CARDIFF & VALE GP CONFEDERATION - OUTLINE PROPOSAL

Purpose

1. At a meeting on10th February 2016 representatives of Cardiff and Vale GPs presented their outline proposal to establish a GP Confederation. LHB Officers expressed interest in developing the idea and requested a discussion document summarising the purpose and key features of the proposal. This is set out below.

GP Federated Working - Policy

2. The concept of a primary care federation was first set out formally by the Royal College of General Practitioners in September 2007. Its publication, The RCGP Roadmap, developed a model where practices would work together more closely to share resources, expertise and services. The RCGP suggested that most health problems in the population, including mental health, could, if resourced, be dealt with in primary care, with short-term referral as needed, to maintain comprehensiveness. It suggested that the role of the acute hospital should be for more serious clinical problems, specialist interventions, care and procedures. Furthermore to achieve optimal care, it recognised the strategic and organisational development of general practice required significant enhancement and proposed that this should be achieved through collaborative groupings or federations of practices.

3. Since 2007 an overwhelming body of evidence has built up in support of the effectiveness of collaborative working of various types. Collaborative arrangements can vary considerably from informal sharing of GP resources, to federations, through to mergers and "megapractices". Work from the BMA, RCGP, Kings Fund and Nuffield Trust suggests that the present network of small independent contractors working in isolation is unsustainable. In England in early 2015, the BMA concluded: "Regardless of the outcome of the general election, policy movement towards more integrated models of working is now inevitable and it is a question of how, not if, sectors of health (and social) care collaborate, re-organise and become subject to new commissioning arrangements".

4. In 2014 the Kings Fund published Making General Practice Fit for the Future where the idea of working 'at scale' came to the forefront. This was subsequently endorsed by the BMA in "Towards a Future for General Practice". These works envisaged that GP practices would collaborate through federations and work at sufficient scale to be able to lead the development of family care networks. Kings Fund envisaged networks of practices serving populations of 100,000 or more, sharing resources and taking advantage of economies of scale in a way that is impossible for individual practices working in isolation. The opportunity this offers is to strengthen the role of GPs primarily as providers of care, co-ordinating the delivery of services on behalf of their patients and working with other professionals to provide joined-up services in the community.

5. The current position in general practice was well summarised by Nuffield Trust in November 2015: "Primary care is facing unprecedented demand to find new ways to deliver care, with an increased emphasis on managing population out-of-hospital through a focus on improved prevention, access and quality of care. All the while, spending on general practice has fallen or flat-lined for the past five years. Collaborative working, including the formation of federations and networks within general practice is at the heart of overcoming these." At about the same time, the Nuffield Trust and RCGP undertook a survey of General Practice in England. This reported that 73% of the GPs in their survey were in some sort of Federation and 44% said that it had been formed the last year. English GPs are concluding that operating at scale is a prerequisite for survival. This is partly driven by the need to compete for contracts, but it also a response to the intense pressure for the NHS to deliver ever greater efficiency.

6. Policy in Wales is set in "Our Plan for Primary Care Services for Wales up to 2018" This confirms that the independent contractor model of general practice will "remain the principal model

in Wales". It also indicates that health boards will need to look at the use of a wide range of other options. Whilst the ethos in Wales is very different to England, the direction of travel is very similar: Welsh Government says that "To be sustainable now and in the future, some practices will need to consider merging or establishing federations." The plan firmly commits the Welsh NHS to use new forms of collaborative working in order to "remain fit for the future". In July 2015 Welsh Government published "A Planned Primary Care Workforce for Wales". This makes the point that "Some independent GP services are facing pressure in remaining sustainable". Collaboration at primary care cluster level is leading to exploring the benefits of GP practice mergers and federations of GP practices. Welsh Government is currently funding small pilot federation projects in Bridgend and South Powys. These schemes carry the potential to make the fundamental changes that the Welsh NHS requires, including to "…take responsibility for the delivery of a wider range of services that have traditionally been delivered by a secondary care provider".

