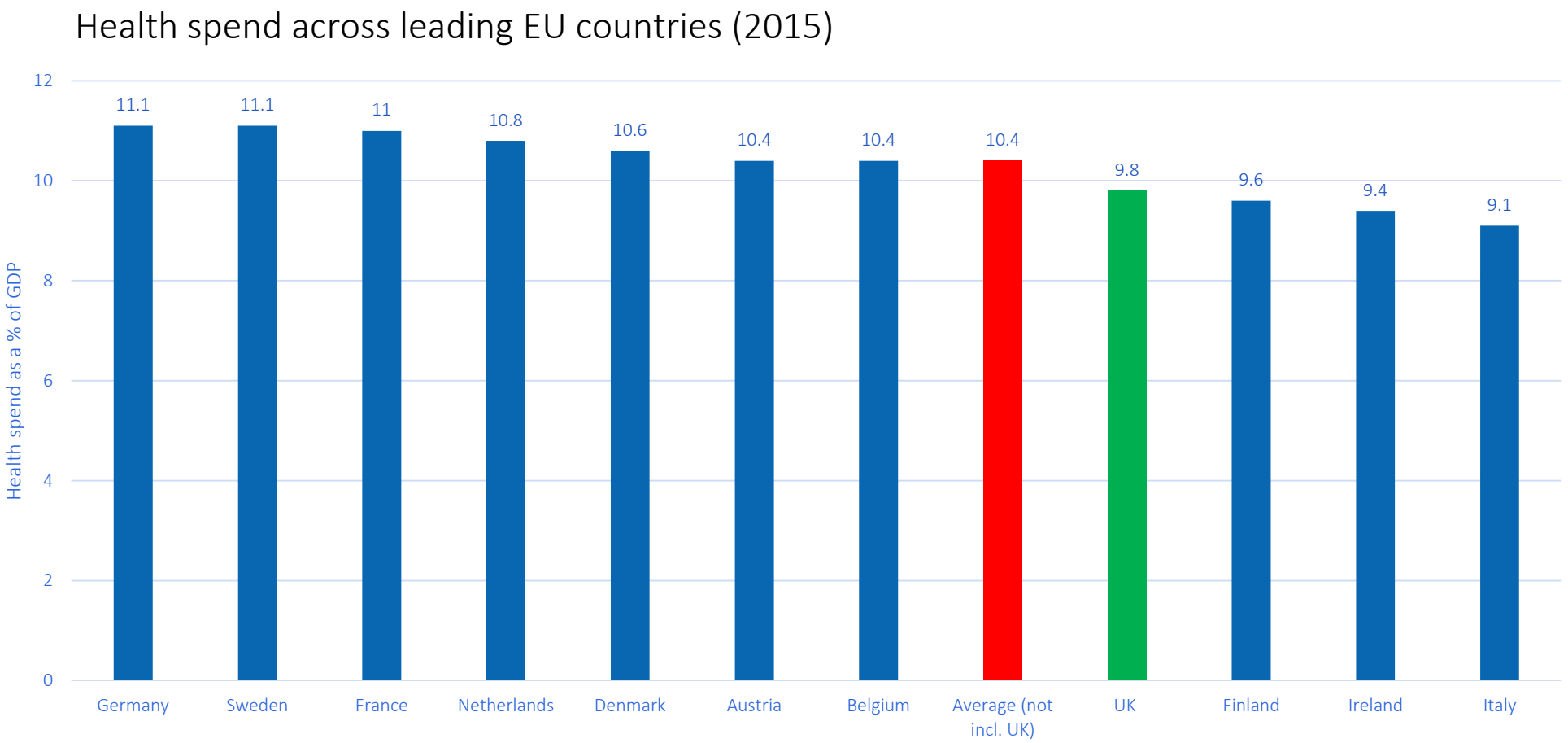

Share of NHS funding invested in general practice (England)

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Year	% total investment	% excluding dispensed drugs
2004/5	10.0%	N/A
2005/6	10.4%	N/A
2006/7	9.8%	N/A
2007/8	9.2%	N/A
2008/9	8.7%	8.0%
2009/10	8.5%	7.8%
2010/11	8.3%	7.7%
2011/12	8.2%	7.6%
2012/13	8.0%	7.5%
2013/14	8.0%	7.4%
2014/15	8.1%	7.5%
2015/16	8.3%	7.7%
2016/17	8.5%	7.9%

