APMS Stakeholder Workshop / Panel

Wednesday 5 October 2016, Leigh Cricket Club

WRITE UP

These notes serve to act as a summary of key points from the stakeholder workshop and panel held on 5 October 2016 at Leigh Cricket Club. Should any delegates feel something important has been missed, please do not hesitate to let us know.

STAKEHOLDER WORKSHOP – MORNING SESSION

In the room for the morning session we had;

- CCG staff – facilitating / taking part
- APMS providers (a range of staff from)
- Patient Participation Group (PPG) members
- Primary Care Committee Lay Representatives
- Third Sector organisation Representatives

Workshop 1: The Commissioning Options

The purpose of workshop 1 was for tables to discuss the commissioning options put forward by the CCG, in terms of whether they felt it was viable and to suggest any other commissioning options.

The table below captures the other commissioning options put forward.

Commissioning option
Renew the contract for that site with no changes
Renew the APMS contract for that site at the same terms/costs as the GMS contract
Merge contract for that site with another APMS contract site and procedure at same terms/cost as GMS contract
Not to renew contract for that site at all
****New Commissioning Options discussed on the tables****
Renew with changes
More local support to increase list sizes for smaller practices
Provide service in 'normal' hours
Convert to PMS contract
CCG help facilitate discussions between APMS and GMS contracts to voluntarily merge
Keep the contracts and use them differently. E.g. use them as Hub sites, cluster work etc

Just continue contract with current provider and CCG take on the risk of not doing anything.

Each table was asked to feedback on whether they had discounted any of the commissioning options put forward and whether they had alternative ones to be considered. Some of the new options put forward were very similar, along the veins of renewing or merging contracts may be possible but not on GMS terms. As a room the consensus seemed to be that renewing on GMS terms/cost was not viable and a level of negotiation would be necessary. There were other options put forward that are not within the power of the CCG at the moment but that would be taken back to NHS England for discussion.

As a room we agreed that the following list of Commissioning Options were viable to take forward and assess.

Commissioning Options Agreed
1. Renew as APMS with no changes
2. Renew as APMS, but with updated service specification
3. Merge with another APMS practice, but with updated service specification
4. Renew APMS, but updated service specification and act as a hub site for new models of care. Act as exemplar
5. End the contract

Workshop 2: Determining the criteria

Tables were asked to review the list of criteria that had been put forward, to critique the list, and to come up with any additional criteria they felt were important to be considered.

Accessibility
Shared GP building
Quality of the building
Opening Hours
Levels of deprivation
Practices within 1 mile
New houses planned
Number of patients registered
Cost per patient
Total cost
QOF achievement

Patient experience
****Additional Criteria put forward by the tables****
Quality of practices within 1 miles
Flexibility to adapt to future changes, i.e. new models, GM Devo
Risk of destabilising the practice and local health economy
List trends – e.g. practice growth per month
Capacity of practice within 1 mile
KPIs/Service standards
Total system cost, e.g. reduced admissions
Contribution to health inequalities
Patient Choice
Continuity for patients and staff
Additional Services provided to their local population
Relative attractiveness to new staff, recruitment and retention
Transport Links
Links to Voluntary Organisations
CQC ratings
Active PPG
Staff experience
Use of new technology
Inter-practice cooperation
Consultation length
Security measures
Health outcomes -
Age Profile – GPs, Nurse prescribers, Practice Managers
Terms on leases/estates terms
Deliverable and doesn't impact on financial stability

As a room we discussed the criteria that were put forward by each of the tables and which may be appropriate to take through to the next stage. Key points to note;

- Felt that Accessibility was a theme under which a number of the criteria would fit.

- We need to have access to information about the criteria that we can apply to each site – it needs to be measurable. If it isn't and we don't have access to the information it can't be included.
- The purpose of this process is not about critiquing the quality of the current provider or reviewing how well they deliver the service; this may come further down the line when considering any bids etc. Any quality criteria would therefore be discounted.
- Important to note that there are no guarantees the current provider would win the tender to provide any contracts in the future – linked to point above about not assessing how the current provider delivers the service.
- There are a number of points that are not necessarily criteria for the purpose of this scoring process, but things that we would want to see written in to a service specification about what level of service would be delivered in the future.
- Discussion around removing all cost elements. First stage is to decide if a service is needed and then to look at the costings.
- Although we are discounted quality of current APMS providers, it is important to keep quality of surrounding practices. If we are keeping the option of ending the contract we need to consider the quality of services that patients may need to access.

Table below summarises the discussions

Accessibility	Is a theme, under which a number of criteria should sit.
Shared GP building	Discounted.
Quality of the building	Included.
Opening Hours	Discounted – is a matter for the service specification.
Levels of deprivation	Included.
Practices within 1 mile	Under accessibility theme.
New houses planned	Included.
Number of patients registered	Included, but including list growth trend.
Cost per patient	Discounted – cost.
Total cost	Discounted – cost.
QOF achievement	Discounted – quality indicator.
Patient experience	Discounted – quality indicator.
****Additional Criteria put forward by the tables****	
Quality of practices within 1 miles	Included.

