Report

Development of a New Practice in the North West Edinburgh Partnership Centre
Edinburgh Integration Joint Board
24 March 2017

Executive Summary

1. The purpose of this report is for the Integration Joint Board to note the requirement originating from the North West Edinburgh Partnership Centre business case (as part of NHS Lothian's Bundle Projects approved by Scottish Government in 2015) to establish a new medical practice in the North West Partnership Centre building, with associated General Medical Services (GMS) costs.

Recommendations

2. That the Edinburgh Integration Joint Board (IJB) agrees to the proposal from Muirhouse Medical Group to establish the new practice as a branch and agrees the required GMS costs to enable this.

3. That the IJB notes that on 14 March 2017, the Muirhouse Partnership agreed to take 1,318 patients from the Inverleith Medical Practice which will close on 30 June 2017.

Background

4. The North West Edinburgh Partnership Centre, adjacent to the Muirhouse shopping centre, is currently under construction and running to programme, with a projected completion date in late 2017.

5. The centre will provide accommodation for the following: a general medical practice; community health services; primary care dental services; children and adolescent mental health services; community paediatric services; a CEC North West Children and Families social work practice; and a base for the North West Edinburgh Carers(this is a voluntary service).

6. When the building was originally designed, it included accommodation to re-provide the existing Muirhouse Medical Group (MMG) with increased capacity to address the current local population pressures and to accommodate people from new housing being built as part of the regeneration of the area. At the time, MMG agreed to grow the size of their practice to absorb this growth.

7. However, MMG and the Edinburgh Community Health Partnership (ECHP) failed to reach agreement on a financial settlement regarding MMG's existing premises and

they withdrew from their original intention to move. Subsequently, the building was redesigned without their footprint, but included accommodation to provide a new GP practice for 5,000 patients.

8. Although no decision was made at the time as to how this practice would be managed in the future, the business case (2014) included revenue costs to reflect the financial support required to initiate a new practice from scratch. The cost modelling assumed financial viability for a practice at around 3,500 patients with the financial support to attain this likely to be required over the first three years.

9. The financial support identified in the business case was £218k over 3 years, over and above the GMS income stream associated with the practice population. At the time of submission, this formed part of the revenue gap associated with the overall project which NHS Lothian intended to address in its financial plan but which now rests with the Edinburgh Health and Social Care Partnership (EHSCP).

10. Scottish Government approval of the business case included the stipulation that development of the new practice should commence a year in advance of the centre opening.

11. Developing a new practice from a zero patient base is both expensive and highly uncertain in the current environment. It is necessary to provide all relevant infrastructure to deliver the service, but the level of income from patients is insufficient for practice viability until a certain level, around 3,500 patients, is reached. It is further compounded by the time lag in receiving that income which is paid quarterly in arrears.

12. It is preferable to start with a cohort of patients and grow from there. EHSCP has good experience of this with the development of two practices using this model in recent years, each growing from an initial core of patients of around 1,500 to1,800. The support required is less, and viability is reached more quickly.

13. To this end, EHSCP initiated negotiations with MMG in 2015, to establish whether they would ‘seed’ a new practice in advance of the centre opening. In return for a level of investment, the practice agreed to this innovative new model which allows them to register patients who are intended to form the new practice when it is fully established.

14. A Service Level Agreement (SLA) was developed with MMG, with the emergent practice referred to as Pennywell Medical Practice (PMP) until such time as a permanent name is established. The terms of the SLA mean that MMG will code any patients intended for the new practice to PMP so that they can be transferred easily and patients are advised of this when registering.

15. The SLA is effective from August 2015 to August 2017, with an extension agreed to complete the time period from August 2017 until the new centre actually opens, in early 2018.

16. To date, c800 patients are attributed to the new practice. At this rate of growth a list size of 1,750 is projected by the time of the centre opening. The planned closure of Inverleith Medical Practice in June 2017 offers the opportunity to transfer to PMP an additional 1,318 patients, who fall within the practice boundary.