NHS budget TDEL, source PESA. GP investment, source HSCIC

GP share of NHS budget – projected change

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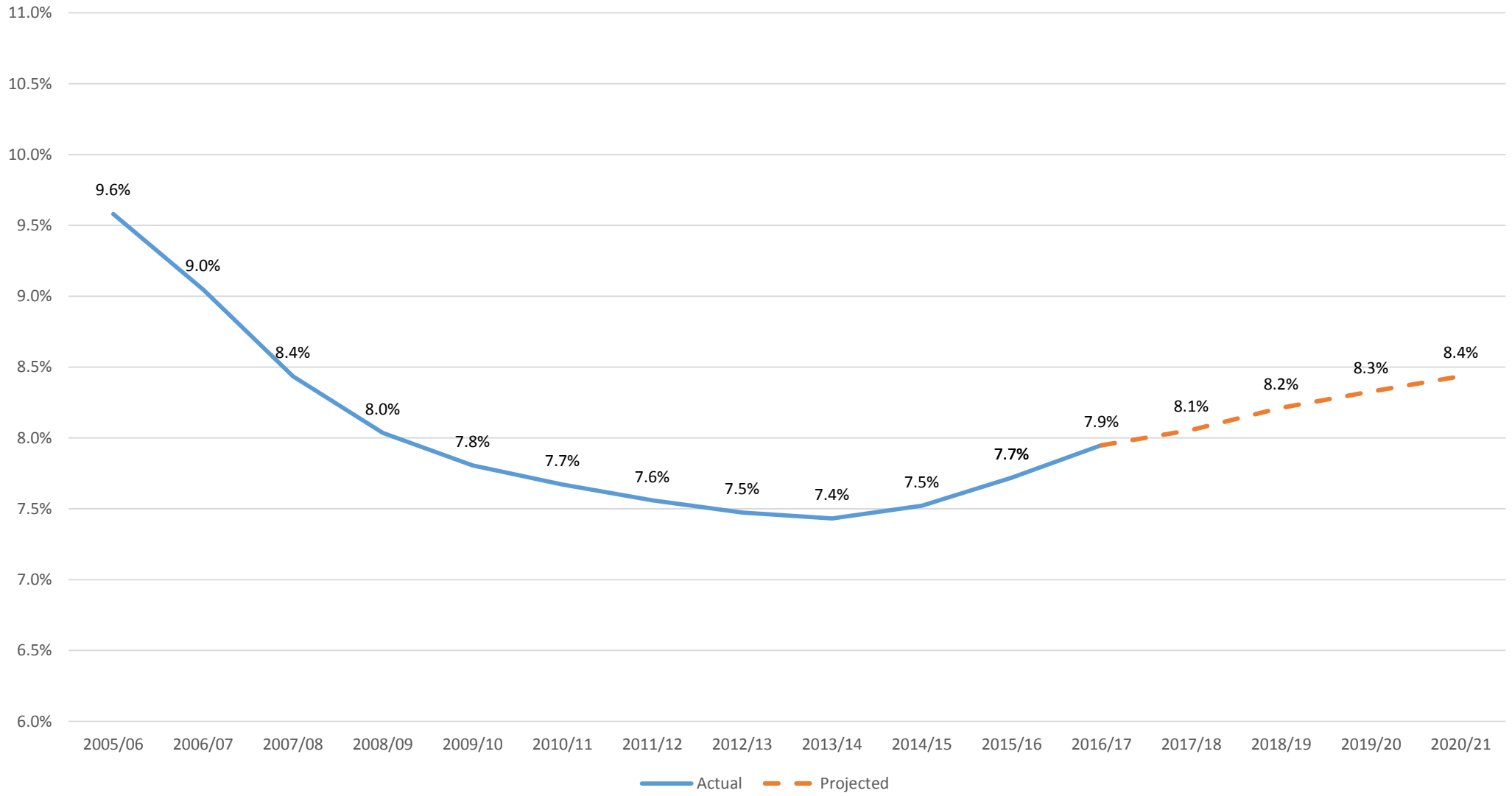

