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Dear Save Our Surgery Campaign Working Group,

Thank you for your recent email and taking the time to respond in such a thoughtful and productive manner. We appreciate your helpful questions, observations and suggestions. These have provided practical examples of issues and helped to shape our thoughts. We hope to continue to work in a collaborative way.

We will endeavour to answer the points you raise in this letter. If you feel that we have missed any of your questions, without explanation, please let us know and we will be happy to review them. To try and give this level of detail would have made our initial letter even longer than it was. Given the large number of questions you raise this reply is, of necessity, very long and detailed. This level of detail is augmented by our wish to provide background information and to add context to our reply. We enclose a shorter precis of this response to make it more accessible.

We do agree that the issues you have highlighted benefit from extra exploration. You are, helpfully, representing a cohort of our population. We have been trying to reply to individual emails about the engagement process as they come in. We are planning on sharing this reply on our website so that as many people as practicable can see our response.

The Partnership has been thinking about how we provide quality care to Polruan and the particular challenges that its geography affords to the patients we have served there for very many years. We have noticed the decline in numbers of patients using Polruan Surgery, the controversies around dispensing and the marked increase in our total patient population and individual consultation rates. Unlike other practices in the county, we managed to find the capacity to reopen our branch surgery for face-to-face clinical care after the Covid-19 pandemic. The pandemic precipitated massive changes in how primary care at practice level is organised and delivered across the country.

We understand that the announcement of our consultation and engagement process has led to upset, anger and concern. The decision to formalise this conversation has been many years in the making and has not been taken without careful thought about how any possible changes might affect individual patients, particular cohorts of patients and our whole registered population.

The current 3 Partners have, between us, cumulatively, looked after the health of people in Polruan for 40 plus years. The 5 Partners of the previous partnership looked after Polruan patients cumulatively for well over 100 years. To be at this point is a source of immense personal sadness and having to have this conversation is not one we relish or would want. We are, at heart, clinicians and providing medical services to a community of genuine character and personality is a pleasure and a privilege. Anything that might affect this relationship is a huge regret to us. This is not a path we have taken lightly.

The consultation process is designed to share with you some of the challenges that we face locally, across the practice and going forward, across our neighbourhood. We are looking to explore the potential benefits and the obstacles that the proposed health service reorganisation will have on us collectively. We want to improve our understanding of the effect of any possible changes that we might explore. To achieve this we need to consult together with you and other interested parties to mitigate any impact that might occur. As you would expect, many of these broader conversations are ones that we have been having for many months, among ourselves, with our neighbours, with our commissioners, our community teams, Local Medical Committees and that the BMA is having with government. Unfortunately, when we are

talking about funding squeezes, financial sustainability, workforce issues and workload pressures, the conversations can seem very negative and gloomy. However, we do have a positive vision for the practice, confidence in the partnership and an aspiration for a different service. This would be local clinician led and prioritise continuity from cradle to grave. This service would need to be sustainable for the partnership and able to benefit from the positive changes outlined in the 10 year Plan.

Following this consultation process, we will decide whether to proceed with any application. This would entail a formal application that would then be considered by the Integrated Care Board(ICB) or it's committees.

We have for some time been concerned about the suitability of our premises in Polruan. Our partnership, and our GP Colleagues' view, is that it is very difficult to provide services from premises that are not specifically designed for health care use. We have considered various options that include larger converted premises and even the use of shared spaces eg Village halls etc. Many of these types of arrangements have vanished over the last 20 years because of their impracticability and inability to provide appropriate venues for care.

We have explored the option of new premises with commissioning bodies over the last 30 years. Our most recent discussions have confirmed our understanding that we are not the highest priority for new premises. We do not envisage any developments in new buildings in the medium term. The focus of new building will, we suspect, align with a vision for the development of Integrated Neighbourhood teams. (INT)

As in the 'boiling frog' apologue, the cumulation of small concerns and an aspiration to keep the branch available for clinical care, has meant we may have had a somewhat 'blinkered' approach to the shortcomings of the building. Indeed, as you expressed, we have largely taken the view that although the site is not perfect, we have to consider the context of the alternative (stone steps, ferries etc). We hope, but doubt, our regulators will take a similar nuanced view. Our various ongoing auditing processes and preparations for possible CQC inspections continue to highlight increasing issues for attempted mitigation. We are approaching a 'break clause' in our lease, and this alongside the other challenges across the whole practice, has contributed to the decision to initiate this consultation at this time.