Need for Change in Cardiff & Vale:

7. The need for change in Cardiff and Vale is set out in the "Shaping Our Future Wellbeing Strategy" in 2015 (SOFWS). It explains how a healthcare system that is already struggling to cope will be required to care for an additional 50,000 people by 2025. It points out that within a rapidly growing population the numbers of over 85s will increase by 32.4%. Unlike the rest of Wales, there is also a predicted increase in children under 4. The growing burden of chronic disease will place additional demands, with 1 in 10 adults with COPD and 1 in 25 with diabetes. Further pressures will be placed as the 2012 South Wales Programme is implemented. This aims to impose new patterns of hospital healthcare across the region based on a smaller number of specialist c e n t r e s , which will have to deal with a greater throughput of patients. As a result C&V will face increased demands for emergency and complex assessment, which will transmit additional pressure through the entire system including primary and community care services.

8. These changes would logically require substantial additional funding. The impact of the 2008 recession and subsequent austerity has made this impossible, a position which is unlikely to change given further world economic turbulence. It has been predicted that the NHS could face a funding gap of £2.5 billion within 10 years. SOFWS points out that between 2012/13 and 2014/15 C&V was required by Welsh Government to deliver efficiency savings of £110m. Board Reports indicate that the LHB is currently in discussions with Welsh Government about a projected year end deficit of £23.2m which is £10m more than it should be. One of the most significant reasons for this is a £5.3m shortfall on planned efficiency savings.

9. SOFWS concludes on page 9:

> "As the needs and demands of our local and regional population change, the way we currently provide our services is no longer sustainable. A squeeze on our resources only adds to the problem. To sustain safe and high quality service in the future we will need to reorganise and redevelop much of the routine care we provide. Services that have been provided in hospital may be more sustainable if provided in the community."

10. The LHB's position is well understood by its GPs. There is also a willingness to work with the LHB to develop solutions. However, there are problems within general practice which also need to be addressed. The pressure of work in primary care has increased substantially over the last decade. The adverse demographic change and increases in chronic disease prevalence are well documented, not to mention work that has already been transferred from hospitals, with inadequate resources. Against this background, investment in GMS has been falling in real terms since 2007/8 and GP earnings reduced each year. Increased workload has been carried by a workforce which has remained numerically broadly flat. This has had a negative impact on morale and brought a recruitment and retention crisis to many parts of Wales and this is now beginning to have a significant effect locally. Against this background any further shift work from secondary to primary care is impossible without changes to the way that primary care is funded and delivered, including the physical infrastructure.

Confederation - Structure

11. A Confederation owned by participating GPs from across Cardiff and the Vale is considered to be the most appropriate and important system change required for the sustainable development of primary care in the area. Practices will remain separate entities retaining their existing GMS contracts, yet having the opportunity of becoming shareholders in the Cardiff and Vale Confederation. The Confederation is most likely to be a Community Interest Company, a legal Form created specifically for social enterprises. It will employ officers and clinical staff. It will have social objectives, concentrating on the improvement of health and well-being of the population it serves. It is likely to have an asset lock preventing the distribution of Confederation profits. These must be reinvested within the company for the benefit of patients. The operational and financial remit will be agreed by GPs on a democratic basis, with a mechanism for all practices to have input, for example with local groupings feeding into monthly board meetings. One of the key objectives of the Confederation will be to support and sustain the independent contractor model of general practice across the LHB area.

12. The Confederation will:

- Provide services across the whole population through constituent practices.
- Provide services, subject to appropriate design and commissioning; some in all practices; some in practices that provide for patients of other practices; or some services provided on a local area basis.
- Develop and establish a model to allow for flexibility of delivery and appropriate mechanisms of support.
- Be formed as a corporate entity enabled to employ clinical and support staff under appropriate NHS terms and conditions including superannuation.
- Provide income stability and opportunities for efficiency gains through economies of scale achieved through collaboration and business development of member practices.

Confederation - Governance

13. The structure, governance and business model of the Confederation will require further detailed work including specialist legal and accountancy advice. Wales Cooperative Centre has been approached and agreed to advise and assist with the set up process. The Confederation will be subject to the normal rules of clinical governance as they apply across the rest of Wales. The owners and operators of the company will be GPs who are regulated by the GMC and therefore subject to annual appraisal and revalidation every 5 years. Any other health care providers e.g. nurses will be overseen by a GP and subject to regulation by their own professional body e.g. Nursing and Midwifery Council. As part of the process of establishing the company discussions will occur about further regulatory requirements with relevant LHB departments, Health Inspectorate Wales and Welsh Government. .