Funding gap to reach 11% investment target

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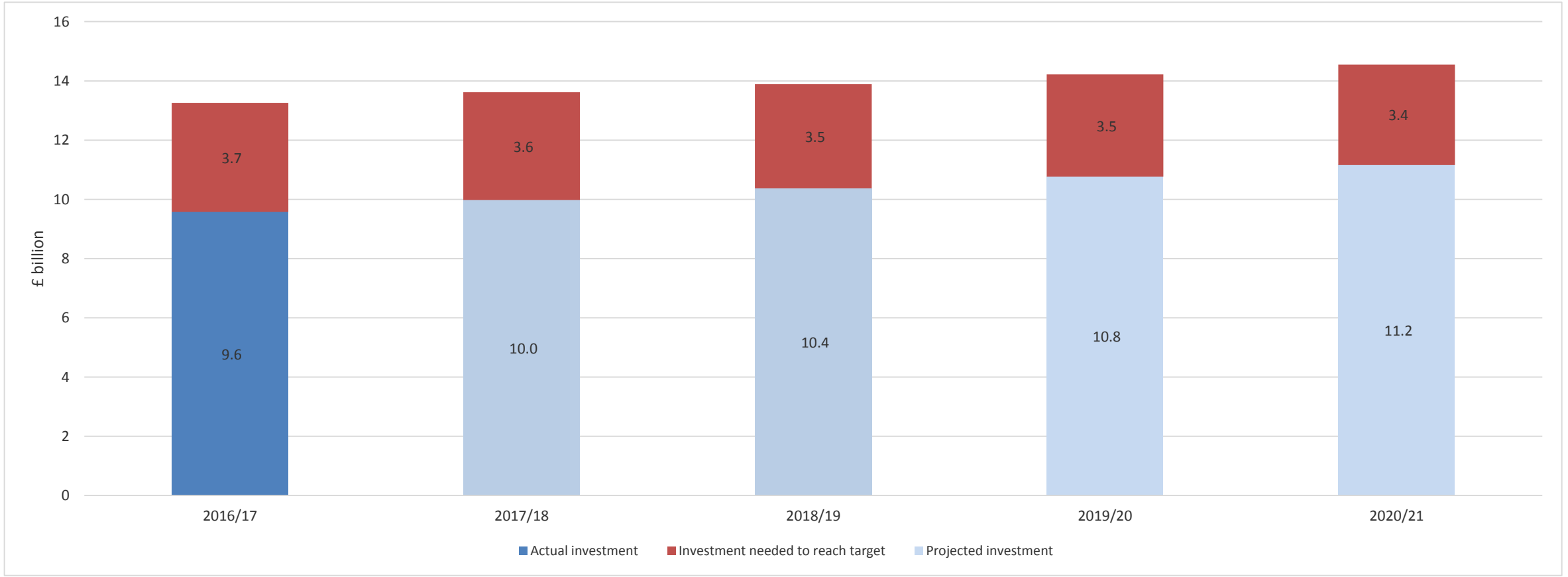
Investment in general practice (excluding drug reimbursement)



Payments to practices in England 2016/17

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(per weighted patient)

- GMS - £147.42 (5301 practices)
- PMS - £155.06 (2127 practices)
- APMS - £224.03 (279 practices)

- Average payment - £151.37
- Average payment for non-dispensing practice - £142.63

Managing and reducing workload

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The UK population is projected to reach 70 million by mid-2027

- By 2039 – 9.9 million 75+, 3.6 million 85+
- By 2020 – 1.1 million 65+, over 300,000 85+

As a result of demographic changes, there have been significant increases in NHS activity across the UK in recent years.

Several studies have examined workloads:

- Between 2007 and 2014 overall consultation rates for GPs in England rose by 13.6%. (Oxford University, 2016). Consultations grew by more than 15% between 2010/11 and 2014/15 (Kings Fund 2016).
- In Scotland consultations rose by 3.9% from 15.6 million to 16.2 million between 2003 and 2013 (ISD, 2013).
- In Northern Ireland, total general practice consultations rose from 7.2 million in 2003/04 to 12.7 million in 2013/14 (BMA, 2015).

*There has been no routine public reporting of GP activity data and no standardised national dataset to date – new NHS England data collections are currently in progress in England.

List closure survey

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Turnout	23.9%			
	Yes (% of respondents)	Yes (% of all practices)	No (% of respondents)	No (% of all practices)
Temporary suspension of patient registration	53.74%	12.84%	46.26%	11.05%
Application for formal list closure	43.96%	10.5%	56.04%	13.39%

"The government needs to understand that this landmark survey sounds a clear warning signal from GPs that cannot be ignored, and that the workload, recruitment and funding crisis in general practice must be addressed with far more vigour and commitment."

Dr Richard Vautrey

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Daily Mail

I disagree with Rees-Mogg on rape and abortion – but how I admire a man of real principle

SARAH VINE PAGES 10-11

More than half of under-pressure GPs now want to close their lists

DOCTORS: WE WON'T TAKE ON ANY MORE PATIENTS

Love Cruise made Katie keep secret for FIVE years

GPC wrote to the Secretary of State

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Stretched GP clinics may have to ban newcomers to ensure patient safety, Jeremy Hunt warned

'GPs would only consider such action as a final recourse'

Ella Pickover | Wednesday 4 October 2017 18:23 BST |

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BMA writes to Hunt warning GPs will close lists 'as final recourse'

4 October 2017 | By Julia Gregory

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EMAIL TO A FRIEND

The BMA has written to health secretary Jeremy Hunt warning that GPs would be willing to close their lists en masse unless the Government tackles the 'urgent challenges which have led us to this position'.

GP Committee chair Dr Richard Vautrey told the health secretary that the BMA is 'deeply concerned' that practices are reaching the point 'where closing their lists seems the only viable way to ensure patient safety'.

He called for a meeting with the health secretary to discuss 'the urgent challenges which have led us to this position.'

