GOSPORT MEDICAL COMMITTEE

AN EXTRAORDINARY MEETING held at Gosport War Memorial Hospital on Tuesday 4th March 1997, to discuss MULTIFUNDHOLDING,

PRESENT:

Drs Tart, Old, Garratt, Bassett, Beale, Brigg, Reid, Lacey, Barton, Erskine, Beasley, Peters, Coonan, Dow, Young, Pennells, Sheila Lynch, Declan Lynch, Grocock, Warner, Practice Managers, and Mr Hugh Janes, Locality Manager.

Dr Barton introduced Mr David Crawley, General Manager Multifunding, Isle of Wight who had come along to speak to the Medical Committee about the concept of Multifunding on the Island..

He stated that his is a small Island authority and there was a need for good relationships. The roots of the Consortium formed in the Island lie in the local Medical Committee. In 1992 it was agreed that a better relationship with the Health Authority was needed and discussions began as to how this could be achieved and discussions take place about solutions to the GPs problems. There was a fear that if practices went fundholding by themselves there wouldbe a fragmented service. The philosophy was to work together as individuals with equity according to clinical need, not whether you have a budget. The GPs felt they would get better management skills. They would recognise their strengths and weaknesses - experience in project management, information systems, training, financial skills. Another purpose was to reduce the Practice burden, with many jobs being done at the Multifund office. Finally, whether to jump or be pushed. The fact that many Practices were going in for Multifunding encouraged others to join, although it was felt a sad reflection that Multifunding had tobe formed.

The reasons for a Consortium -

There was a two tier system
Health Authority Contracts were not meeting patient needs
Health Authority were not listening
Better Management skills
GPs on mainland getting better services then IOW
Reduce Practice burden
Jump or be pushed

Internal Relationships -

Everyone has to become accumstomed to working together with a common agenda. There was a tremendous level of agreement about what was needed on the Island. (There was an appalling need for Cardiology, District Nurse levels were going down and things like Medicine at St Mary's Hospital. There were relationship problems with the Health Authority, which were getting worse)

After a year there were still some problems but the Consortium had created a reason to tackle many of the problems which had arisen.

Good Communicaions needed -

There are monthly Executive meetings, the board consisting of a Chairman, Vice Chairman, Hon. Treasurer and Secretary and David Crawley.

Monthly Executive board
Monthly board meetings
Monthly Practice Managers meetings

Quarterly Data Entry Staff meetings
Lead GP mechanism
Voluntary
Deals with Service Issues

The Lead GP mechanism delegates responsibility to certain GPs to cover particular areas, ie to sit with the Consultants and negotiate how to improve quality of service, to improve the letters going out, early discharge - how this affects the community. Once a decision has been made upon how a service should work, it has been found this has gone very well.

External relationships -

Finance - now very positive
Commissioning - very good relationships now
Feel Good Factor

During the first year things went downhill, but the relationship with the Health Authoirty has now turned around and regular quarterly meetings with the HA has achieved a lot.

Internal relationships -

Things are improving following regular metings with the Island Purchasing Advisory Group and better one-to-one communications. The reasons for any failure have been lack of communication and openess, with personalities taking precedence over issues.

How to get agreement to move things about -

The Health Authority now listens, although they are inclined to see things differently from the GPs. They regard it an achievement that analysis shows 36% of patients being seen in a certain time until it is pointed out that therefore 6,000 patients are not seeing a Consultant.

Need for Relationships - Service problems; Access; Quality.

GPs need good relationships. The appalling access to Cardiology with long waiting lists has now been turned around from 18 to 3 months. This was resolved by working together.

Trust Management problems -

This is being sorted out through joint Purchasing pressure. The two Trusts on the Island are being merged with the consequent loss of one set of executives, but the savings will go to patient care.

In conclusion David Crawley stated that you must get relationships right - with the Health Authority and the non-fundholders and build up good relationships with the Consultants in the hospitals. There is a long way to go but the feeling is that the Consortium is going in the right direction.

Of the 73 GPs on the Island, 43 are in the Multifunding Consortium. There are 11 non-fundholders and the balance are standard fundholders. The non-fundholders benefit from the efforts of the Consortium with equal access to CArdiology etc., the Consortium working to improve the lot of the Island as a whole.

David Crawley and a part time Secretary run the fundholding office, receiving 28/29% of the Management Allowance to cover computers, rates, rent, staff

costs, Consultancy fees etc. Data Clerks are employed by the Practices, a copy of the data base being received by the Fundholding Office once a month.

Dr David Paynton, GP Tutor and Chief Executive for Multifunding, Southampton East when then introduced to the meeting.

Southampton East Multifund -

12 Practices
10 Fundholding Units
43 GPs
250 Practice Staff
75,000 patient
£17,000,000 budget

(2 of the non-Fundholding Practices have now asked to join and there will then be 100% Fundholding in Southampton East)

This was originally seen as a Multi-Purchasing group, using the maximum of fundholding money and money from the Management Allowance to do it.