14. The concept of a Confederation has been discussed with practices using a GP lead from each cluster area. From these initial discussions it has been established that there is significant support from practices across the LHB area to warrant more detailed proposals. A significant number of practices (though not all) are expected to join the Confederation at the outset. On the basis of experience elsewhere this would not be unusual and would not affect viability.

Confederation - Relationship with Clusters

15. One of the prevailing conceptual challenges about the formation of a Confederation relates to the perceived (political and practical) conflict with Clusters which are presently at the centre of Welsh Government and Health Board policy and primary care delivery. However as demonstrably different entities in both constitutional status and remit, the Cluster and Confederation models can and should co-exist.

16. Clusters are a new tier of the NHS. Localities and Clusters were created by Welsh Government in Setting the Direction in 2009. As NHS controlled bodies Clusters have no guaranteed future or funding. There is a widely held concern that over time Clusters will go the same way as FHSAs, FPCs, AHAs, SHAs, LHGs and the 22 LHBs. Unlike LHBs they have no legal status and cannot spend or receive money. They can only provide care through staff seconded by the LHB or through payments from the LHB to individual practices. The decision making processes and accountability of Clusters is variable or completely absent. Their remit goes well beyond General Medical Services and, over time, they are set to include membership from hospital staff, social care, local authorities and the 3rd sector. The remit of Clusters is very wide, including assessing the health and social care needs of local populations, planning and coordinating delivering services and facilitating all parts of the NHS to work together with social services. Clusters are locally sensitive organisations, typically working with populations of 50-80,000. Clusters meet for a short time 3 or 4 times a year and have no permanent officer or accommodation therefore lacking the appropriate executive and infrastructure to provide and manage medical services in the community at scale. To add to the uncertainty, funding for GP participation in Clusters is through the QOF section of the GMS contract, which is subject to constant review and change.

17. By contrast, a Confederation is a large scale provider of medical services owned by constituent or member practices with legal status established through its company formation, shareholder agreement and articles of association and bound by associated legislation. It will provide very specific and quality assured services to agreed standards. Like primary care contractors the Confederation will be accountable to the NHS, but run entirely independently and free from political pressure. The Confederation would work in close partnership with the existing clusters and Clusters would provide the ideal local groupings to feed into the Confederation board; indeed the structure has already been used in the initial consultation with local GPs and is a recognised model elsewhere.

How might it work? An illustration using Diabetes Services

Diabetic Services - Background

18. The Cardiff and Vale Community Diabetes Model evolved from the Diabetes Delivery Plan (2013 – 2016) with a vision to provide “seamless diabetes services across primary and secondary care, co-designed with people with diabetes and their carers, to enable the best possible health outcomes” established upon principles of:

- Patient self-management;
- Primary care practitioners as the people working with people with diabetes;
- strong and effective expert support and advice resources for those practitioners;
- enhanced skills and improved confidence in primary care;
- rapid access to specialists;
- continuity of care through multi-disciplinary team working;
- reduced variation in practice;
- less duplication and waste.

19. The situation that existed in Cardiff and Vale prior to this had limited support for primary care, resulting in a variation in the standard of expertise and confidence within general practice. This caused a variation in the referral pattern resulting in large numbers of patients being referred to secondary care for issues related to titration of medication, introduction of new medication and insulin initiation. The resultant pressure on secondary care caused very long waiting lists, delays in patients receiving appropriate management.

20. The Plan was to be delivered through:

- Dedicated Consultant inputs - each GP practice having access to a named consultant providing visits to the practice for both case and guideline review along with email advice in a prescribed time;
- diabetes specialist nurses supporting both therapy optimisation, including insulin initiation and titration and educational support;
- comprehensive delivery of structured education programmes for patients.

The driving principles were:

- Upscale primary care to manage non-insulin-dependent diabetes more effectively;
- decrease referrals to secondary care;
- facilitate discharge of diabetic patients admitted for other issues.

21. The expectation was that this would result in improved diabetic control, fewer referrals to secondary care, allowing diabetologist to concentrate on more complex cases and prevent delayed transfers of care due to concern about management of diabetes in the community. There was a secondary outcome to try and identify patients with NIDDM badly controlled on analogue insulin and transfer them to human insulin in an attempt to improve control. Due to the significant cost of the analogue insulin this would result in significant cost savings, which should be used to offset the costs of the service.