The letter is in response to the survey conducted by the GPC, which found that 54% of practices said they would consider temporarily suspending patient registration to concentrate of delivering safe care to

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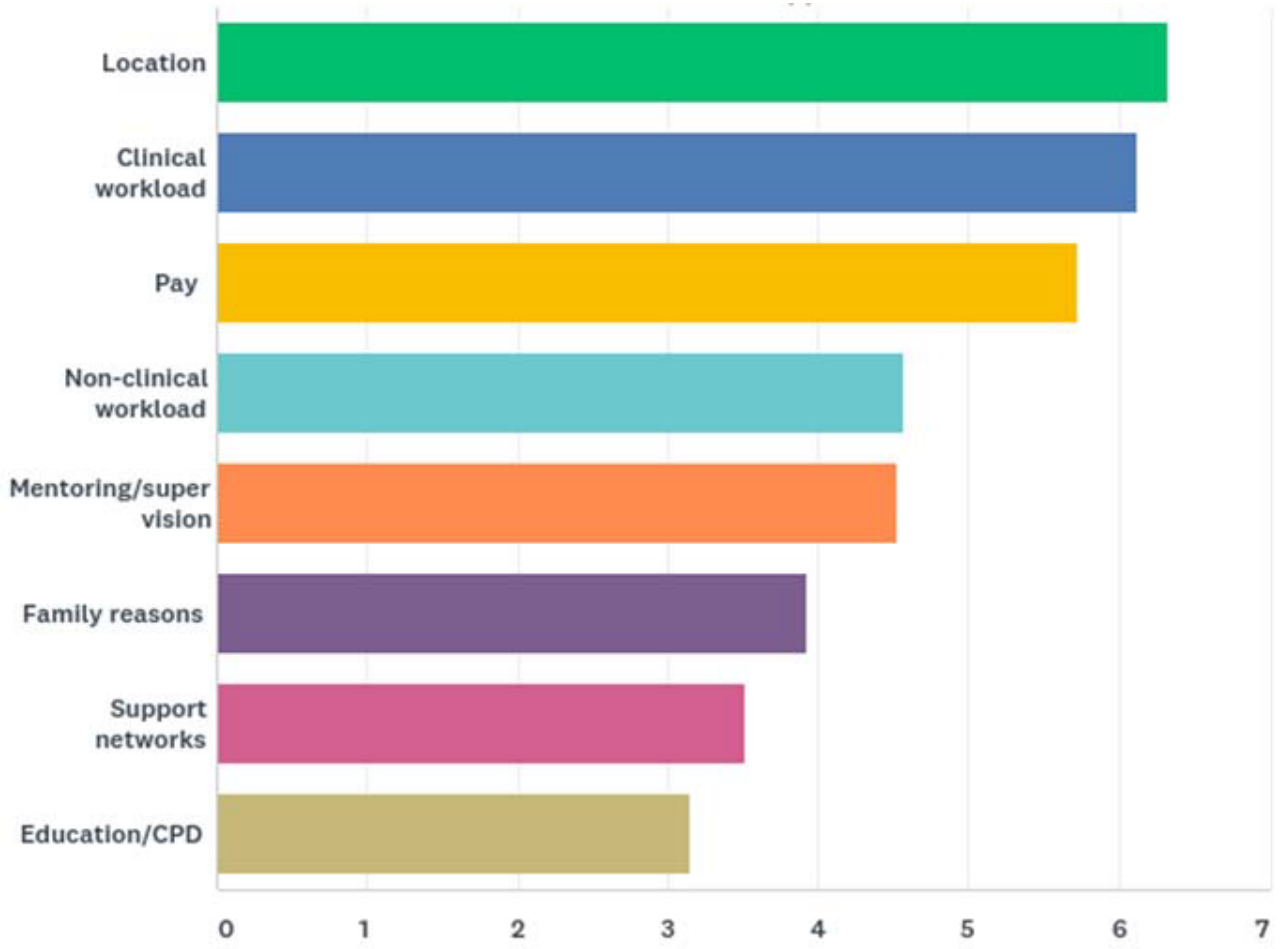
GP workforce

London trainee survey 2017

Next career choice:

- Salaried GP 47%
- Short-term locum 19%
- Long-term locum 18%
- Other 12%
- Partner 4%

Factors affecting job choice



GP Workforce - 5000 more GPs?

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Current reality (excluding locums):

March 2017 – June 2017

- 39,884 GPs, an increase of 224 (0.6%) from 39,660
- 33,236 FTE GPs, an increase of 263 (0.8%) from 32,972

March 2016 – March 2017

- Number of FTE GPs fell by 1252 (-3.7%)
- Number of FTE consultants rose by 1465 (3.4%) to 45,096
- Number of doctors in training rose by 843 (1.7%)to 50,969

Clinical Pharmacists in General Practice

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- July 2015 – pilot as part of General Practice Workforce 10 Point Plan
- £112 million co-funding programme started January 2017
- Practices receive partial, tapered funding for 3 years
- 1061 practices, (covering nearly 18.5 million patients) were approved in the first two waves of applications
- Third wave closed at end of September 2017
- 520 WTE clinical pharmacists in over 1,790 GP practices (when combined with the numbers from the pilot)

