Candesic

Go large with that? The rise of the 'GP super practice'

Candesic reviews the rapidly moving landscape within primary care and how the time is ripe for investment

Primary care, including general practice (GP), is the gateway to NHS services. In fact, Health & Social Care Information Centre data reminds us that around 90% of patient interaction is at the primary care level. This gateway or, more precisely, gatekeeper role, is essential for managing demand for secondary and tertiary care services and for achieving the laudable aim of delivering more healthcare in the community and within the home.

Using primary care as a positive transformation of patient experience whilst making the system more efficient could develop into a win-win situation. What this future looks like is still evolving but the building blocks are now in place. However, GPs urgently need to secure resources to deliver such changes in a cash strapped NHS environment; this opens up opportunities for external partners and investors to become part of this ecosystem.

In recent years, GP has been seen as (or certainly felt like) a neglected service, with a succession of headlines reporting imminent crises in primary care due to the number of GPs retiring, unsuitable premises and unsustainable growth in demand from an aging population. However, staffing, infrastructure and an aging population, against a background of constrained resources, are challenges faced by the entire NHS, not just GPs. The NHS is recognising these challenges and hiring more GPs, investing in new premises and suggesting new American-style 'GP associates' to boost numbers. The 'Five year forward view' (FYFV) strategy document, published last October, envisages a reinvigoration of primary care and new opportunities for GPs to reconfigure and run a range of services. Whether it is a grand plan with a well-designed system at its heart, or piecemeal reforms which add up to something far greater than the sum of its parts, GPs are being positioned to drive change. There are four broad areas of opportunity for investors:

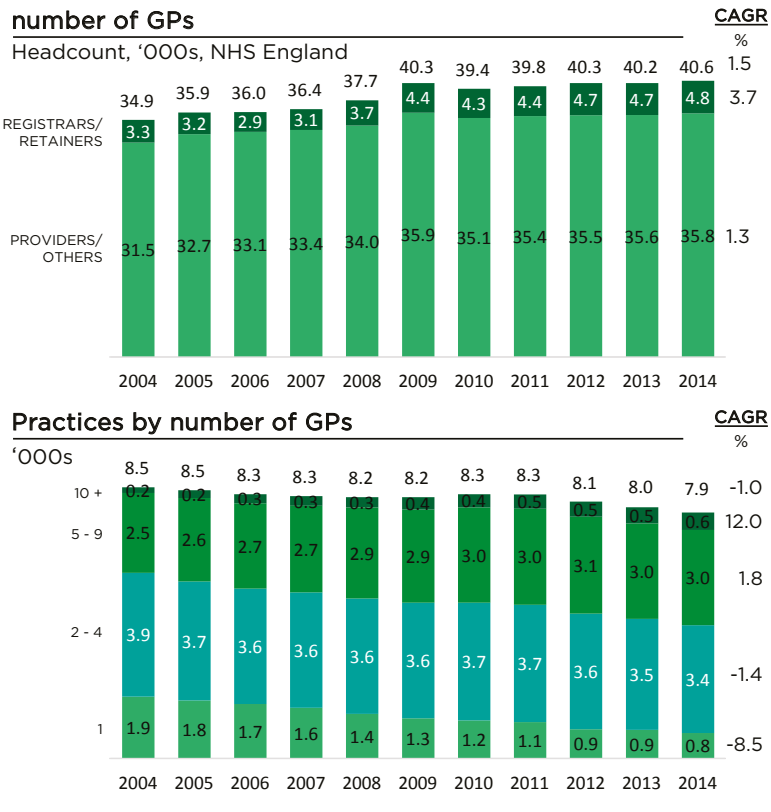
1. Property

The first is already well established; investors should focus on property development and facilities management, in particular, leasing new premises and, in some cases, providing a selection of back office services in return for a service fee. Quite simply, a greater number of GPs are needed to meet demand from a growing and ageing population, plus to offer additional services. GP headcount increased by 16% between 2004 and 2014 and the government has promised 'up to' 5,000 more by 2020: all these new GPs need places to work. More of them are salaried employees, and more are working within expanding practices instead of setting up on their own *(figure 1)*. With six in 10 practices telling the British Medical Association's 2014 survey that they have to share consulting rooms, the pressure on premises is clear. Meanwhile, the introduction of Care Quality Commission (CQC) inspections from 2013 and the requirement for better disabled access has highlighted the deficiencies in the material condition of many practices. At CQC registration, 10% of general practice providers declared themselves non-compliant with 'safety and suitability of premises'.

