Transforming general practice within Kent and Medway; the challenge

Briefing for Kent Health Overview and Scrutiny Committee for presentation at a meeting on 5 September 2014

1. Summary

This paper sets out a summary of the key challenges currently facing general practice and the need to transform the way that GP services are delivered in order to address these growing challenges and to ensure the future delivery of good quality, local care to patients in a sustainable way.

A national report published by NHS England earlier this year summarised the overarching issues facing general practice across the country, many of which are equally applicable to Kent and Medway. These challenges include:

- an ageing population and an increasing number of patients with complex care. needs and multiple long-term conditions, who require more intensive support from GP services.
- increasing pressure on NHS financial resources.
- dissatisfaction amongst patients about the ability to access GP appointments and rising patient expectations about this.
- variation in the quality and performance of local services and health inequalities.
- growing reports of workforce pressures, including recruitment and retention problems.

The national report published by NHS England, Improving General Practice - A Call to Action, describes some of the work that is taking place at a national level to develop GP services fit for the future.

In addition to the work that is continuing to take place to determine what national incentives and actions might be necessary to support the transformation of GP services, within Kent and Medway we are also considering what action might be required locally in order to meet the specific needs of our local communities.

This paper sets out the potential implications of the challenges currently facing local GP services and considers how services might need to develop and change in order to meet the priority of providing good quality, accessible care to all local patients, both now and for future generations.

To help put this in context the next section of the paper provides a brief overview of the current contracting arrangements for GP services.

2. GP contracts

Across Kent and Medway, NHS England holds 260 individual contracts with GP practices. Each contract allows the provider to deliver primary medical services to its patient list.

There are 3 different type of contract held with GP practices. These are:

General Medical Services (GMS) contract: GMS contracts are nationally negotiated. These contracts run in-perpetuity and provide the contractor with considerable flexibilities in terms of being able to take on new GPs as partners to the contract. This allows GMS contracts to be handed on from one GP or group of GPs to another without this requiring the agreement of NHS England as the commissioner (subject to the individuals concerned meeting certain conditions as set out in the national GMS regulations). GMS contracts can only be terminated by the commissioner should there grounds to do so (i.e. fundamental concerns regarding patient safety). GMS contracts cannot be held by public limited companies (PLCs).

Personal Medical Services (PMS) contracts: These are locally negotiated contracts between NHS England and local practices which give local flexibility compared to the nationally-negotiated GMS contract by allowing the opportunity for variation in pricing and the range of services that may be provided by a GP practice.

32 practices across Kent and Medway hold this form of contract (1 of which is in Medway). PMS contracts cannot be held by PLCs.

Alternative Provider of Medical Services (APMS) contract: APMS contracts vary from GMS and PMS contracts in two key ways. Firstly they can be held by any form of entity (including PLCs, local GPs and third sector organisations). Secondly they are for a fixed-term period. 14 practices across Kent and Medway currently hold APMS contracts, five of which are in Medway.

It is important to note the following two points:

a) GP practices that hold GMS and PMS contracts have considerable influence over determining the service model and the configuration of GP practices across a local population. This is because they can decide who they might take on as GP partners, who they pass their contract onto and at what point in time, or whether, they wish to resign their contract. Should they wish to resign their contract then they need provide only a limited period of notice (six months for a GP partnership, three months for a sole practitioner contractor).

b) When NHS England is considering awarding a new contract for GP services it is now always likely to be in the form of an APMS contract. This is because APMS is the only contract platform available that meets the requirements of procurement law and its underpinning principles (in terms of being open and non-discriminatory). This is because both GMS and PMS contracts are seen as being “closed” contracts as they cannot be held by certain types of organisational entity and because they effectively run in-perpetuity and are not therefore subject to subsequent market-testing. The existing GMS, PMS and APMS contracts that NHS England hold with various local GP providers were inherited by the organisation when it came in to being in April 2013.