➢ We need sustainable funding for a genuine workforce expansion

Other GPFV workforce commitments

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Mental health therapists

- Extra 3000 in primary care to expand IAPT programme by 2020
- Majority of expansion will be new integrated services
- Employed by existing IAPT providers but based in general practices or within primary care based teams

Physicians Associates

- Consultation on regulation

Physiotherapists

- Physio first schemes

Managing and reducing workload: Primary-secondary care interface

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- Changes to the standard hospital contract 2015/16 and 2017,eg:
  - *hospitals are responsible for providing patients with fit notes*
  - *hospitals to provide discharge summaries within 24 hours*
  - *Hospitals to stop asking GPs to re-refer DNA appointments*
- Helping practices and LMCs hold CCGs and trusts to account, by providing template letters to report and push back on breaches
- Working with NHS England to communicate changes to trusts and patients (eg new patient facing leaflet)
- Is there a better way to develop better collaboration?

MCPs “not the only game in town”

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- Aims of MCP/ACO model can be implemented without practices relinquishing their GMS/PMS contracts

Working at scale can be achieved by GPs working collectively through a variety of models:

  - Formal or informal networks
  - Federations
  - Locality teams
  - Collaborative partnerships between local health organisations
  - Super partnerships
  - Primary care home models

Accountable care systems & Accountable care organisations

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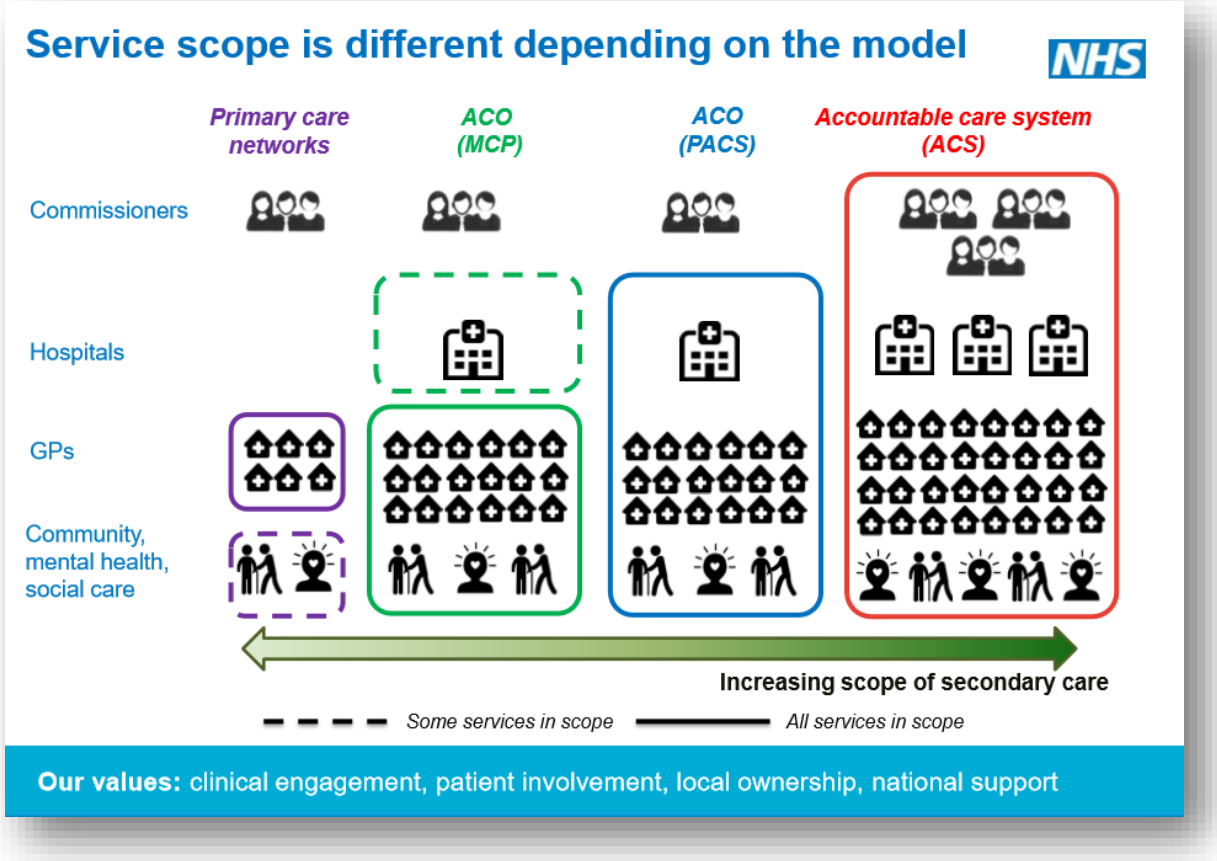
- Accountable
- Whole population
- Single budget
- Competitive tender
- Salaried and managed service?