2. Super-size GP practices

Secondly, GP surgeries have already been joining together to form federations, and the new GP contract announced by the government in September is aimed at encouraging GP practices to super-size. One such trailblazer is the 'super-partnership' merging 35 Birmingham practices, which includes: 150 GP partners, ▶

FIGURE 1: PROPERTY AND FACILITIES MANAGEMENT INVESTMENT OPPORTUNITIES



Driving demand for new premises

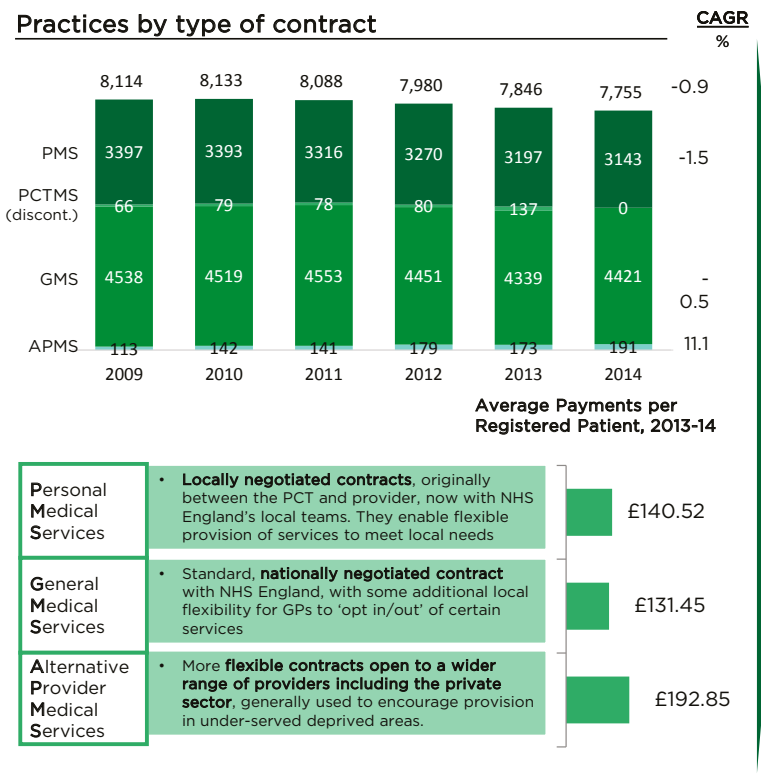
- Growing number of GPs
- Trend towards larger practices
- Replace unsuitable premises

A major BMA survey of around 4,000 GP practices in England (half the overall total) in July 2014 revealed the depth of this problem:

- Over half of the practices have seen no investment or refurbishment in the past 10 years
- Four out of 10 GP practices feel that their current facilities are not adequate to deliver basic GP services to patients
- Six out of 10 GPs have to share consulting rooms restricting the number of appointments and affecting overall service delivery
- Seven out of 10 GPs feel their facilities are too small to deliver additional services.

Source: HSCIC; BMA; Candesic analysis

FIGURE 2: EVOLUTION OF CONTRACT TYPE



Future trends in contracting

- NHS England is managing a process of alignment between PMS and GMS contracts
- The net amount spent on primary care should not fall, but it does reduce the attractiveness of PMS, since they can be more easily terminated and may have obligations above and beyond 'regulated' services
- The GP Council of the BMA is therefore recommending GPs exercise their right to return to a GMS contract rather than stay on a PMS contract

- At the same time, NHS England is invoking competition law in a new policy to ensure that all *new* GP contracts are APMS, that is procurement of an entirely new GP service, for example, after another contract has been terminated or to expand provision
- APMS contracts were originally conceived to improve provision in deprived areas where traditional GP partnerships had been reluctant to move in. Therefore, they specifically allow for independent and private sector providers.

Source: HSCIC; Candesic analysis

50 salaried GPs and a combined registered list of 275,000. This new single body, called Our Health Partnership (OHP), is set to launch in November 2016 and will be the largest single partnership providing primary care in England with even more practices considering joining. OHP aims to make GPs more efficient by having a central hub of functions such as recruitment, purchasing, accounting, locum organisation and administration.

NHS England is also expected to incentivise practices to move to the new seven-day voluntary contract, from their existing GMS, PMS and APMS contracts. For many years, the standard nationally negotiated general medical services (GMS) contract with NHS England provided a standard service specification with some additional local flexibility for GPs to 'opt in/out' of certain services. The introduction of the personal medical services (PMS) contract provided a route for flexible specification of services to meet local needs and the start of greater variation in what GPs could be contracted to provide for their patients. Finally, APMS contracts were introduced as a means of encouraging other provider types, including private sector corporates, into areas where it had been difficult to recruit GPs (*figure 2*).

3. GPs in the driving seat

The third opportunity is about putting GPs in the driving seat of a genuine joined-up transformation in the way healthcare is delivered. Over 70% of CCGs are set to co-commission primary and secondary health (figure 3). As co-commissioning gathers momentum and experience, more opportunities will open up for agile, flexible primary care providers to offer broader service packages. This will lead to GP surgeries drawing activity out of acute hospitals.

To a point, some of this has always been possible. The Practice, for example, provides a range of property and support services to general practices, and also a selection of other medical services which can be delivered efficiently at the practice premises. At the moment, these are ophthalmology, ENT and dermatology services, but preventive health services, such as weight management and diabetes screening, and other minor secondary care procedures, such as diagnostics and outpatients, could and should also be provided in a primary care setting.