Diabetic Services - Analysis

22. For the successful delivery of the diabetic community model there was the assumption of a uniform delivery of care, with all consultants and general practices engaging in a similar manner. There was also a significant reliance on diabetic specialist nurses supporting the general practice in an ongoing and comprehensive manner. Unfortunately there was significant variation in the engagement of consultants and general practices. There was also considerable variation in the uptake of the expertise of the diabetic specialist nurses. This has resulted in greater variation in service delivery, with some general practices having regular input from their consultant being able to manage almost all their NIDDM patients " in house", thus decreasing referrals and improving care, but with other practices, which have had little or no consultant input, showing no alteration in management or referral patterns.

23. The Diabetic Plan has resulted in a service that is significantly less efficient than it could be, without a consistent ability to modify the secondary care provision, thus achieving better use of the specialist expertise. Effectively there has not been the scale or standardisation of treatment to ensure all patients in Cardiff and Vale have the quality of treatment proposed by the community model. Evidence from across the UK suggests that voluntary agreements do not result in the scale and standardisation of delivery of care. Closer analysis suggests that many of the problems have arisen as a result of the lack of:

- a clear specification
- specified objectives and timeframes
- a clear planning and monitoring process
- formal contracting with providers
- adequate stakeholder engagement (particularly primary care providers)
- appropriate resource identification for the entire service
- a comprehensive change management programme

Diabetic Services - Proposed New Model

24. So what would change with the existence of a GP Confederation? First and foremost it would bring opportunity for a new contractual arrangement between the LHB and the service providers (the GP Confederation). Although this would require significant change within the Health Board in terms of a desire to deliver a comprehensive service spanning all current sectors - and a

willingness to overcome or dismantle current boundaries – the Confederation would bring necessary scale and sector wide (primary care) engagement, delivery support and outcome progress - and ultimately outcome certainty. It would also require the development of a fully defined specification for diabetes services in both the community and hospital setting, with sequential investment priorities identified to underpin system and organisational change set to occur over a defined period (3 – 5years). As the Confederation will be an organisation resulting from general practices who have all agreed on the method and outcome of delivering services, there is a guarantee of quality and engagement.

25. In addition to developing primary care services offered by constituent GP practices (committed through their Confederation engagement to a continuous improvement programme). The Confederation would employ appropriate personnel to deliver the certain services including - Diabetes Specialist Nurses; Community based Consultant Diabetologists; a primary care support team of clinicians including GP's, ANP's, dietitians and others within an evolving skill mix of practitioners. Supported local service development would occur at practice, Cluster and Locality levels -the latter occurring in conjunction with the evolution of "Locality Hubs".

26. In the model proposed by the Confederation there would be guaranteed involvement of the consultants with the involved practices, resulting in universal delivery of service. The Confederation would monitor the service delivery and, in practices that are struggling, it would be able to provide support. This would ensure all patients get an equally high quality of care, resulting in better diabetic control close to home and delay in the development of life changing complications. The closer involvement of the consultant body should result in fewer referrals, thus freeing secondary care to treat patients who need early access to specialist expertise. The Confederation would ensure that patients suitable for the switch from analogue insulins to human insulin would have taken place, thus providing potential significant savings. The aim of the Confederation would to deliver specific service developments and objectives within the defined contract period (3 – 5years) including or relating to:

- patient focused outcomes
- prevention and screening
- prescribing and management outcomes
- referrals within the service and between sectors

Confederation - The Way Forward

27. The GP Confederation Steering Group requests that LHB Officers consider the proposal for a Cardiff and Vale GP Confederation and offer their support, initially in principle and with further dialogue, to establish the appropriate mechanisms to provide formal support within a clear timetable within the 2016/17 financial year.

28. The GP Confederation Steering Group will simultaneously

- share this proposal document with Cardiff and Vale GP's and, with their support, take initial steps toward company formation
- approach Welsh Government with a request for pathfinder status or alternative funding and support opportunities

Dr Sarah Morgan
Dr Kay Saunders
Dr Haydn Mayo
Mr. Derek Fishwick **April 2016**