LMC Working at Scale Breakout group

Is there a case for change?

- Workload: Increasing patient demand with inexorably rising consultation rates, greater complexity/comorbidity of our patients and increasing super-specialisation in secondary care have dramatically changed our jobs.
- Bureaucracy: Each day we are faced with a veritable tsunami of path reports, scanned letters, task, forms, meetings and of course those two imposters; Revalidation and CQC; though I'm not sure which would claim to be triumphant.
- Recruitment: The popularity of general practice has waxed and warned over the past 30 years, the tide seems to have well and truly gone out now though. The make up of our profession has also changed with nearly 50% of doctors now choosing to be sessional, not a ringing endorsement of the current partnership model. Those at both end of the career journey are choosing other options, older GPs are leaving due to pension changes and burnout and our more junior colleagues are choosing other specialities with a more defined workload.

Is working at scale the answer, part of the answer or yet another blind alley?

- Security: My children loved Lemony Snicket's tales of the unfortunate Beaudelaire orphans in the aptly titled " A Series of Unfortunate Events ," sadly general practice is more than too often only one event away from disaster.
- Innovation: GPs have excelled at innovating and shaping health care, larger organisations can, to use a trendy phrase, give a bit more head space to allow this.
- The Money: If you spend less you tend to earn more, larger organisations can reduce duplication, expenditure and costs and thus increase their profits.
- The Future: A common theme of all 44 STP plans is quality, at scale general practice. This view is mirrored in Sir Robert Naylor's “Review of NHS Property and Estates”.
- Working at scale covers a broad range of options, or a multitude of sins depending on your view. Simon, Marie and I have been travelling round the country looking at many of the current models, let's briefly examine them in turn;

Super-Partnerships

This encompasses three basic models, which funnily enough exist just down the M6, cheek by jowl in Birmingham.

MMP (Midland Medical Partnership)

- This is a fully integrated model, each partner working in a very similar manner.
- Covers 70k patients
- 12 sites across the City
- Single GMS Contract (in fact the largest in the country)
- Single IT system.
- Effective cross-site working with easy access for all patients at any site.
- three phlebotomy hubs with open access.
- Partners also work effectively across the different sites.
- Steadily improving CQC, last year 554.5/545
- Rated Outstanding by CQC, first Super-partnership to achieve this. Aided by standard policies and procedures across the organisation.
- Influence in the system, has a seat on the STP board.
- Set up by the GPs, with no set up or pump priming costs, migration of profits by higher earning and lower earning partnership to a common mark over a number of years.

Comment: Very effective totally integrated model but this means significant loss of autonomy by the partnerships, which may affect the rate of expansion of the partnership.

OHP (Our Health Partnership)

- This is a maximum autonomy model, each partnership is treated as a cost/ profit centre (a common model in industry, but not in medicine). Basically each partnership keeps the profits it individually makes, minus the patient based levy for being a member of the partnership. (My practice (Lordswood Surgery) is in OHP).
- 340k patients (by far the largest GP organisation in the UK), 40 partnerships mostly based in Birmingham, but six in rural Shropshire.
- Central elected board, small employed corporate team.
- Levy of £2 per patient which is tax debatable.
- Plan is to earn this back by savings generated by the organisation, eg central accountancy/banking, internal locum pool, internal employed salaried doctors, MDO negotiated reduction, buyers group.
- Increased resilience, formation of internal resilience team of doctor/manager/nurses.
- Influence in the system (covers population of a CCG/DGH) and has a seat on the STP board.
- Focus and lead for integration project, working with other non-OHP practices to improve the geography and further increase numbers.
- Set up was largely funded by partners following a CCG funded working at scale project for partnerships wishing to form a super-partnership, federation or GP provider group.

Comment: Large numbers of already successful practices attracted by high autonomy model. History of cost centre models is that they tend to coalesce, this is already being seen with five Sutton practices merging to form one cost centre within OHP.

Modality (formally Vitality) Partnership.

- Started with the merger of two large partnerships and now 150k across five sites, Birmingham, Sandwell, Walsall, Hull and West Berkshire.
- All consultations are done by phone or Skype initially, the percentage that have a face to face consult is then 30%
- All calls go through a call centre in Birmingham, debate as to whether to route calls from Hull there, or to set up a satellite.
- Tiered levels of salaried doctors (SGP, associate GPS) and three levels of partner (salaried partner, fixed share partners, equity partners). Doctors can move from level to another, both up and down this ladder.
- No longer have individual practice managers and have centralised HR, IT finance and governance. Idea being to employ higher quality staff and provide a better centralised service.
- Already view themselves as an MCP, as they offer extended integrated care.
- Have philosophical reservations about the current PMS/GMS contract model as they feel it can result in the inverse pay and care law becoming more entrenched.
- Benefited from significant Prime Ministers Challenge Fund award.