Add to this the FYFV, where the new models of care offer very clear and significant opportunities for ambitious GP federations:

A. **Multi-speciality community providers:** this model encourages the merger of

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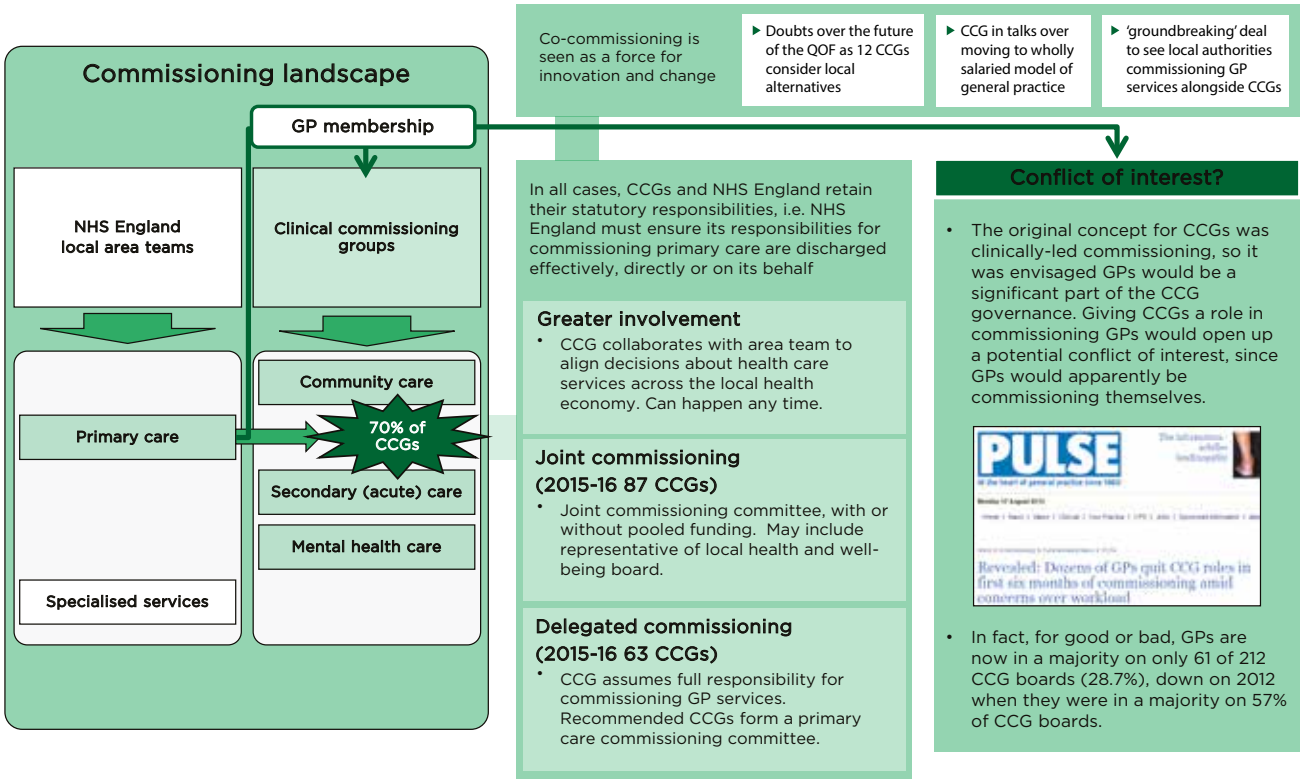
FIGURE 3: CO-COMMISSIONING OF GP SERVICES



Sources: NHS England; Pulse magazine; Candesic analysis

GP practices to offer a wider range of services, including specialist care currently undertaken in hospitals

B. **Primary and acute care systems:** a single provider system offering joined-up general practice and acute hospital care

C. **Enhanced health in care homes:** where GP-led multi-disciplinary teams offer active health and rehabilitation services to support older people and prevent hospital admissions

D. **Urgent and emergency care:** a model that combines GPs out-of-hours services with other urgent care services, to reduce the load on A&E.

The first round of vanguard sites for trialling these new models of care have already been selected and what works well will gradually emerge over the next year or so. However, NHS England is clear that commissioners and providers cannot afford to wait for proven success, and must get on with rolling out these new models of care everywhere if efficiency savings are to be realised.

4. New technology

Fourth, but by no means least, is the opportunity for technology to revolutionise flexible and remote primary care access. This encompasses everything from GP telehealth to skype consultations; Babylon, Push Doctor and DoctorCareAnywhere being such examples.

Then there is the explosion in medical self-management technology enablers, one such example is Mapmydiabetes which offers online support. Dr Matthew Goodman from Mapmyhealth says: "New 'technology enabled care services' provide the light-touch, but ever present support and education that is critical in improving outcomes in lifelong conditions." Technology of tomorrow will fundamentally change the doctor-patient interaction and enable more care and self-management to be delivered away from inpatient bedside.

Finally, all this change is creating a new breed of commercially astute GPs looking for ways and means to grow profitably within the NHS, without destroying the deep and inherent trust patients place in their GP. The most canny GPs have already been building the commercial structures to deliver innovation and many are now looking for the financial backing to take them on the next stage of their journey. Investors may have to kiss a lot of frogs to find their prince, but as the FYFV shows, there is real interest in taking risks to improve the way the NHS works and an appetite for sharing some of the benefits with those who take the risks. ■

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