3. Current challenges facing general practice in Kent and Medway

3.1 Demographic change and epidemiology

The populations of both England and Kent and Medway are increasing in size and increasing in age. This change in our demography has a significant epidemiological dimension as an increasing number of people are now living into their 80s and 90s.

By 2021, there is expected to be an overall increase of 5.4% in the total Kent and Medway population. However, the number of people in the area aged over 65 years is expected to increase by 25.5 per cent during this period, while the number of those aged 85 years and above is expected to rise by 34.1 per cent.

The relevance of this demographic change to general practice is that it means that many more of us are, and will be, living for longer with multiple and complex long-term conditions.

These changes are already having a significant impact upon GP practices and GPs. Nationally it has been estimated that there has been a 95 per cent growth in the consultation rate for people aged 85-89 in the ten years up to 2008/09.

GP practices across Kent and Medway will therefore need to be prepared and equipped for the rising demand on local services as a result of the ageing population.

3.2 Public expectations

Changes in the age and health profile of the population are also matched by changes in patient expectations. The most recent GP Patient Survey showed that nationally, although 76% of patients still rated their overall experience of making an appointment with a GP as good, there have been further reductions in overall satisfaction with access to GP services, both for in-hours and out-of-hours services.

Improving patient access to services is therefore a key factor that will need to be addressed in transforming primary care services.

In this respect a group of practices within Kent and Medway were amongst 20 pilot schemes awarded support from the Prime Minister's Challenge Fund earlier this year to pilot a range of options to make GP services more accessible to patients. Practices within Folkestone and Dover will benefit from £1.89 million of support with which to improve access to care for almost 95,000 patients and have come together to pilot various initiatives aimed at achieving this, including:

- extended opening hours from 8am to 8pm, seven days a week
- an urgent home visit service outside of core practice hours (8am-6.30pm)
- enhanced community care with short-term residential facilities in the community to avoid hospital admissions
- and for patients with urgent mental health needs, a new rapid assessment service delivered by a primary care mental health specialist, either at a patient's home or at their GP practice.

NHS England will use the learning from this and other pilot schemes across the country as we seek to develop new models for the future provision of primary care which will improve access to services and ensure the highest quality care for patients.

3.3 Workforce

Changes in the GP workforce are one of the biggest single drivers to the changes that we are now witnessing in terms of the potential future configuration of general practice services (alongside the impact of an ageing population and the changing health needs associated with this). There are several important strands to this, which are all interconnected. While the narrative below highlights some of the key issues, a more comprehensive summary can be found in a report published by the Centre for Workforce Intelligence in July 2014. A copy of the report is available on their website and was commissioned by the Department of Health and Health Education England (which is the organisation within the health service with overall responsibly for providing system wide leadership and oversight of workforce planning, education and training).

The Centre for Workforce Intelligence concluded in their review of the GP workforce that the current level of GPs being trained is inadequate and likely to lead to a major workforce demand-supply imbalance by 2020. The key findings from this review were:

- Growth in the GP workforce has not kept pace with the increase in medical consultants or population growth. According to the report, nationally the number of GPs rose by 23 per cent on a whole time equivalent (WTE) basis between 1995 and 2013. By contrast the number of consultants in other medical specialties doubled over the same period. On a per capita basis, the number of GPs per 100,000 population in England has actually fallen to 59.6 GPs. It is expected that the GP per capita ratio will only return to its peak of 61.5 GPs per 100,000 population by 2015.
- Boosting the number of GP trainees is proving difficult
- The GP workforce is getting younger and more females are entering general practice. The review concludes that a larger number of GPs will be needed to ensure the appropriate WTE workforce is in place , as a higher proportion of women work less than full-time hours for some periods of their GP career.
- There is significant geographical variation in the distribution of GPs.
- The review concluded that simply increasing the number of GPs will not necessarily lead to a more equal distribution of doctors.
- The GP role has become broader and more complex
- General practice activity and workload has increased substantially for GPs and other practice staff
- Available evidence suggests the GP workforce is under considerable stain and current levels of activity may not be sustainable in the face of rising demand for services

Across Kent and Medway there are a number of GPs working either as GP partners or as single handed GPs who hold contracts with NHS England and who are likely to retire within the next three to five years. Defining the precise number is very difficult as it is a matter for the individual GP to determine when they will retire and cease working. This uncertainty creates difficulty in planning for service change.