We have previously investigated, with builders, what is possible in the Polruan site to ameliorate some of our concerns. You will be aware that the surgery was substantially altered probably 30+ years ago to cover the front of the premises to allow access upstairs and incorporate the new entrance corridor and toilet into the building. The right hand wall of the corridor as you enter the surgery is the outside wall of the original building. Making changes to the doorway in this wall and involving the corridor linking reception to the consulting room, would involve a significant amount of work and would be unlikely to improve the functional capability of the building. It would involve closing the building completely for the duration of the works. The expense of such changes would be significant and prohibitive. We believe that the expense of any such internal adjustments, as well as other changes made to meet our health and safety obligations would need to be met by the partnership. Hence, we have not had specific discussions with the freeholder. Ultimately, and unfortunately, this raises issues regarding sustainability and how we manage costs across the whole practice.

You confirm that access to the bottom of the village and parking is difficult. Our medication wholesaler has particular issues with this. As we intimated in our previous letter, the forced reduction in our dispensing numbers means that when drivers are running late they will sometimes abandon their trip to Polruan. It is understandably low on their priority list, with the small volume of trade we provide and the difficulties of accessing the site. This means that we maintain larger stocks (at increased cost due to our lesser 'buying power' and higher potential wastage) to ensure continuity of supply for patients.

We, perhaps wrongly, assumed that the Town Trust would be very aware of these broader issues and whilst we have not contacted them, we are delighted to hear, both for ourselves and other businesses residents and users of the Quay that plans are evolving to ameliorate the current challenges. We would have been pleased if they had contacted us as a stakeholder to discuss the impacts of the known difficulties on the surgery as we assume they did with other businesses.

Patient confidentiality is an ongoing concern to us. A sliding window in reception would reduce these risks partially. We do already have a wooden shutter that is more effective at dispersing noise. Our staff struggle to keep this closed as they have to talk to patients attending for appointments and needing medication dispensed. We are more concerned about the corridor between reception and the consulting room. The floor is uneven and the consulting room door cannot be effectively soundproofed. We know that when patients are distressed this can be clearly heard in the corridor. We have sometimes postponed difficult discussions and arranged a follow up in Fowey or Par where confidentiality can more easily be assured. Access close to the consulting room in Polruan is available even before reception is reached. Controlling access to 'sensitive areas' of the surgery is a particular challenge when compared with custom built surgeries. Members of the public, not necessarily registered at, or using the practice, often use our toilet whilst accessing the Quay. The front door is sometimes left open by these visitors. This makes us more vulnerable to breaches of confidentiality as well as having implications for lone working staff. For many years we have not opened the windows of the consulting room, that open onto the Quay, following a significant event regarding a potential breach of confidentiality.

The public byway side of the fire exit is indeed in good order. The issue is the large drop from the floor level of the building to the steps. This drop is 35 cm onto granite steps. This hazard might be reduced by creating another step outside the door. This would potentially obstruct the steep steps and would, arguably, present more of a hazard to the population than the admittedly low risk of fire.

We are pleased that our staff's flexibility in accommodating suitable patients in the downstairs consulting room has been recognised. Our nurses bring the required equipment, dressings etc downstairs with them in this scenario. The equipment needed by the nurse in her room is substantially different from that required by the Doctors. We had considered the use of the downstairs room by the Nurses. This consulting room is small at 9.6 square metres. (The recommended size for a consulting room is 16 square metres, with an absolute minimum of 12 square metres, the absolute minimum for a treatment room is 16 square metres) The downstairs consulting room is not large enough to hold both sets of equipment nor to allow for a room setup that allows for access to both sides of the examination couch, which is a requirement for a treatment room. A consulting room can have a couch against the wall. We have not been able to fit a modern, compliant, adjustable, examination couch in downstairs. (Hence the short narrow somewhat tall examination couch that is there at the moment!) Therefore we have maintained the existing arrangements, but we are always happy to provide the acknowledged flexibility.

