HUK Trustee Network Call Notes, 16/06/22:

GP practices and hospices: Navigating the NHS framework, Professor Sean Hilton and Annette Alcock
(Notes to be read in conjunction with Slides)

PRESENTATION

1. Following from Annette’s last presentation around SPOC (Single Point of Contact), grants and statutory income, Professor Sean Hilton was invited to speak at the next session with Annette to share his thoughts about GP practices and share his reflections on the similarities and differences with the hospice sector. Professor Sean Hilton was a General Practice Principal for 30 years and held a parallel career in education and training.

2. GP practices and hospices, differences – slide 2.

   - **NHS funding: capitation vs standard contract** - Differences are not stark but nuanced. GP rest on capitation system whereas hospice chairs are bound by contracts which don’t have direct relationship to the portion of care of number of patients. Capitation used to be predominant mode to determine GP income but this has dropped over the years. Each practice has a registered list of patients which has implications on patient care, public health and other funding streams.
   
   - **Service provision: generalist throughout life vs specialist end of life** – Hospices provide specialist end of life care, although they do so through a holistic, generalist lens which matches the ‘whole person medicine’ approach provided by GP practices.
   
   - **Voice in the system: primary care vs ‘voluntary sector’** – major differences. Given volume of NHS work that passes through general practice primary care, there is a strong voice as a provider, although most GP believe it’s a quieter voice than the acute systems.

3. GP practices and hospices, similarities – slide 3.

   - **Independent Business** - Within the body of the National Health Service, there are similarities in independence. In general practice, this was strong in early years but have been progressively eroded over time. In the beginning, the general practice practitioners held contracts with the National Health Service as NHS contractors and they were independent. Early model was single handed practitioners.

   - **Embedded in local community** – Pressures have increased on inner city, highly populated areas but general practices are local provisions. Hospices and GPs work alongside the NHS acute trusts and specialist provision.
- **Necessity to work closely together** – There is a pressure to collaborate and increase effectiveness and efficiency. For general practices, the pressure comes more consistently over the years as a means of control, whether that be cost or contractual.
- **Staffing structures** – Many GP clinical staff are on NHS pensions and pay schemes, general practice has followed, especially in clinical roles, the Agenda for Change salary structure in the NHS. Princess Alice Hospice track the NHS AfCs in clinical staff pay structure. 
- Core of general practice is the registered list of patients, the community based continuity of provision of care, the referral system and a generalist approach to diagnosis (not on the list of similarities, but is fundamental). As hospices, there are different terminologies for holistic care and that is an essential component to general practice.

4. **Collaborating within the wider system – slide 4.**
- Slide 4 was shared in the last meeting where there were discussions around what the wider healthcare system looked like and where hospices fit and the topic of hospice collaboration as well as wider sector collaboration.
- What have individual GP practices, as independent businesses done in that space of having to collaborate in and with the wider system.

5. **GP practice collaboration – slide 5.**
- **A look into why GP practices have come to be doing collaboration work** – central government policy has a huge influence. Collaboration naturally happens when partners are nearing retirement or looking to leave. The contracts partners hold is called ‘in perpetuity’, the GP partners own the practice and the practice holds a contract with national government indefinitely. It is up to the GP partner to find new partners to carry on the work if they choose to leave. More people are finding the business model hard work so people do now hand their contract into national government as they can’t find replacements, which can then go out to tender and a non-GP partner market.
- The focus is independent GP practices, which are run by partners and how and why they might have looked to merge and work more closely together in different collaborations.
- It started in earnest with GP fundholding and then the Prime Minister’s challenge fund required practices to join up with other practice locally and work together to build up networks. The push was for numbers and geography and acted as basis of ways of working. Models of care was pushed where they proposed that GP practices can be bigger and multi-disciplinary. When CQC registration needed to be set up, networks moved together to a bigger federation. The fund had stopped but other funding was coming out for services above GP practices so they needed to work together to achieve the funding.
- Collaboration is mainly policy driven but general practice has tried to make it work locally. The main reasons for collaboration is around efficiency, having an efficient back office to share. This applies to clinical staff and shortage of expertise. There are also some service provisions that are better placed than others and how multi-disciplinary teams can work together. Finally, it is to have a stronger voice in wider systems.
- Many advantages to working together but also challenges. The reality of relationship and technical challenges are significant, joining up to determine finances and profit will be tricky and how to navigate around the clinical governance across organisations that are independent but working together.

**DISCUSSION/CHAT**

- Hospices have grown out of communities, and their local identity is important to their move to the future
- Are GP resources threatened by private sector activities e.g. Livi? – Not necessarily, the private sector is separate and within the NHS the funding goes to who is providing a particular service. The threat is there are fewer partners and people who want to run GP practices as well as an increase of salaried GPs. Funding will always come but the more it goes out to private companies within the NHS, the more it changes the landscape on who is providing the service and what their profit priorities are. Some real concerns around whether business have the right understanding around health and social care in the community, when it’s so crucial to know the population and their needs.
- GP practices have struggled to replace retiring GPs with GP partners and the challenge is the culture of GPs and is it not inevitable that primary care will become part of the acute NHS management structure?
- Where do you see Hospice/GP Surgery collaboration opportunities arising? Are there other opportunities for Hospices to look at looking forward? – Once the Integrated Care System and subsidiarity has happened, place-based provider partnerships and neighbourhood primary care networks are set up to encourage local collaboration. Areas of collaboration could mean:
  o Working with the GPs and their palliative care registers to discuss advance care planning,
  o Exploring Living Well services
  o Offering bereavement spaces – connecting with social prescribing link workers to host sessions, death café
  o Providing/Sharing education and training – every area has a Training Hub which is where the Health Education England funding goes for primary care education and training
- Dorothy House covers 700sq. miles and have implemented The Buurtzorg Model, a model around self-managed teams in communities. Wiltshire and North Somerset have gone into 10 neighbourhoods and embedded themselves in general practices in the areas which have been proving successful in reaching to wider communities. See model here: [The Buurtzorg Model - Buurtzorg International](https://www.thebuurtzorgmodel.com/)

This network call is Kate Tompkins’ last session with Hospice UK and all attendees thanked her for leading the trustee network and for all the work she has put into nurturing and building the trustee network.