The Centre for Workforce Intelligence report highlights that one of the former PCTs within Kent was one of only 11 former primary care trusts (from an overall total of 151) where more than 35 per cent of local GPs were aged over 55. The Seventh National GP Worklife Survey (Institute of Population Health, University of Manchester, 2013) also found that 54.1 per cent of GPs aged 50 or over expected to cease providing direct patient care within five years, which the British Medical Association (BMA) claim is driven by low levels of job satisfaction and high levels of stress (as opposed to pay).

Given the ageing GP workforce one of the challenges that needs to be addressed is whether the number of new GPs coming through the system will be sufficient to maintain existing service levels and the rising demand for GP care.

Alongside this, an increasing number of the new generation of GPs who are entering the profession are often seeking different types of fulfilment in their careers compared to their predecessors. A number of younger GPs are now choosing to work abroad particularly in the first years following their registration as doctors, while others favour the flexibility that working as a locum provides. Some decide to follow a portfolio career which entering in to a GP partnership arrangement does not allow for. A significant number of younger GPs are therefore no longer attracted to the prospect of becoming a partner within a practice; favouring working as either salaried GPs or as a locum instead.

In this respect, partnership working comes with considerable responsibilities and obligations. As a partner to a practice you effectively become jointly responsible for the management of the practice and the risks and benefits associated with this. For many GPs this involves making a long-term commitment to the practice and the community that their surgery serves. We are now seeing many GP practices experiencing difficulty in recruiting to partnership vacancies and they are instead having to backfill with locum GPs or appoint GPs on a salaried basis.

As we develop plans for the future of services, NHS England (Kent and Medway) will be working closely alongside local colleagues at Health Education England to identify the approaches we can take locally to address the workforce challenge effectively.

3.4 Professional accountability

All GPs are now subject to professional revalidation, which is the process by which GPs demonstrate to the General Medical Council (GMC) that they are up to date, fit to practice and are complying with the relevant professional standards. GPs must be revalidated in order to maintain their license to practice. A GPs revalidation takes place every five years and is based upon an evaluation of their practice (through annual appraisal) during this time.

The processes of appraisal and revalidation are important in terms of providing safeguards about a GPs fitness to practice. However this process does place a significant responsibility upon individual GPs in order that they can demonstrate they meet the required standards.

3.5 Regulation

GP practices must now be registered with the Care Quality Commission (CQC) and have to meet the regulator's "essential" standards for delivering general practice services. The CQC is responsible for monitoring, inspecting and regulating GP practices to ensure that services are meeting the relevant quality standards.

GP practices need to ensure their registration with the CQC is in place in order to operate legally. To do this they need to ensure both their premises and services are of an acceptable standard and will stand up to scrutiny, in the form of an announced or unannounced visit by a CQC inspection team.

In August, the CQC announced that is planning to introduce a system of special measures for GP practices from October 2014. This means that GP practices that provide inadequate care will be given deadlines for improvement or could potentially face closure. NHS England's area teams will be working together with the CQC to support a timely and coordinated response with regards to any GP practices that are providing inadequate care and who are placed into "special measures". This will ensure that any such practices do not continue to provide inadequate care to patients.

As HOSC members will be aware, the clinical leadership at the Lakeside Medical Practice in Sittingbourne recently changed following a CQC report published in June, which raised serious concerns about the services that were previously provided to patients at the practice under the former sole practitioner GP contractor.

3.6 Viability of local practices

NHS England provides funding to local GP practices to cover the cost of providing core services to patients. GP practices are nonetheless managed by independent contractors who need to operate at a profit in order for their surgeries to be financially viable.