In your letter you mention the difficulties of taking a pram across the river on the passenger ferry and we acknowledge that this is a significant challenge. We have had occasions when parents have left their prams outside as they have been unable to access the consulting room, fortunately these episodes are uncommon. Unfortunately, the opening width of the external door doesn't meet minimum requirements- 775 mm of clear opening. This is complicated by the fact that accessing the consulting room requires 2 right-angle turns in quick session in a corridor that is 880 mm narrowing to 780 mm wide, which arguably does not give a wheelchair room to manoeuvre. The toilet facilities available also do not meet recommended requirements. Given the absolute limitations in space it's difficult to see how this situation can be ameliorated. Even if there was a workaround identified it unfortunately raises the spectre of the cost, the particular financial and practical challenges that multi-site practices face and the impact that this might have on the overall sustainability of the practice.

We are aware of the ferry and transport costs locally. We, and our staff, pay these. We appreciate that this is a huge issue for patients without access to transport and this applies to our patients living in Polruan. Patients resident in some of our other isolated communities eg Golant and the Luxulyan valley, also face significant issues with transport.

We could create clinics or specific appointments ringfenced for Polruan patients at our other sites. They might be transported by the Community Bus? This was tried at flu /covid clinics and was very helpful and successful. As part of our consultation, we will be reaching out the community bus and the Fowey Town Bus to have discussions on how any changes, if made, might be mitigated in terms of transport. We would welcome any further suggestions about transport from you, as key stakeholders and ultimately the people who know the population best.

There is a substantial difference between sanitary and clinical waste and the regulations and facilities for managing, transporting and disposing of these. When we investigated this, our usual suppliers of clinical waste services would not countenance servicing our Polruan site. Partly again because of the access issues for their specialist vehicles and because we generate only small volumes of clinical waste. We have been adopting a "work around" which involves the Doctors, but it is not an ideal situation. The suggestion that PHS might be able to support us with transporting and disposing of clinical waste is incredibly helpful. Thank you, we have made contact with PHS and hope they can accommodate us.

We have an almost constant recruitment process that reinforces the comment that recruitment has been a longstanding challenge and many non-clinical posts sadly remain unfilled. Our experience is that there are very few people looking for even part time work opportunities in the surgery. Our current recruitment issues are not specific to looking for staff to populate the Polruan branch but across the whole practice. The challenge, particularly as it relates to Polruan, is that because as well as working 'front of house', they are skilled dispensers and need to be flexible and multiskilled to work across our sites in multiple roles.

Consecutive administrations have placed a heavy emphasis on ease of access to General Practice (and with good reason, we agree). There is now mandatory/contractual unlimited access via our digital front door and the Klinik online consultation tool during working hours (0800-1830). This means that our front of house team are not now receptionists but in a very real sense care navigators. It is skilled, unrelenting and challenging, though we hope ultimately rewarding work. Our secretarial and management teams also do increasingly sophisticated and complex work. We are incredibly grateful for all their commitment, hard work and expertise without which the practice could not function. It is the nature of all this work and the timings, that does not seem to attract applications for people who looking for part-time work fitting round the school day. We are delighted that we have just appointed new staff. There will always be further opportunities and if anyone is interested in working for the Practice we have frequent adverts and would love to hear from them!

Patient numbers have grown substantially in the last 15 years. Our list size has grown from 6500 to 8400, with our Par site being particularly affected with an increase from 3500->5000. We are unclear as to why the numbers in Polruan have dropped. We speculated that this was because of an increase in second homes? We are aware, from our discussions with Lostwithiel, that there are some patients registered there. New patients may not register with the practice until they need medical attention. We know of some patients who have moved and finally registered 2 years after their arrival in the area! Our core funding is based on a per capita basis and falling numbers represent a significant worry for us. (£125 per patient is paid to provide total General Medical Services for a YEAR, though this figure is weighted for age and other factors).

