Where now for General Practice?

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Putting patients first

- Shared decision making: “Nothing about me without me”
- PROMS, patient experience data and real time feedback to rate services and departments
- HealthWatch England to be created
- Democratic involvement through local authority

Putting Patients First (2)

- Involvement in decisions about service change or cuts
- Patient Participation Groups
- Giving voice to the voiceless

The Information Revolution

- NHS Choices and other online services
  - How accurate will they be?
- Quality Accounts produced by all providers
  - How expensive will it be?
- Staff feedback publicly available
- Patient control of their records
  - Could control and download this to show third party
- Summary Care Record to be more limited
- No clarity about future IT arrangements currently fulfilled by PCTs

Patient Choice – promote competition

- Choice of any willing provider
- Choice of consultant-led team
- Extended maternity choice
- Choice of mental health service
- Choice of treatment, care in long term conditions and end-of-life care
- Choice of any GP practice – not limited by where a patient lives or practice boundary

Regulating Healthcare Providers

- Monitor
  - promote competition
  - regulate prices
  - support service continuity
  - licence providers
- Care Quality Commission
  - licensing providers for essential safety and quality
  - quality inspections
  - take enforcement action when required

Performance management

- What will be the role of the National Commissioning Board?
- Devolved responsibility to consortia?
  - Responsible Officer
  - Appraisal
- Consortia to work with practices to drive up quality and improve use of NHS resources
- Peer pressure and benchmarking practices
- Could ask for practice to be expelled from consortium

A new GP Contract?

Para 3.21

"In general practice the Department will seek **over time to establish a single contractual and funding model** to promote quality improvement, deliver fairness for all practices, support free patient choice, and remove unnecessary barriers to new provision. Our principle is that funding should follow the registered patient, on a weighted capitation model, adjusted for quality. We will incentivise ways of improving access to primary care in disadvantaged areas."

Para 5.12

"GP consortia will align clinical decisions in general practice with the financial consequences of those decisions."

A New GP Contract?

- Proportion of GP practice income linked to the outcomes that practices achieve collaboratively in consortia and the effectiveness with which they manage NHS resources
- Quality premium paid to consortium and they decide how to apportion to practices
- QOF to focus more on health outcomes and 15% linked to public health
- All funded from existing resources
- Local Enhanced Services – national Board or locally commissioned?

A new way of working?

- Commissioning/Provider split
  - Dealing with conflicts of interest
- GP provider groups
- Federated practices
- Multiple-site practices
- Federated consortia

Risks…

- Damage to doctor/patient relationship
- Privatization by the back-door
- Funding formula not accurate
- GPs blamed for cuts
- GPs accused of making excessive profit
- Enough local leaders with the right skills?
- Enthusiasts without a mandate setting an inappropriate agenda

…and risks…

- Some GP consortia will fail – what then?
- PCT implosion, loss of key staff and skills
- PCT clustering – another re-organisation.
- Competition v collaboration
- Conflict between practices
- Fail to learn lessons of PCG/PCT mergers or Fundholding
- DH doesn’t give changes long enough to work.

…and opportunities?

- Clinical leadership
- Real involvement in re-designing services and improving services for patients
- Developing practices
- Developing meaningful partnerships with local authority and hospital Trusts.
- Reducing bureaucracy – for how long?
- Can we avoid the re-creation of PCTs?

Next steps for consortia

- **Money matters:** Half the resources of PCTs
  - £2 per head on top of current PBC scheme money for development
  - £25-£35 per head running costs by 2014/15
  - PCT debt to be dealt with by PCTs and SHAs
- **Size matters**: balance risk management, power and influence v practice engagement
  - small consortia with regional NHS service agency
  - large consortium with locality sub-structure
  - effective and consistent engagement with other organisations
- **People matter:**
  - Accountable Officer
  - Chief Financial Officer

Next steps for consortia (2)

- **Rules matter**:
  - governance arrangements must be adaptable
  - all doctors should have a voice
- **Collaboration matters**:
  - local consultants
  - Public Health and Health and Wellbeing Board
  - other health care professionals
  - patients
- **Names matter**: Local Commissioning Groups v GP Commissioning Consortia?
- **Philosophy matters**: NHS v commercialisation

Next steps for practices

- Work with LMC, PCT and existing consortia
- All practices in an area should be involved in discussions about future arrangements
- Identify local skills and expertise
- Consider provider possibilities
- Engage with patients.