As confirmed above, general practice services in Kent and Medway are still largely provided by GPs working in partnership, or as sole practitioners under a General Medical Services (GMS) contract. These GPs draw a personal income from any profit margin generated by their practice. If profit margins are too low then a practice might struggle to recruit and retain GP partners and/or salaried GPs.

GP earnings have reduced in each of the last several years. This followed substantial increases in average earnings following the changes the GP contract in 2004.

The 2014 Review Body for Doctors and Dentist Remuneration highlighted that in 2011/12, average income for United Kingdom GPs was £103,000, with average expenses of £164,900. The expenses to earnings ratio increased slightly on year, from 60.9 per cent in 2010-11 to 61.6 per cent in 2011-12. This was because while average income decreased by 1.1 per cent between 2010-11 and 2011-12, average expenses increased by 1.5 per cent.

3.7 Involvement in clinical commissioning groups

Each GP practice is required to be a member of a clinical commissioning croup. This necessitates the practice becoming actively involved in the work of its CCG to support improvements to the overall health of the local population. This includes by inputting in to the development of new care pathways and services designed to ensure the effective management of patient care. GP practices will be supported by their CCG to understand their own referral patterns, their use of prescribing and how their patients use local accident and emergency (A&E) services and out-of-hours care as part of this work.

In May 2014, NHS England confirmed that it was inviting CCGs to express an interest in taking a greater role in the commissioning of local primary care services, in order to help support the integration of different health services and as part of efforts to achieve sustainable services in future years. NHS England has received expressions of interest from all local Kent and Medway CCGs in response to this invitation and work is now taking place alongside the CCGs to explore the potential for the effective co-commissioning of services further.

This could therefore also have a potential impact on the way that local GP services are developed over the coming years.

3.8 Parallel contracts and accountability

Previously GP practices sourced almost all of their contract income from one commissioner, under the single contract they held with their former primary care trust (PCT). Following the Health and Social Care Act 2012, GP practices now obtain funding and income from NHS England (as the commissioner of core GP services), from their local CCG (for services previously commissioned as Local Enhanced Service Schemes) and from their local authority public health team (for health improvement and health promotion services such as smoking cessation and sexual health).

GP practices therefore need to deliver services in accordance with the contracts they may now hold with three separate commissioners. This creates additional transactional work for practices and increased levels of monitoring and accountability which they need to be able to manage in order to provide the necessary assurances about the care they are delivering to patients.

4. Implications and Consequences

4.1 Vacancies and increased use of long-term locums

A number of GP practices across Kent and Medway have been and continue to experience difficulty in recruiting to partnership positions. A recent partnership opportunity at a successful and well respected practice in Maidstone attracted only two applicants, whereas 10 years ago a similar opportunity at the same practice attracted in excess of 50 applications. GP practices in the coastal areas of Kent appear to be experiencing the greatest difficulty in recruiting GPs to partnership positions and there are some practices where there have been substantive vacancies for prolonged periods.

As a consequence practices often make use of locum GPs to backfill for partnership vacancies and to ensure services continue to be provided. Locum GPs tend to be less popular with patients, many of whom prefer to see a GP they know and trust, and are expensive to engage by the practice.

4.2 Practice mergers

During the last 18 months several practices have decided to merge. This means that their respective contracts and patient lists are brought together and managed under one contract. We are also considering a further request from two practices in Faversham who wish to merge their contracts.

The merger of contracts is possible but does require the support and agreement of NHS England through the Kent and Medway Area Team. Each case is considered on its own merits and will take into account feedback to the practice from patient consultation, the benefits to the practice and to patients, while also being mindful of the potential for loss of patient choice and competition in an area if practices merge.

We anticipate further requests from practices to merge in the coming months and years**.**

4.3 Closure of branch surgeries

The Area Team has seen a small but noticeable increase in the number of applications it has received from practices to close their branch surgeries. In this respect 5 applications for branch surgery closure have been received since April 2013, three of which were approved.