In answer to your question about Lostwithiel. We assume you are referring to their longstanding Orthopaedic Clinic, which is a legacy of a scheme initiated many years ago called Practice Based Commissioning. We have patients who have been seen there as these appointments are available via

“Choose and Book”. This is the NHS’s appointment booking system and Lostwithiel appointments, when available, should be signposted to patients who have been referred for Orthopaedic opinion as an option by the Referral Management Service. These appointments are open to any patients in the county, but we are aware that there is only a limited supply of slots at this site (certainly, when compared to the huge number of appointments at RCHT, Derriford and other providers.) This is not a Fowey/ Lostwithiel issue and Lostwithiel Medical Practice have been clear to the whole of the Primary Care Network (PCN) that they are available for booking (but in short supply!) Indeed, Lostwithiel practice has been good enough to flag to PCN partners if they have unfulfilled capacity and our patients have benefitted.

Thank you for pointing this out though as there may well be opportunities with our close relationship with Lostwithiel through the PCN to take advantage of benefits that they might naturally have as a host practice and we will discuss this with them. Lostwithiel are now also providing expertise and support to the wider Integrated Neighbourhood Team, alongside a consultant anaesthetist, in an Orthopaedic Pre-assessment Pathway Pilot. This is funded by the ICB and benefits the whole PCN population. Practical benefits in smoothing the patient pathway have already been demonstrated. From this clinic appropriate patients have been signposted to considerably shorter waiting lists with alternative providers.

Over the past 10 years, General Medical Services (GMS) funding has not seen a consistent real-terms increase. Although total nominal spending increased, the core funding available to practices has fallen in real terms when adjusted for inflation and rising demand, especially between 2022 and 2024. The Primary Care Network (PCN) from 2019 has been the only real vehicle for significant Primary Care investment. The PCN funding recognised the lack of funding and falling GP numbers (probably about 15% fewer full time equivalent (FTE) GPs per 1000 patients in the last 10 years) and an emphasis on co-operative working at scale. General Practice represents extraordinary value with approximately 90% of total NHS patient contacts taking place in primary care for the cost of around 10% of the budget and never any deficits. If we do not engage with and support the PCN our patients lose the opportunity for new services and initiatives. We, the largest of the Three Harbour Practices (Fowey, Middleway and Lostwithiel), provide half of the PCN strategic management along with the Bodmin Bosvena practice. Dr Cockshott is the co- clinical director, along with a Bosvena GP.

Our involvement is essential if we are to shape the direction of the PCN and make sure the needs of our patients are prioritised and met. The work is remunerated and supports us in employing the excellent salaried doctors and nurses who support our care. It is worth mentioning that in most ways the PCN has been a huge success but you are right that there is ultimately an opportunity cost in experienced partner time, which we know patients value. It is an interesting observation that although participation in a PCN is optional it is an illustration of the degree of funding that 99% of English Practices are part of a PCN.

We have developed different clinical teams and services with our PCN colleagues. There are too many initiatives to mention here but they are all available to the whole PCN population.

To, perhaps unfairly, give a couple of examples:

Anyone who has worked with our Health Coach is full of praise about the health behaviour changes that are mentored and supported and the long-term benefits to individual outcomes that often ensue. Our PCN Diabetic team has developed novel interventions that have received widespread recognition.

The PCN Paramedic and Frailty teams are probably the most visible to individual patients. We can send the Paramedic to visit patients who need assessment at home. They assess patients and discuss their management with a GP far earlier in the day than would otherwise be the case. GPs have fully booked surgeries in the morning and afternoon and as such will usually, except in exceptional circumstances, visit either at lunchtime or in the evening.

These highly skilled professionals cannot fully replace GPs, as they do not have the breadth of knowledge and skills. For example, many of these clinicians are not prescribers. They require support and mentoring, and our partners provide much of this support. Dr Marrett is clinical lead for the frailty team and provides support for the Pharmacy Team, Dr Knobloch is the clinical lead for the social prescribing team, Dr Cockshott is clinical mentor for our paramedic and Ronan Sheehan (Lostwithiel partner and pharmacist) is clinical lead for the pharmacy team. However, despite this need for mentoring they provide a valuable resource for increasing options for patient care and speeding access on occasions. This along with ICB investments in eg an Xray car, taking X-rays at home, virtual wards and acute assessment services often avoid the necessity of travel and admission to a major hospital.

