What the Changes to General Practice mean for Primary Care Premises

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more consultations A DAY than they did seven years ago

THE CURRENT CRISIS IN

GENERAL PRACTICE

97% of GPs say that box-ticking and bureaucracy has increased since 2012

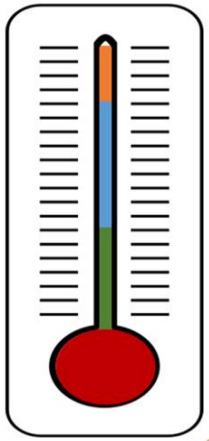
9.1% of GP positions are currently unfilled

93% of GPs say that workload has negatively impacted on care

71% identified workload as having the highest negative impact on general practice

37% think current workload is unmanageable

16% report an unmanageable amount of work-related stress



GP average income before tax **FELL** by **20%** since 2004...

...BUT Practice costs **ROSE** including a **9%** rise in the cost of locum medical staff, a **9%** rise in CQC fees and a **25.5%** rise in GP indemnity fees

72 practices closed between April 2013 and April 2015...

...displacing **157,246** patients

1 in 4 practices has a two week wait for a non-urgent appointment

4 out of 10 practices feel that their current facilities are inadequate to deliver basic GP services to patients

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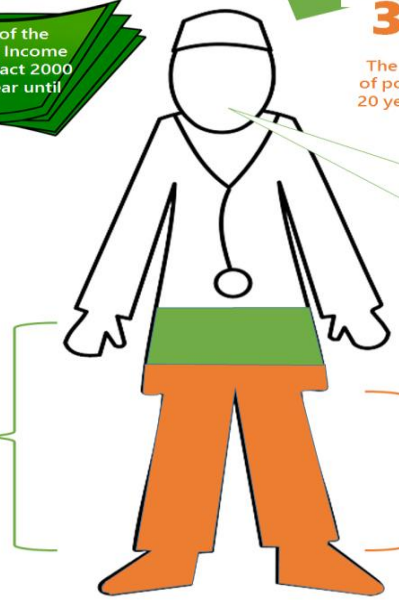
THE FUTURE CRISIS FOR

GENERAL PRACTICE

The number of consultations per head of population has more than doubled in 20 years (from 3.9 in 1995 to 8.3 in 2014) and continues to increase

The withdrawal of the Minimum Practice Income Guarantee will impact 2000 practices every year until 2020/21

47% of GPs report that their practice will lose a colleague to retirement or emigration in the next 12 months



87% of respondents to our survey said that cuts to social care would significantly worsen the problems their practices face

34% of GPs intend to retire from General Practice in the next 5 years

It is predicted that there will be a **20%** **increase** in the number of people with at least one long term condition by 2025

90% of respondents to our survey say that 7-day opening will make the problems facing their practice *"significantly worse"*

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Impact of crisis on premises

- Insufficient estate to manage increased demand
- Estates charges part of burden of increased costs - rising charges for estate from NHS Property Services
- Falling numbers of partners (down 9% in 10 years) less willing/able to invest in property
- Increasing number of owner partners looking to “cash-in” property

Changes are a response to the crisis

1. New roles / practice efficiencies
2. Operating at scale
3. New models of care
4. External support: ETF & beyond

1. New roles / practice efficiencies

- Additional roles to manage demand within cost envelope – space often barrier
- Increasing shift to telephone/web based appointments
- Additional cost of larger premises a real barrier
- Real thought being given to possibility of reducing number of premises (politically difficult) – practices need help with this

2. Operating at scale

- Not a golden bullet – fail as well as succeed: Horizon in Bedfordshire; Danum Medical Services in Doncaster
- Shift from additional services - growth in primary care owned community estate (e.g. Whitstable) exception not rule
- Developing efficiencies
- Hot and cold working: St Austell
- Federations to super-practices: City & Hackney, Suffolk
- Approach no longer primary vs secondary care

3. New models of care

Primary care home:

- To enable co-located productive partnerships (e.g. Bassetlaw)
- Relationships plus council and voluntary sector/social prescribing (e.g. Oxford Terrace, Gateshead)

Multispecialty community providers:

- Exit plan for practices
- Ability to cash in buildings = key driver

PACS:

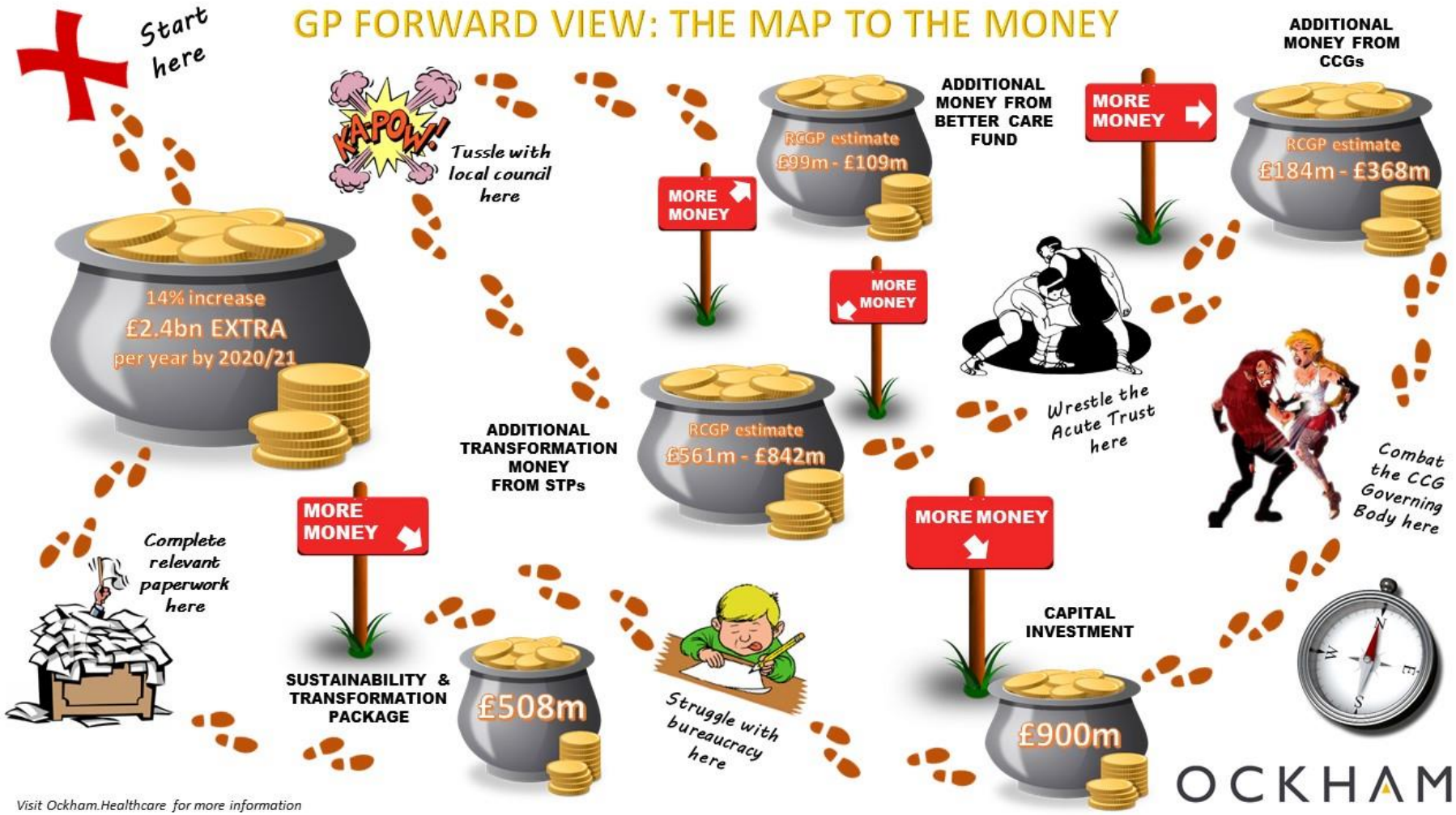
- Rely on relationships with general practice (e.g. Yeovil)
- Not just PACS – Northumbria, Chesterfield, Wolverhampton etc

4. External Support: ETF & beyond

Estates and Technology transformation fund

- Technology combined with estates
- Removal of match-funding expectation welcome but increased expectations
- CCGs feel like recipients of decisions not decision maker
- Revenue consequences remain a barrier

Beyond the Estate and Technology Fund...



Access and the Money

- £3 per head; £3.34 per head in 2018/19; £6 per head in 2019/20
- £500m recurrent from 2020/21
- Encouraged for groups of practices: accelerate “hot” & “cold” working
- Implications for out-of-hours?

Impact of CCGs

- Location of decision making - will co-commissioning make a difference?
- CCG local GPFV plan due Dec 2016 – address GP crisis or access/scale agenda?
- "*If you don't have a plan for primary care, you don't have a plan for premises*"
- STPs may have greater impact on primary care premises…

Impact of STPs

- Common theme of redesign of community/primary care
- Starting point reduction in spend, not challenges in general practice
- Successful vanguards based on development of trust across organisations over time
- “Plan-based” change initiatives unlikely to gain GP buy in, but estates can be a sweetener
- STP areas may develop central control of estates, e.g. Hampshire

Summary

- Financial pressure/less partners mean more GPs want to “cash-in” their buildings
- MCP/PACS seen as way out, if premises buy-out included
- Scale will increase split of hot and cold GP practice sites, accelerated by access funding
- STPs likely to have greater influence on primary care premises than CCGs
- Community providers, acute hospitals & councils increasingly influential decision makers in future

Questions?

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