<u>Three drivers:</u>

1. Recognition in England that current system set out in 2012 Health & Social Care Act isn't working
2. Could a 'population health' approach deliver improved care for patients?
3. Financial constraints



MCP/ACO voluntary contract

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- Integrates primary and community health services, built upon the GP registered lists of the practices involved

- The contract is aimed at practices who wish to work within this new integrated care model, covering populations of at least 30,000-50,000 patients

- 3 proposed contract types for MCP/ACOs:
  - *Virtual*
  - *Partially integrated*
  - *Fully integrated*

MCP/ACO contract models

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Virtual

- alliance agreement with the commissioning body would overlay (but not replace) regular commissioning processes
- requirement to achieve greater integration of these services (e.g. shared managing of resources, governance arrangements, risk sharing agreements, operational delivery of services)
- services remain governed by the regular commissioning procedures and contracts (e.g. G/PMS)

Partially integrated

- single contract for everything that would otherwise be in scope of the full MCP/ACO, outside of core general practice
- could include local enhanced primary care services, QOF and DESs
- practices hold their G/PMS contracts, anything beyond that would require them to form a joint legal entity in order to bid for the contract for any other services

Fully integrated MCP/ACO

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- Primary care and community services are procured in a single contract between a single legal entity and the relevant commissioning bodies, holding a whole population budget

- Full MCP/ACO contract likely to take the form of a hybrid of G/PMS or APMS and the NHS Standard Contract

- Contract will run for a limited period of 10-15 years, and include an early break opportunity (e.g. at 2 or 3 years)

- Amendment to primary care legislation to allow for the GMS/PMS contracts of the member practices to be 'suspended' for a defined period of time with an option to reactivate them at a later date should the contractor so wish

Service specification, funding & procurement

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- The range of services defined within the individual contract agreement
- Funded via a capitated population based budget, comprised of 3 elements:
  - **Base £ per head for the MCP/ACO's registered list:** i.e. the combined lists of all constituent practices creating a single 'whole population budget'
  - **Performance pay**: QOF replaced with a new performance related pay system linked to local and nationally defined targets
  - **The effect of any risk sharing agreements with local acute providers**: e.g. to reduce avoidable activity in secondary care.
- Would require procurement process but bids would need to demonstrate support of local GPs. Not yet clear how this will operate in practice

Employment models & conditions

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- No explicit mention of what employment models should be utilised within MCP/ACOs
- Each MCP/ACO will organise its workforce as it feels best fits with its organisation structures
- Locally negotiated employment contracts
- No national protection for salaried GPs

Exiting the MCP/ACO

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- Practices in a full MCP/ACO can return to GMS and ?PMS at agreed break points
- At first break point practice re-claims its previous patient list

But

- Once a practice joins an MCP/ACO, it may prove difficult to disentangle itself
- New patients stay with MCP/ACO by default
- After initial break **all** patients stay with MCP/ACO by default

QOF in England advisory group

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Comprised of: DH, NHS England, NHS Employers, NHS CC, NICE, PHE, RCGP and GPC advising on review of QOF

Started in July 2017 with aim to report by June 2018

- How QOF currently works and its impact (within and outwith the GP contract)
- Learning lessons from Scotland, Somerset, Dudley, Aylesbury and Tower Hamlets
- Context and future direction for QOF (making any system future-proof)
- Reformed scheme – how could it work (QOF stays, amended QOF, new QOF, new system?)
- Detailed analysis, impact assessment – are proposals better than current QOF?

➢ July 2018 onward – negotiations and potential implementation

State backed indemnity scheme

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- Clinical negligence cover to providers of GP services (including OOH providers of GP services)
- Available to all contractors: GMS, PMS and APMS plus any other integrated urgent care delivered through NHS Standard Contracts
- Includes GP contractors, salaried GPs and locums
- Includes practice staff and other medical professionals working for the practice in the provision of contracted services, and students/trainees working in this area

- Decisions yet to be made about inclusion of doctors working in other public sector settings including prisons and the MOD – GPC will be pressing for all GPs to be covered