If we had not engaged with the programme of PCN development our patients would have not been able to benefit. Different PCNs may develop and deliver different services based on the needs of their practices and populations. We suspect that the development of Integrated Neighbourhood teams (INT) will allow a further increase in resources and services to patients in the community that are not available to individual practices. This will, we suspect, mean that individual Practice funding remains flat into the future. The PCN and INT developments do provide increased resource to patients in Primary Care, but there is an argument that this disproportionately disadvantages smaller Practices. Our feeling is, and the general consensus is, that there is an explicit intent to encourage bigger Practices working over a large geographical area (a "neighbourhood") within the 10-year plan.

Our PCN looks after 42,000 people. It seems likely that will constitute our neighbourhood, along with adult social care, community teams and the third sector. The ICB has invested in the PCN as one of the first wave sites for INTs. It is important to realise that "HOME" in the context of the 10-year plan means the PCN footprint stretching from Duporth/ST Austell in the West, Polruan in the South East, towards Lewannick in the North East and out of Bodmin towards Wadebridge in the North. This neighbourhood approach allows us to better identify and support patients living in areas with huge deprivation, and hence clinical need, eg ST Blazey and parts of Bodmin.

This is a hugely positive change but how practices keep their character, culture and local say in those units is going to be a key part of what general practice looks like in the future. This reinforces our drive to be as resilient as possible to protect and support these local voices.

We have, as you rightly say, been substantially affected by the decision to limit our dispensing to any patients within a mile, as the crow flies, from Fowey Chemist. Previously the NHS accepted that the river made this decision impracticable. Since we were informed that the decision was going to be implemented rigorously, we have discussed it with the relevant NHS bodies on a number of occasions. Other surgeries in a similar situation eg Flushing/ Falmouth, have made similar representations. It has been made clear to us that this decision will not be changed. We have been allowed a legacy clause whereby patients who we dispensed to previously, but living within the boundary, would not be removed from our Dispensing list. Once these patients leave that property new patients registering at that address will not be allowed to join our Dispensing list.

At the risk of being nihilistic all our discussions suggest that this decision is unlikely to be re-visited or re-negotiated. We would be delighted if it were to be changed but we think it unlikely that lobbying by the MP or anyone else, will make a difference. We are aware of many representations over the years that have been futile. We recently met with Anna Gelderd, the SE Cornwall MP, and were pleased that she agreed to investigate this matter. We would be delighted if any interventions changed the current position.

You ask whether increasing the numbers will affect profitability. Given the small numbers involved we think this is unlikely. Nationally it is estimated, by specialist medical accountants, that one third of all practice dispensaries are operating at a loss. The Times, on 11/2/26, contains an article on how rural Community

Pharmacies are facing a wave of closures. These Pharmacies face similar pressures to Dispensing Practices, and similar changes in funding streams, that are affecting profitability.

You have asked for some data regarding appointments and visits. This data has to be mined by hand from our computer system and it is an extremely time consuming and lengthy process. We will provide you with some of this where it is available, as a gesture of goodwill. It will likely take a few more days to collect this data and we will forward when available. It is important to realise that there has been a significant increase in remote consulting since the pandemic. Telephone and electronic consultations make up a substantial proportion of total consultations. These consultations are available to all our patients and are delivered from our Par and Fowey sites.

Some of the requested data is not available. For example, the total number of requests for appointments and home visits that were requested but not fulfilled. With respect to appointments, there are numerous routes for requests: in person, on the phone, by letter, by email, via Klinik, our electronic consulting system. We do not collect this data, nor would it be possible to extract this data short of listening to every single phone call and looking at every single Klinik. Currently we field on average well over 300 phone calls and the best part of 100 Klinik consultations every day (and rising fast) and I'm sure you agree this would be impossible.

With respect to home visits, we would expect that there are very few clinically appropriate requests that are not fulfilled. All requests for home Visits are triaged by our doctors and, if clinically appropriate, they will organise a visit, either by a doctor or our PCN paramedic. Sometimes they will negotiate an alternative if acceptable and appropriate, or, on other occasions, if there is clinical need, advise an ambulance call.

We do not envisage an increase in Home Visiting requests. A home visit as a patient choice is not an entitlement nor is it contractual as part of our GMS contract. The decision to provide care at home is a clinical decision, based on clinical need. Having said that it has always been the culture within the practice to have a very low threshold for initiating visits. We have found that our patients, across all the communities we serve, are responsible in using resources. We do not envisage that any changes being explored will lead to an increase in demand on admissions, ambulance call outs and impacts.