Flexibility to adapt to future changes, i.e. new models, GM Devo	Discounted – is a matter for the service specification.
Risk of destabilising the practice and local health economy	Included.
List trends – e.g. practice growth per month	Included, merged with number of patients registered criteria.
Capacity of practice within 1 mile	Included, part of considering if a practice could be destabilised.
KPIs/Service standards	Discounted – quality indicator.
Total system cost, e.g. reduced admissions	Discounted – cost.
Contribution to health inequalities	Discounted – quality indicator.
Patient Choice	Included.
Continuity for patients and staff	Discounted. Important to manage but not a criteria. We have to undertake this process so cannot offer continuity.
Additional Services provided to their local population	Discounted – service specification matter.
Relative attractiveness to new staff, recruitment and retention	Discounted – part of renegotiating terms/service spec.
Transport Links	Under accessibility.
Links to Voluntary Organisations	Discounted – service specification matter.
CQC ratings	Discounted – quality indicator.
Active PPG	Discounted – service specification / quality matter.
Staff experience	Discounted – quality indicator.
Use of new technology	Discounted – would be a service specification / quality matter.
Inter-practice cooperation	Discounted – service specification matter.
Consultation length	Discounted – standard for APMS practices.
Security measures	Discounted – would be picked up later in process.
Health outcomes	Discounted – quality indicator.
Age Profile – GPs, Nurse prescribers, Practice Managers	Included – but under criteria around destabilising.
Terms on leases/estates terms	Included.
Deliverable and doesn't impact on financial stability	Discounted at this stage, but important consideration.

The following list of criteria was agreed by the room…

Criteria
Accessibility: including; disability, location, hours & transport links
Risk to destabilise practices in the area
Levels of deprivation in the area
Quality and capacity of practices within 1 mile
Number of patients registered and list size growth trends
Patient Choice
Quality of the Building
New houses planned
Estates lease terms

Tables were asked to assign priority to each of the criteria, 1 being the most important and so on. These were inputted on to an Excel spreadsheet and averages were worked out.

		Tables				
Criteria	**Weighting**	Table 3	Table 2	Table 1	Table 4	Ave.
Accessibility; disability, location, hours & transport links		1	1	3	1	1.5
Risk To destabilises practice in area		3	4	1	4	3
levels of deprivation		4	5	2	2	3.25
Quality & capacity of practice within 1 mile		2	2	5	6	3.75
number of patients registered - trends		5	6	6	5	5.5
Patient Choice		7	3	7	7	6
Quality of the building		8	7	8	3	6.5
new house planned		6	8	5	8	6.75
Estates lease terms		9	9	9	9	9

This gave us the following rank of priority

Criteria	
Accessibility: disability, location, hours & transport links	1
Risk to destabilise practices in the area ***	2
Levels of deprivation in the area	3
Quality and capacity of practices within 1 mile ***	4
Number of patients registered and list size growth trends	5
Patient Choice	6
Quality of the Building	7
New houses planned	8

Estates lease terms	9

On reflection, Quality and Capacity of practices within 1 mile would be the data used to assess whether there was a risk of destabilising practices in the area. Those two criteria would therefore be merged, leaving us with 8 criteria to look at.

We did not have enough time as a room to discuss the weighting of the criteria, i.e. how much importance should be placed on each. Feedback received from some delegates over lunch suggested that the weighting could be determined in line with the ranking / average score. An alternative would be to assign equal weighting to all 8 criteria.

STAKEHOLDER PANEL – AFTERNOON SESSION

Taking Part in the Panel in the afternoon we had;

- Lead Practice Manager (non-APMS practice)
- 2 X Primary Care Committee Lay Representatives
- GP (non-APMS practice), Clinical Champion
- 2 X CCG staff, Strategy and Collaboration Team

6 members from the morning session stayed behind to witness the panel. There were no questions at the start of the process but those in the room were able to ask questions for clarity during the discussions.

The panel started with a discussion around what data / information could be looked at for each of the criteria. As we did not know what the list of criteria was going to be for the afternoon session, we could only partially prepare and we did not have all the information needed for the new criteria.

Criteria	**Information needed to assess it**
Accessibility: Disability, Location, Hours & Transport Links	Disability – Check compliance with standard/estates. Location – number of practices within 1 mile. **Hours – (as service specification issue, to be discussed whether to be removed in line with previous discussions with stakeholder)** Transport links – defined as bus stop with 100 meters.
Risk to destabilise practices in the area ***	Number of patients to be dispensed. Quality of practices; CQC, QOF Capacity: clinical/workforce capacity and estates capacity. Will need to approach practices to provide this. We may already know about any upcoming retirements etc.

	Practices wouldn't be obliged to share information – potential issue.
Levels of deprivation in the area	Information available from a national online tool.
Quality and capacity of practices within 1 mile ***	Merge with criteria 2
Number of patients registered and list size growth trends	Information available to us. Need to check this with the providers.
Patient Choice	Available for us to consider. Impact to Patient Choice.
Quality of the Building	Information available to us.
New houses planned	Further information to be gathered to determine houses planned within 1 mile for consistent application
Estates lease terms	To be obtained from providers and information already requested.

It was explained that this scoring methodology was one provided to the CCG by The Consultation Institute. As not all information was available, the panel were only able to partially score each option for each site. They were able to start scoring the following criteria based on the information available to them;

- Levels of deprivation
- Number of patients registered and trends
- Patient Choice
- Quality of building

The panel also started to score the 'new houses planned' but part way through the process decided that more information was needed around new houses planned within 1 mile, rather than generic locations and so stopped scoring this and it will be repeated once the information is available.