17. It should also be noted that, the Scottish Government position is that only core GMS income i.e. only Global Sum and Enhanced Services income and excluding the former variable QOF component which is now a fixed allocation, is available for growing populations and GP lists. This effectively means that additional patients to a practice list have to be taken at a discount of c20% each. The non recurring allowances for New Patient Premium have been built into the modelling.

Main report

18. There are 3 options as to how the new practice could be delivered once the centre opens:

    - directly managed/salaried as per a Section C (Primary Medical Services Act) direct managed contract;
    - a 17J contract - independent contractor (standalone); or as a
    - Branch practice.

19. Negotiations have been ongoing with MMG as to whether the practice wished to continue the management of the new practice once the centre opens, and how they would prefer to do so.

20. MMG has indicated that, should they retain an involvement, they would wish to manage it as a branch, and have submitted their cost projections, for developing this model.

21. The initial financial modelling, based on a starting list size of 1,750, indicates that a standalone practice would be the most expensive. A salaried model would be marginally cheaper, but the most cost effective option is a branch which offers more flexibility in the development phase. For instance a salaried service would have to open Monday to Friday, from 8am to 6pm from day one, whereas a branch does not have this requirement as patients can be seen at the main surgery if the new practice is only available for certain sessions.

22. This flexibility is beneficial should the ongoing support until financial viability is established be required for longer than anticipated, and builds on the already established infrastructure of a well developed practice. It is also worth noting that the modelling indicates that more than 3,500 patients will be required to achieve sufficient income to attain break even. In part this is due to the changes to the GP contract with loss of Quality and Outcomes Framework (QOF) income to core – this is a national pressure yet to be addressed by Scottish Government.

23. Although a directly managed option may be delivered at a cost close to the branch model, it brings greater risk and uncertainty around employing GPs and practice staff, with the additional need to provide a five day service from its inception. Recent attempts to recruit staff for advertised established practices have proved

challenging, and there is added risk around advertising a new venture with a limited patient base. The directly managed option still needs the interim support package as the list size grows.

24. The modelling undertaken assumed a starting list size of 1,750 patients. On 14 March the Muirhouse Partnership agreed that 1,318 patients would transfer from Inverleith and the financial modelling will need to be adjusted.

25. The difference in the cost of the MMG support package from the business case (c£100K per year for three years) comprises adjustment for out of hours, locum fees, property costs, profit/risk adjustment and other expenses. There is also the not insignificant adjustment required due to changes in the national GP contract to a fixed Quality payment that does not vary with list sizes there is a loss of Quality Income to Core (QOF income), equating to £84k over three years.

Key risks

26. Failure to reach settlement with MMG to run service as a branch.

27. Growth takes longer than projected to reach viability and support is required for a longer period.

28. The failure to recruit GPs if directly managed.

29. The destabilisation of the Muirhouse Medical Group. This could arise if the Pennywell Medical Practice became a competitor with a stand alone model, or the MMG faced insurmountable challenges associated with moving from a 13,000 to 18,000 patient population over two sites.

Financial implications

30. A support package of £387k from GMS sources to MMG was modelled over three years. This was designed to establish and develop the new practice to financial viability. With the addition of the Inverleith patients this level of support may be able to be reduced. The support package has moved from the original estimate of £218k due to higher property costs and the impact of Quality income.

31. The IJB should note that the additional revenue required over the first three years to stability is anticipated to be able to be funded from primary care sources. This will need to be reassessed as the 2017/18 GMS funding becomes clear, along with additional Lothian Health Board and Scottish Government Transformation funding. A requirement to supplement the funding from a non primary care income stream is not anticipated.

Involving people

32. There is no direct impact on people as a result of this paper; however, the failure to establish a new practice would directly affect EHSCP's ability to provide GMS services to the population in the area.

Impact on plans of other parties

33. None

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Links to priorities in strategic plan

Ensuring a sustainable model of primary care: actions 15, 16 and 18