You ask for some details about our contracts which is enclosed here:

<https://www.england.nhs.uk/publication/standard-general-medical-services-gms-contract/>

<https://www.england.nhs.uk/gp/investment/gp-contract/quality-on-outcomes-framework-qof-changes/>

<https://www.england.nhs.uk/publication/network-contract-des-contract-specification-2025-26-pcn-requirements-and-entitlements/>

It is worth noting that some services that we, and many other, Practices provide are not part of the contract and not paid for by the NHS. We deliver them, without remuneration, to improve access and care for patients. In many other parts of the country these services are funded by commissioners as 'enhanced services', other practices do not provide these services at all. Latterly the ICB has started to provide contracts for some of these services to bridge these 'commissioning gaps', which is most welcome. For example, post-surgical dressings and care were previously supposed to be delivered by the relevant hospital teams. Clearly this would mean that patients would have to return to the Hospital for dressings etc. For over 30 years we have provided this service to patients, at a cost to us, to avoid the long trip to our local District Hospital. Fortunately, it has been recognised that this is not fair or sustainable, and we are now mostly reimbursed for this work.

It will, however, surprise many patients that many "simple" services eg ECGs, simple and complex wound dressings, catheter care, spirometry, cryotherapy and phlebotomy have been delivered by Practices over many years, without funding. Latterly the ICB has provided some or partial funding for some of these services, and our Local Medical Committee continue to fight for a tightening of these 'commissioning gaps'.

The ICB have also developed clinics for these services at selected sites eg at Bodmin Hospital with the Bodmin Diagnostic Centre. Our partners in the PCN more local to Bodmin use these widely. We have not routinely used these clinics as although they would reduce our workload, and costs, what we hear from our patients is that they (very reasonably) do not want to have to travel to Bodmin for a simple blood test or ECG.

We should outline some more background information about how General Practice is funded as it is complicated. We are aware from discussions with our Patient Participation Group and others, since this consultation has started, that the way General Practice works is not universally understood.

Most General Practices are partnerships of, usually, Doctors providing care to a population of patients. In effect the NHS sub-contracts the provision of services to Practices and this model has, to a greater or lesser degree, been unchanged since the inception of the NHS. The Partners of the Practices are individually and collectively responsible, with unlimited liability, for running their Partnership and business. Unlike Hospital and Community Trusts, and like non-medical businesses, we cannot run a deficit. If we make a loss we are bankrupt, and we and our families, would bear the consequences of that. (There have been Practices in Cornwall that have gone bankrupt so this is not a theoretical concept). About 1000 (20% of the total) GP Practices have been lost to closure/merger in the past 10 years.

Effectively the partners are not salaried employees, if the partnership fails to make a profit, then the partners are not paid and the practice is unsustainable. Talking about profitability sounds mercenary, but ultimately profitability is a measure of governance, sustainability and, importantly, the viability of our, and your, practice.

We recognise that we are incredibly fortunate, privileged and well remunerated for doing a job that we love and that is rewarding and satisfying. We have always prioritised providing good quality patient-centred general practice above maximising profits. However, we do have an obligation to all our registered patients to be responsible by preparing for the future and ensuring the sustainability and success of the practice.

We have had two retirements recently. We have lost 80 years of clinical and management experience and some of the financial security that partners support. We want to persuade a doctor, perhaps with a student loan debt, mortgage and a young family, to take on the unlimited liability and financial risks of a Partnership. Alongside the added clinical responsibility, governance burdens and long additional hours, the partnership needs to assure them of financial sense and security and professional fulfilment. It is interesting to note that over the last few years most GPs qualifying do not wish to pursue a Partnership and would prefer to work as an employed salaried Doctor (Full Time Equivalent partner numbers have decreased by 30% over the past 10 years).

Working as a Partner involves a substantial increased burden of workload and responsibility. Investigating job advertisements locally, it is clear that GPs are in such short supply that they can command salaries similar to what they might hope to get in smaller partnerships as a full-time partner but without the additional stresses. We have previously been able to recruit Partners whose values are similar to our own and for whom money is not the primary driver but, it is an increasingly important consideration for applicants.