- 12-18 months to establish – GPC will be fully involved in its development

CQC ratings as at 31 July 2017

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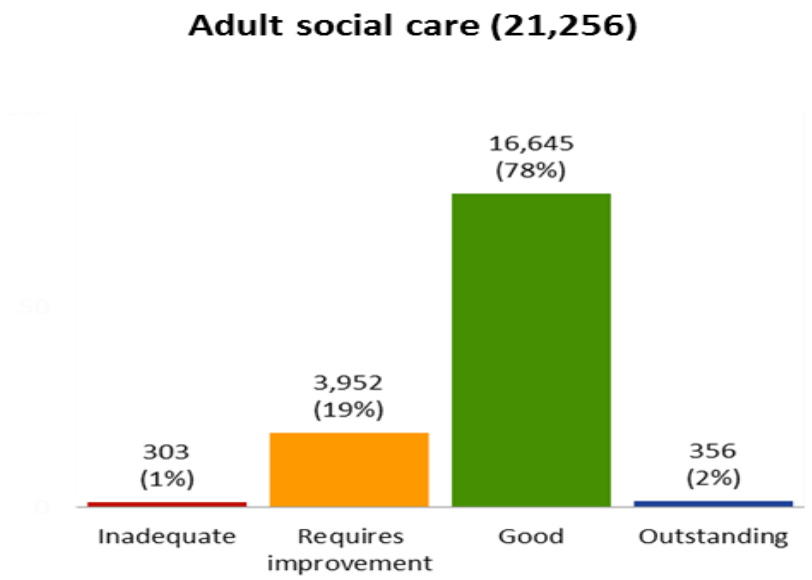

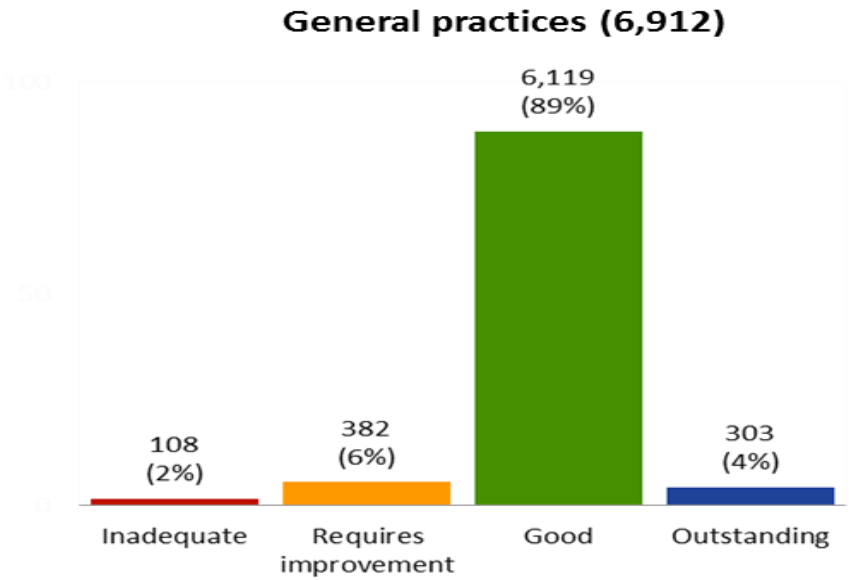

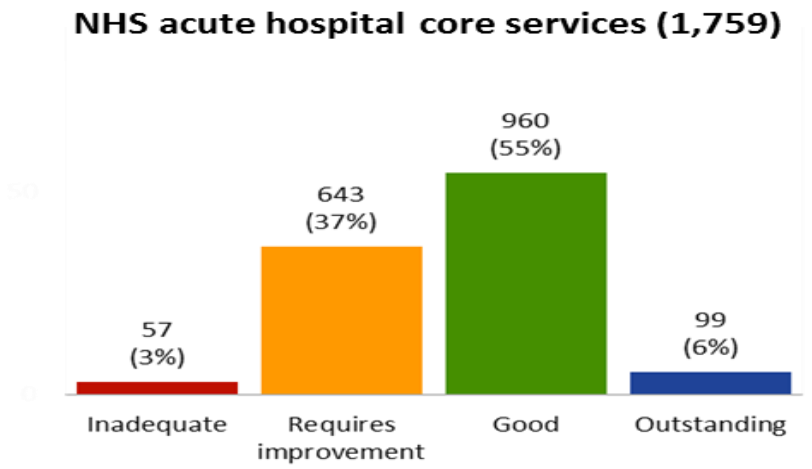

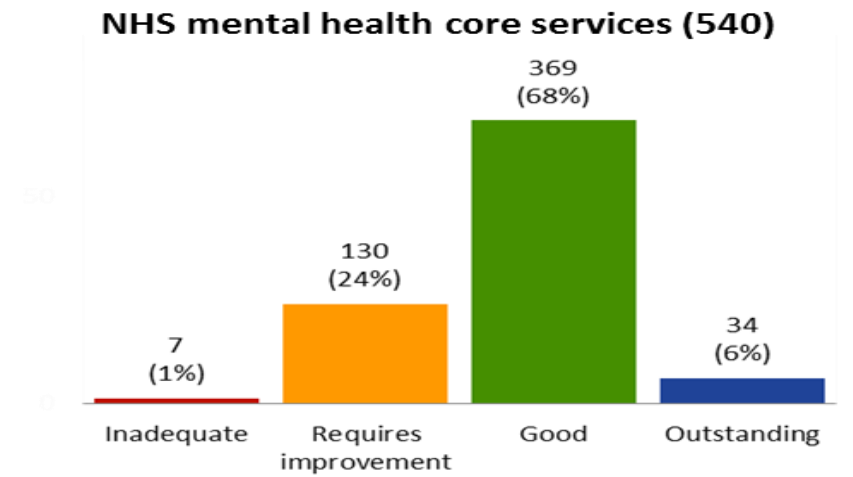

CQC report – State of Care in General Practice

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- GPs provide the highest quality care (93% good or outstanding compared to 71% for acute trusts and 74% for NHS core mental health
- Report warned that increased funding in general practice was vital to avoid a significant deterioration in services
- General practice is delivering over 90% of all patient contacts on just 7.9% of overall NHS budget

