North Cumbria Primary Care (NCPC)

Who we are and what we stand for

Prof John Howarth
Deputy Chief Executive CPFT & NCUH,
System Clinical Lead North Cumbria
Shareholder NCPC
North Cumbria Primary Care is a new not for profit model for primary care in which GPs become salaried, surpluses are reinvested in patient care and system partners, patients and the third sector join the partnership board
NCPC founding principles:

- We are the **NHS**
- We are *local*
- We are influenced by the 7 international *co-operative principles*
- We will work to a set of *values and behaviours*:
  - **Kindness**
  - **Collaboration**
  - **Ambition**
  - **Respect**
NCPC founding principles:

- We are *not for profit*

- We will have **strong financial control** and **strong clinical governance**

- We will *invest surpluses to improve patient care, and support our staff*

- Our partnership board will have nurses, third sector, patient and manager representatives
Our partners

The GP practices

Our patients

Third Sector

Cumbria Health on Call

University of Central Lancashire

School of Medicine and Dentistry
Alliance practices - North Cumbria Primary Care

- A partnership made up of the practices themselves, UCLAN medical school, CHOC, local NHS Trusts, patients and the third sector

- 13 practices so far interested /committed 120,000 people (38% of population) More interested.

- 9 practices in the first and second ‘waves’ April – June 2019

- GMS contracts will novate to NCPC

- Offering a premises solution (CPFT and eLIFT have created a new Joint Venture company to deliver premises solutions – 70% NHS owned)

- Taking business liabilities/worries off the partners

- GPs still leading clinically
Why are we doing this?

It is much more than just stabilising practices:

- Developing a multi-speciality multidisciplinary model of primary care
- Improving patient care access and experience
- Improving staff experience and morale
- Creating the ability to work at scale
- Developing workforce model at scale
- Recruiting young doctors
- Strengthening the patient voice
Draft Clinical and Operating Model

To give you a flavour of the things we are working on and our ambition.

There is a lot of stabilisation and recruitment to do so the following slides are likely to be a several year programme.
The 4 pillars of our clinical model:

- ‘Same day care’ – this is care which patients need to **access** on the day, today.

- **Complex and long term conditions** – this is care which requires good **co-ordination** and **continuity**.

- **Improving the population health** – this is the community focus of looking at the wider determinants of health, reducing variation and starting to close the gaps.

- **Patient activation** – to be truly **person centred**, patients must be activated in their own health needs and been seen **holistically** in relation to their health and wellbeing needs.
Same Day Care

- **At scale urgent and same day care** organised by locality e.g. an integrated urgent care hub at West Cumberland Hospital for Copeland.
- **At scale home visiting and care home support** controlled centrally but delivered by locality. Dedicated multidisciplinary home visiting team with a car and driver plus technology to allow efficient full mobile working.
- **At scale clinical triage of calls**
- **A clear plan for digital health developed with the first components working by end of 2019** – namely e consulting and remote consulting to boost capacity within our practices
- **At scale pharmacist led medicines management** system taking the bulk of this task off GPs.
Complex and long term conditions

- LTC/multimorbidity/Frailty clinics arranged around the person rather than the disease addressing all the LTCs at once plus risk assessments (e.g. for frailty or for likely hospital admission).

- Face to face appointments by GPs to move to 15 minutes allowing time to really sort out complex problems.

- Continuity provided by small team to include GP, medical assistant (‘close support’) and nurse.
Improving the Population Health

- An understanding of the ‘Gaps’ – mortality gaps and differences in healthy life expectancy, care and wellbeing gaps. Regular reporting on this at leadership meetings
- Business intelligence on the gaps available for teams to action provided by RAiDr
- An active programme to reduce the mortality gaps (this will include hard edged medical approaches – e.g. case finding for BP, AF COPD, more use of statins etc.)
- An active programme to reduce the gaps in care (this will especially support those in the most deprived areas learning from the Deep end project in Scotland)
- An active programme to improve wellbeing. Alliance practices will become wellbeing practices encouraging third sector involvement and presence.
Patient Activation

Measurement of patient activation for patients with long term conditions reported within the RAIDr population health dashboard.

A programme underway to improve patient activation.
Workforce

- Recruitment and retention is probably our biggest risk (GP vacancy rate is approx 40% in wave 1 and 2 practices).

- Whole programme of work starting on this across clinical and non-clinical teams.

- It’s not just GPs - building the multidisciplinary/multispecialty team – clinical pharmacists, first contact physios, primary mental health workers, physicians associates, nurse practitioners.

- Recruiting GPs to portfolio roles – working across primary and secondary care.

- Focussing on attracting young doctors (4 young doctors so far have signed up as partners, attracted by the values and ethos of this approach)
How we will support Alliance practices

- Workforce
- Recruitment
- Academic Links
- Business Support
- Business intelligence
- Premises solution
- Clinical leadership
- Estates Solutions
- Urgent Care 7/7
- Condition management
- Primary care at scale – networks
- Variations
- Place and population health
- Integration into place
- Crisis support and relief – system led
- Stabilisation & Sustainability
- Clinical Model
- Back office at scale
- Procurement
- Health & wellbeing
- Training & education
- Improvement

A great place to work
Progress over the last year

- NCPC established as a company
- Support (hard & soft) from trust provider Boards
- Dodd and Co detailed financial due diligence on wave 1 and 2 practices
- Established joint venture estates vehicle (NHS and eLIFT) - surveys and offers on first 4 buildings
- CQC application complete
- Pensions application
- Meetings to navigate CCG and NHS E processes
- Practice manager meetings
- Staff meetings
- Built a small team headed by Christine Weaving
- Listened to what matters
### Just a few legal documents ...