These applications often to relate to branch surgeries that are located in poor accommodation and/or where the opening hours, range of services offered by the practice, and utilisation of the branch surgery by patients makes its continuation difficult to justify from the practice's viewpoint. A number of practices are finding it increasingly difficult to run branch surgeries unless these can support a sufficient number of patients and can provide a full range of services.

Each application is considered on its own merits and taking in to account local patient needs. Decisions about any proposed branch closures are also only taken following a period of consultation and engagement with patients, but it does appear that there may be a slow but steady move by practices away from maintaining small branch surgeries.

4.4 Requests to close practice lists

The Area Team is also seeing an increase in the number of practices that are enquiring about closing their lists to new patient registrations. Since April 2013 three practices have gone on to submit formal applications for list closure, none of which were approved.

These requests are considered carefully on a case-by-case basis. The practices that have applied to close their lists often cite patient safety issues and recruitment difficulties as the underlying reason for their applications.

4.5 Fewer smaller practices

Single-handed GPs who hold a contract to provide services at their surgeries could potentially find the challenges facing general practice more significant than those GP practices which are managed by GPs working in partnership, or by limited liability companies or PLCs. Partnerships and companies are arguably better placed to manage the responsibilities that come with holding a GP contract. This is because the workload associated with holding a contract for delivering GP services can be shared amongst a team of staff.

It is expected that the number of sole GP contractors will diminish over time. This will reflect how the system of general practice itself evolves and responds to the challenges that it is now faced with and because NHS England is less likely in the future to commission new contracts for relatively small patient lists, as these are no longer considered to be sustainable (except perhaps in remote rural communities). NHS England's general view is

that general practice is more likely to be able to successfully deliver high quality services that offer the best value for the taxpayer when operating at greater scale. It is however important that we ensure that all GP services continue to be responsive to the needs of their individual local patients.

4.6 Average GP practice list sizes are growing

Across England the average GP practice list size has grown by almost 20% between 2002 and 2014. In 2002 the average GP practice patient list size was 5,891. By the 1 January 2013 this had increased to 6,911 and by 1 January 2014 it stood at 7,052 patients.

On the one hand this is a reflection of demand for services, as the size of the population has grown. However it also reflects supply side issues too. There have been, relatively speaking, only a small number of new GP practices commissioned to provide services to patients (such as the walk-in centre contracts in Minster, Sheppey and at the White Horse Surgery in Northfleet) during this time, while some practices have also merged or closed.

We expect average patient list sizes to continue to grow, largely as a result of the way that general practice is responding to the challenges it faces. Many practices are taking steps to consolidate and come together through mergers with other local practices in recognition that operating at larger scale brings benefits in terms of operational resilience.

It is however interesting to note that alongside this change, the average number of patients managed by each whole time equivalent (WTE) GP is moving in the opposite direction. The average number of patients managed by each WTE GP reduced from 1,764 in 2010 to 1,569 in 2012, for example.

4.7 Redefining continuity of care

Some patients say that they value the care provided to them by their local family doctor and the continuity that this provides in terms of the care that they receive.

There will however be occasions when the care patients receive cannot be delivered by the same GP (including taking in to account any annual leave or part-time working arrangements for example).

The challenge for general practice therefore is to try and retain the best of the personalised service that patients value, while also providing patients with access to support from a greater range of health and social care professionals who are linked with practices and who can help meet patient needs in an integrated way. This includes for example the adoption of personalised care plans for the most vulnerable patients, or those who may have complex needs, in order to ensure they receive the best possible care that is tailored to their individual needs.

The Government announced an amendment to the GP contract at the end of last year, which places a responsibility upon GPs to co-ordinate care planning for frail and elderly patients in order to help avoid them being admitted to hospital unnecessarily.

4.8 Other contract terminations and procurement decisions

A contract with a GP practice may have to be ended for a number of reasons. These include:

- a decision by made the practice to end their contract
- the death of a single-handed GP who holds the contract for services at their practice (as recently occurred at the former Wyvill Surgery in Medway)
- the expiry of a fixed-term APMS contract, or
- a decision taken by NHS England to terminate a contract because of concerns it holds about the delivery of services to patients and/or management of the practice.