Maintaining GP popularity with patients

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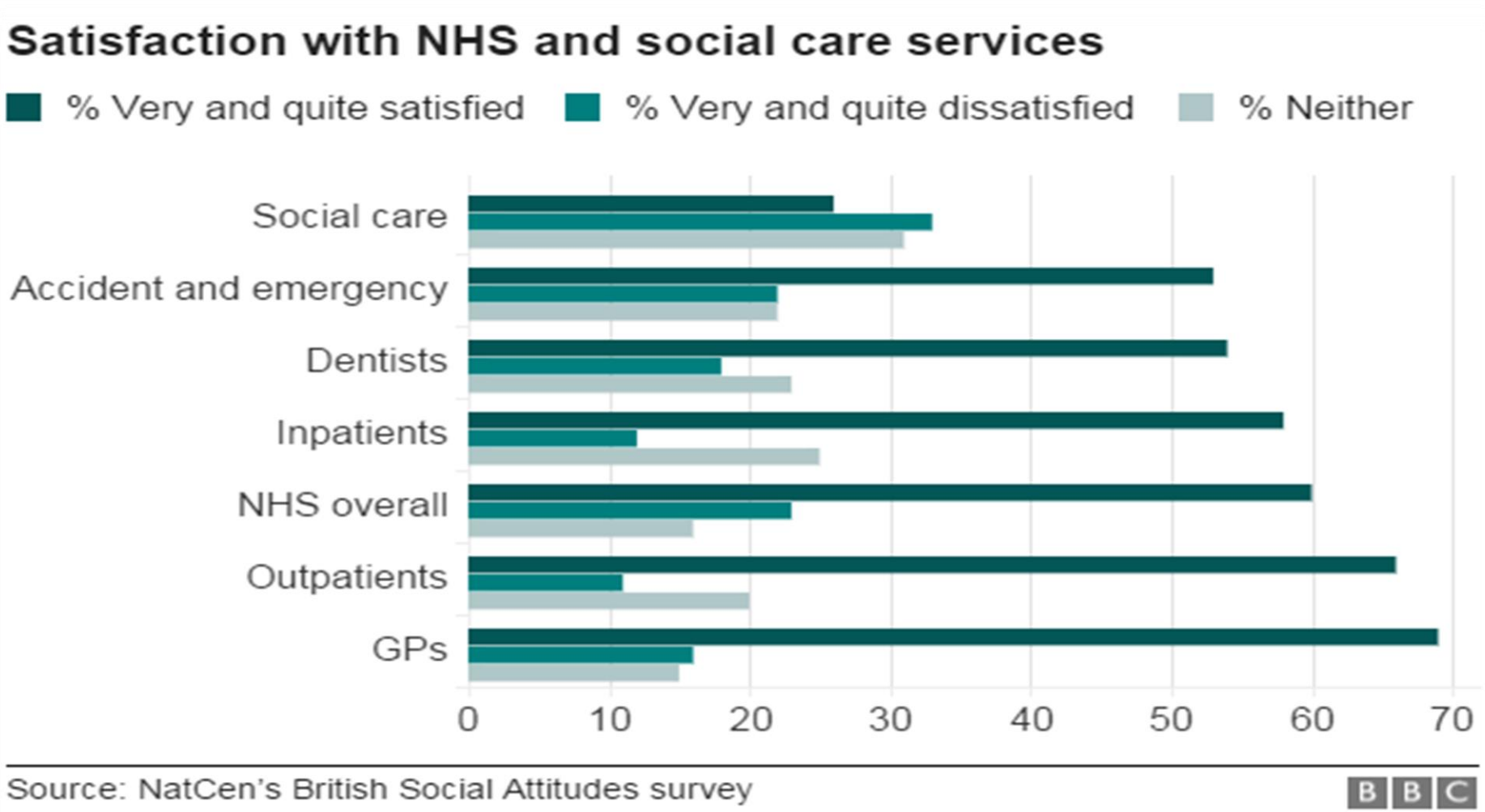

Towards a healthier future for General Practice

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- Sustained and significant funding investment
- More GPs, nurses, clinicians and support staff
- Highly skilled practice management
- Manage workload enabling quality consultations
- Building collaborative teams in each locality
- Premises and IT development
- Build on national GMS contract
- Culture change in the NHS