Aims: "Aims in Health Care will be defined in terms of quality in life rather than purely in survival."

The Group started in 1992 but without a budget the GPs had no voice and therefore it was decided to form a Multifund. Multifunding was seen as improving the way of the GPs with support to make their jobs easier. There were differences between the Health Authority and the way the GPs wanted things done - the Health Authority were not reasllly listening to what the GPs wanted to say.

How do you get 43 GPs to agree? Key priorities for the Multifund had to be agreed. A business manager was appointed, initially on a six month contract at £30,000 a year, but has remained, with contracts very much on an annual basis.

Because you are dealing with computer budgets for 12 practices and using public money it is necessary to advertise all over Europe. Much more sophisticated Computers will be required and this is the chance to install a very good IT system. There are many advantages to all having the same computer system, although initially during the first year or two whilst getting to know the fundholding system the current computer systems could be continued with. Some advantages of a common computer system for instance might be to link with GWMH to book appointments automatically; link to the out of hours Centre/ Pathology/X-ray to obtain results directly.

Constitution -

There are three decision making bodies:

Executive board
Practice Managers
Main board

The Practice Managers were the key to the success of the Multifund.

The Main Board has 10 votes with the Chair having a casting vote but key votes must be carried by a consensus. The group is known as an "Association" and therefore there is no tax payable, but there shouldbe no surplus at the end of the year.

The Executive Board - 4 GPs
1 GP (Chair)
1 Practice Manager
1 Business Manager

The job of the Executive is to form ideas and then put the ideas to the Main Board.

Management Allowance -

The Allowance can be given to the Practice, the day to day collection of the data being controlled by the Practice. Some will be payable to the Lead GP in the practice, but some of the money will be available for someone to take time out to develop the good of the whole.

Another option wouldbe for the Health Authority to give the whole of the money to the Centre but funding the data clerks. (Kingston multifund do this but Southampton have gone for Option 1)

Pooling of budget/contract

Although a Multifund group, there are still 10 individual units with their own budgets. There shouldbe good monitoring systems to pick up something which might go wrong with one of the Practices. Southampton have a Pharmaceutical advisor who goes around looking at everyone's prescribing and discusses this with them.

Concept of total purchasing for the area -

What is a fair budget for the whole patch? Where will purchasing end?
Tiered approach to purchasing -

- individual level	- prescribing
Practice level	- Pathology/ some elective care/ community nursing
Locality level	- Some community nursing elective care acute care cancer care
District level	- some high case/low level services i.e. neonates/ some cancer care some acute care
Regional level	

As a Purchaser for routine health services probably this will go to Localities and the GPs mustmake sure that they control this.

Multifund Achievements -

Practice based Physiotherapists
Locality based U/S and direct access to X-ray
Services purchased for Gastroenterology at Nuffield
Up to £50,000 savings

Future Developments -

Common IT system
Common Community Nursing strategy
Out of hours District Nursing

Back pain service
Specialist nurse support
Widen contracts with other providers
Dedicated OP services - Medical / ENT
Rehab beds
Contract for midwifery care as part of a Maternity strategy

It has been difficult at times but generally the Group are learning to live with the Health Authority and they are beginning to see the GPs are doing things they have not been able to achieve.

The crucial thing is to have a good professional manager at the centre of it all. The focus has been on the hospitals ratherthan primary care and investing in the community care and Dr Paynton feels that the GPs must be the ones to use Locality Purchase strategy to make the quality of patients' lives a lot better.

Out of Hours -

An out of hours Centre was set up by the Southampton group and patients encouraged to attend the Centre or can be given advice by telephone. It has been found that 80% of calls can be dealt with this way. If a visit must be made thiscan be done by one of the GPs or Health Call, and between midnight and 7 a.m. all calls are taken by Health Call.

Instead of a doctor always going out on a call perhaps a nurse or paramedic could go in the first instance, only sending a doctor if necessary. Looking at the use of the budget perhaps the Ambulance service could be paid to bring people in.

Dr Tart asked whether morale has improved since the formation of the Multifund group. Dr Paynton replied that there is a group of GPs who feel a greater sense of ownership - however, some feel what is being done has passed them by. If you can identify interests and give them something to do for the locality many will get a greater sense of ownership within the locality. It is about everyone getting involved and feeling it is their organisation. As to morale, it seems there is a greater sense of satisfaction and control over their lives. Regrettably there is still a two tier system.

As a group Multifunding has reduced the workload of the GPs. The GP is able to access things not available before. Nurses doing the flu jabs/ taking blood etc does make a difference. Things like bringing in Practice Psychiatrists/Counsellors has taken some of the pressure off the GP.

Dr Paynton said that in some ways he would like to have seen more GPs involved in Multifunding. However, with 25% involved in one way or another this wasn't too bad and there was nothing major that he would wish had been done differently.

Dr Barton thanked Dr Paynton for taking the time and trouble to come along and speak to the Medical Committee regarding the concept of Multifunding for General Practitioners.