Under each of these scenarios, NHS England is then faced with an important commissioning decision with regards to how it will ensure patients will continue to be able to access GP services after the end of the contract under which their care is currently managed.

Commissioning decisions made by NHS England will always take in to account patient needs, but this paper gives an indication of some of the other factors we also need to take into account in such circumstances.

4.9 Emerging principles for the future commissioning of local GP services

As a result of feedback NHS England received as part of the Call to Action debate on the future of services, the organisation identified five areas where it believes GP services need to be improved in order to ensure the delivery of excellent services across the country, both now and in the future. These are:

Ambition 1: proactive, coordinated care: anticipating rather than reacting to need an being accountable for overseeing your care, particularly if you have a long-term condition.

Ambition 2: holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

Ambition 3: fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.

Ambition 4: health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.

Ambition 5: consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

These national priorities are also reflected in the local principles that NHS England (Kent and Medway) has begun to identify as being important to the future development of services in local communities). These include:

Kent and Medway emerging principles for the commissioning of GP services

Values	**Principles**
Equity and fairness	Health promotion and prevention are priorities and key to tackling health inequalities. Money should follow the patient.

	Commissioners and providers will be open and transparent in their dealings with the public and each other
Patient centred care	No decision will be taken about a patient without their involvement Care closer to home will be commissioned Services should be accessible and responsive to individual need Excellent information to patients and the public about health and primary health care services Patients to be treated as individuals and will be involved in decisions about their care with access to their clinical records Patients will be treated with respect Patient views are considered as part of the process of driving service improvements Continuity of care will be a priority
Choice	Excellent information to patients and the public about health and primary health care services There will be a range of services available
Sustainability	Reduced carbon footprint Services will be economically viable for the provider Services that are good will be built upon and learnt from in order to optimise potential. Workforce planning, training and education will be a priority Collaboration will be promoted including with the private sector, voluntary sector and local authorities
Value for money	Innovation and productivity Resources will be managed wisely Competition will be used to drive improvement and value Duplication will be reduced and eliminated wherever possible The commissioner will operate within available resources Money should be targeted on the patent facing services rather than on buildings

High quality	Evidence based services will be commissioned Minimum standards will be maintained The importance of continuity of care will be recognised and its role promoted An open and transparent culture will be embedded There will be a focus on coordinating care, especially for those patients who are at the greatest risk There should be senior clinical input at the front of the care pathway The number of times a patient is transferred between professionals or passed from organisation to organisation will be kept to a minimum There will be access to patient information for everyone that needs it Commissioner and providers will work to reduce variability/standardise the model

5. Conclusion

This paper has sought to brief the HOSC on the current challenges facing general practice and how it is responding and evolving to these challenges. In this respect we are witnessing some GP practices choosing to form larger practices as a result of contract resignations, mergers and we are also seeing some practices wish to consolidate the provision of services across fewer sites.

In order to address the various challenges outlined in this paper and to ensure sustainable services, a strategy for the future commissioning of local GP services is under development. NHS England and CCGs are consistently highlighting the importance of moving towards integrated primary care services, which places general practice at the heart of out-of-hospital care and where the GP holds the role of care navigator to ensure patients get the right care and treatment from a range of different service providers. We are working with CCGs and practices to identify how practices can work across local networks in order to be sustainable while delivering excellent care that drives improved outcomes for patients and communities. This strategic change model needs to work alongside individual practices as they continue to hold their own individual contract for GP services.

Our strategic approach will need to build upon the emerging national framework for primary care services which is being developed in order to ensure some national consistency in the provision of services where this is needed. It will also need to build upon NHS England's ongoing discussions with local CCGs about any future co-commissioning arrangements.

Our priority continues to be to ensure that all patients in Kent and Medway have access to a full range of good quality, local GP services. We will continue to keep HOSC members updated as these plans develop.