<table>
<thead>
<tr>
<th>Document</th>
<th>Purpose</th>
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<tbody>
<tr>
<td><strong>Memorandum of Understanding</strong></td>
<td>The key objectives of the North Cumbria Primary Care Alliance&lt;br&gt;The principles of collaboration&lt;br&gt;The governance structures the Parties will put in place&lt;br&gt;The respective roles and responsibilities of the Parties within the Alliance</td>
</tr>
<tr>
<td><strong>Articles of Association</strong></td>
<td>The constitutional document for NCPC Ltd and will incorporate the governance structures developed by NCPC under the MOU.</td>
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<tr>
<td><strong>Facilities Agreement</strong></td>
<td>To govern the financial arrangements</td>
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<tr>
<td><strong>Indemnity Agreement</strong></td>
<td>Sets out the terms in which the shareholders shall operate and how CPFT will indemnify the individuals for liabilities arising out of these arrangements.</td>
</tr>
<tr>
<td><strong>Business Transfer Agreement</strong></td>
<td>Sets out the terms on which NCPC shall acquire the business and assets of the practice from the current GP partners including warranties and indemnities from the GPs.</td>
</tr>
<tr>
<td><strong>Service Level Agreements</strong></td>
<td>Sets out the terms on which CPFT shall provide services to NCPC to support delivery.</td>
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<tr>
<td><strong>Leases</strong></td>
<td>NHSE approved lease between Premises JV and NCPC for each practice within the NCPC model securing the flow of rent back to the premises JV. (the establishment of the joint venture estates company has its own set of legal documents!)</td>
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### FAQs - structure

#### Who holds the GMS contract?
- The contract will be held by North Cumbria Primary Care (NCPC)
- This gives it the ability to hold GMS contracts and NHS pensions. We aim to increase the numbers of shareholders to include GPs from each locality.

#### Why is NCPC constructed with 2 GPs as shareholders?
- This means that any surplus will be invested either into developing the clinical model or to supporting staff. The decision on this will be taken by the partnership board.

#### What does not for profit mean?
- This is the leadership board for NCPC with GP partner, nurses, practice managers + reps from the other partners (UCLAN, Trusts, CHOC, Third Sector and patients).

#### What is the partnership board?
- CPFT has provided funding and back office support to mobilise the company. They have created the JV estates company and will inject working capital at the start governed by a facilities agreement. In return the GPs cap their income by becoming salaried, align the practices to system goals for example around improving population health. CPFT along with other system partners have a seat at the partnership board.
FAQs - Financial

Is it financially viable?

- We have done detailed financial modelling using Dodd and Co which predicts a surplus. We have done ‘upside’ and ‘downside’ modelling which also predict surpluses.

What if NCPC makes a loss?

- The expectation is that we operate within the envelope of income and make surpluses to invest in the practices. If we make a loss there is no financial liability directly to the salaried doctors. The indemnity agreement sets out the detailed commercial arrangements between CPFT and NCPC.
FAQs - Building

Can you buy my building?

• Yes – joint venture estates company (‘One North Cumbria’) is established. Offers to buy the first 3 GP premises have been made and accepted. NCPC will sign the ongoing lease.

Is it bought at the market value?

• Offers so far have been on a ‘going concern’ basis—modelled on notional rent plus adjustments for condition and longevity of building.

Will it cost £40 to change a lightbulb?

• No – maintenance agreement will be cost plus 10%.

What if I have a lease?

• NCPC will take over the lease

Will there be consolidation of buildings over time?

• This is the sort of decision for the partnership board but plans already underway e.g. in Workington to build a single new facility based at the stadium. Estates company is potentially a route for improved premises but this would need CCG and NHSE support.
<table>
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<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>Will staff TUPE into NCPC?</td>
<td>• Yes</td>
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<td>What about the practice managers?</td>
<td>• We still need local leadership but there will be opportunities for practices managers to lead on areas across practices</td>
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<td>Will I get an NHS pension?</td>
<td>• Yes – it will be just the same as in your existing practice</td>
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<td>Will we have fewer staff over time?</td>
<td>• We are not coming in with the intention of laying staff off but we need to work differently and more efficiently so roles may change over time</td>
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# FAQs - Doctors

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<td>What are the options for doctors?</td>
<td>- There will be a ‘partner’ option and a traditional salaried option. Medical defence fees and employers will be paid, attractive pay rates</td>
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<td>What does it mean to be a partner?</td>
<td>- Put simply the ‘partners’ will lead their local practices clinically plus elect representatives to the strategic partnership board. There will be no buildings, staff or financial liability</td>
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<td>Can I develop a portfolio role?</td>
<td>- Yes – this is strongly encouraged. We have already created a number of academic roles, and portfolio roles in e.g. neurology</td>
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<td>Can I work part time, on a retainer scheme, flexible school hours, take sabbaticals, annualised hours etc.</td>
<td>- Yes and encouraged. We want to provide a home for this sort of working. Happy docs.</td>
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<td>Will doctors have to work across sites?</td>
<td>- Normally doctors will be allocated to a practice. Some new roles may be more flexible.</td>
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Thank you & Questions?