Comment: Probably the most pyramidal of the three models, has been well funded but have used this to alter the consultation model and expand their numbers.

Federations:

- These are generally more widespread than super-partnerships.
- Looser arrangement
- Probably easier to set up.
- Less binding and easier to leave.
- Potential stepping stone to a super-partnership.
- MOU is still a minimum requirement and will still need legal and accountancy advice.
- Probably less you can do in a federation (though their proponents might disagree with this view). Common issues tend to be, who takes the responsibility for employing any new staff and the fact that if you offer services to another part of the federation you are then liable to VAT.

Comment: The word federation can mean all things to all men, undoubtably some have brought practices together and introduced the partnerships to joint working, some though have been set up at no little expense with little in the way of tangible outcomes.

Hubs:

- Formation of hubs is of course another form of working at scale.
- This can even out the inevitable fluctuations in demand that occur across a group of practices, by creating an overflow facility.
- We visited Gosport in Hampshire, where they have two hubs. One is set in a Community Trust-owned property and deals with urgent requests from four practices.
- The calls are triaged by a doctor/ANP and 40% then go on to have a face to face consultation.
- The services have been expanded to offer patients an MSK assessment or a geriatric opinion.
- A hub model also operates in Birmingham, where patients are directed to the hub after an agreed number have been seen in the practice. This is popular with the GPs, but less so with the patients who have to ring at a set time and if they're not lightening quick on the buzzer will get directed to the more distant hub, or told to phone again in the afternoon.
- There can be issues with practices gaming the service to make life easier for themselves.
- Most hub models have been set up with additional central funding and it is not clear how they will continue when or if this ceases.

Comment: Hubs (either physical or virtual) could be operated by a super-partnership or a robust federation, this might offer a more tailored service for the local population (and thus be more popular and acceptable) and avoid some of the problems such as gaming that have been reported.

All these models are primarily about improving practice resilience, reducing workload and making general practice more sustainable and profitable. These are not to be confused or conflated (a good word of Simon's) with the MCP Voluntary Contract, which is addressing a different agenda. This is nevertheless worth a few words, as to borrow a bit of NHS Management speak, is certainly part of the current landscape.

MCP Voluntary Contract:

- As the name implies this is voluntary and is NHS England's bright idea, or mainly from what we hear Ian Dodge's. It addresses different issues re the integration of care and sorting out the finances. It is a laudable aim to breakdown the divide that exists between different services, as currently a Masters degree in NHS management is a prerequisite to successfully navigating the system.
- This is a big change from the current system of (to quote Simon's Laws); a registered list of patients, a contract in perpetuity and a proven balance between patient care and business interest.
- Three models; Virtual, Partially Integrated or Fully Integrated.
    - **Virtual:** You keep your contract, but sign an alliance agreement with other providers, this sits over but doesn't supersede the traditional contract though still may influence your practice quite significantly.
    - **Partially Integrated:** You keep your contract. There is an Integration agreement, MCP risk strat is applied to all practices, ICA sets out strategy including that for estates. Enhanced services will probably be included.
    - **Fully Integrated:** Old contract goes and is replaced by one lasting for 10-15 years. Contributors to this WPB (Whole Population Budget) are primary care, social care and public health.This will be pooled and diverted to areas of greatest need, not necessarily GP. The WPB is calculated from historical commissioning spend and then top sliced (2.5-4%) and this can be earned back by delivering on agreed quality metrics that are liable to be refreshed (a lovely innocent word) every few years. There is a gain/ loss agreement to incentivise better management of patients in the community, avoid unnecessary social intervention and less patients pitching up to A/E. The latter in particular might be a tad challenging.

Comment: Worth thinking carefully before catching this particular train, probably quite difficult to get off and 10 years can go by in a jiffy! Perhaps worth examining all of the other options.

Summary:

- Super-partnerships, federations and hubs can all offer greater resilience, potentially decrease workload, allow a little bit of time to innovate and give general practice a voice in the system that can be of some influence.
- Many GPs we've spoken to have set up these new structures with minimal or no additional funding, some though some have obviously benefited from PMCF or Vanguard funding.
- Over the past decades, most successful development of general practice has come from within the profession. Here GPs are seizing the initiative, taking some risks and not waiting for permission or funding to build on the current model.
- The Government has a laudable agenda to integrate care, their solution is the new Voluntary MCP Contract. However they state in their own blurb; 'much of the MCP model can be delivered by the current contract framework through closer working.'
- A super-partnership or robust federation could be the basis and leader of a model of integrated care.