We have recently changed accountants to a specialist medical accountant. They service c 400 medical Practices across England. They tell us that our profits are in the bottom 10% of all their clients. The lower earning Practices are characterised by a number of features including small list size, non-dispensing or dispensing for small numbers and multi-site practices. The highest earning Practices have larger list sizes, often large dispensaries and are on single sites. We, as Partners, have never prioritised income above

everything else, but with profitability as a surrogate for resilience and sustainability and with such uncertain times ahead it is our responsibility to consider the long-term future.

You ask for specific data about Practice income and expenditure for Polruan. We do not hold this separately in that income and expenditure are not apportioned to individual sites. The majority of all our expenditure is staff costs and all our patient facing staff work over multiple sites. A lot of care and contacts provided for Polruan patients is delivered from other surgeries. Having two, and certainly three sites, substantially increases our costs. Our costs are approaching double those of a single site similarly sized Practice. We also have, utilities x3, insurances x3, equipment and maintenance x3, wastage x3, increased CQC costs etc..

It can all seem rather negative when we talk about the pressures of long-term underinvestment in core general practice and the more significant investment in broader clinical networks and neighbourhood health. We recognise the support from the partnership that this requires, and the additional provision of population level clinical leadership. For us, there are additional pressures of partner retirements, the challenges of clinical and non-clinical recruitment, demographic and population changes. How do we balance these pressures across our three sites?

There is the inexorable pressure to provide more and more immediate access which sometimes seems to come at the cost of quality access care for more vulnerable patients. There are the more specific challenges within Polruan with an ageing not-purpose-built building and the financial hit of an anachronistic rules system on dispensing. Added to all this we are facing seismic changes in how the health service is organised. This does not look like it is likely to favour the small local clinician model of general practice provision that we represent.

However, we do have a positive vision that we could potentially implement over the coming years. What we have been hearing from our patients over the past five years is not that people cannot get prompt access to appointments but that they cannot access a doctor or clinician of their choice. What we hear time and time again is that you want to see your doctor. We could consolidate resources and staff, recruit a partner and more clinical staff. This with a shift to increasing IT capabilities for risk stratification/segmentation, and continuing to upskill and support our staff and broader network teams could provide huge opportunities. This model would allow us to meet the demands of our acute access requirements and more importantly vastly improve continuity by running a much more traditional 'named GP list'. This would create a more resilient, sustainable practice, which could interact meaningfully with all the predicted benefits outlined within the 10-year plan. Primarily, however, this would improve the experience and care available for our whole population including the population of Polruan.

We can continue to provide a service out of Polruan surgery. Of course, there is great uncertainty, and we anticipate significant risks to this approach. The building would need considerable investment, and even then, given the concerns mentioned above, we think that there is a risk that the regulator comes that they still may find the building 'not fit for purpose'. We can continue to dispense to what we fear will be a dwindling number of patients at a likely increased loss to the practice as a whole. We think as a practice with resources spread more thinly and our costs increased we would be less well placed to take advantage of the benefits the 10-year plan has to offer and more vulnerable to being pushed towards a much larger unit of clinical care provision.

Alternatively we might consolidate how we operate, our staff, our clinicians and our resources. That is a painful thing to contemplate but it is a decision that we need to at least consider and explore. We do recognise that closing the Polruan branch would have significant consequences for some of the local population. The geography and transport are particularly challenging.

We think there may be ways to mitigate the changes for patients. Ringfencing "Polruan" surgeries at either or both of our other sites is possible. We wonder if this might be supported by some sort of transport

solution, which we have successfully implemented in the past? We are planning on continuing discussions with community transport provision on both sides of the river. You know your community best and you may have insights into the practicalities and likely pitfalls.

For the relatively small number of patients we still dispense for there are additional challenges. There are a broader range of NHS supporting prescription delivery services than ever before. Our dispensers and social prescribers could potentially support patients with registering for these. We are also reaching out to Boots in Fowey, who we understand are now providing a delivery service for some patients, to have a conversation with them as to what might be possible.

We recognise there will be certain individuals for whom these changes, if pursued, might be particularly disadvantageous. We know many of these people and are reaching out to them individually. If you feel this describes you or someone you know please let us know.

This consultation is not a fait accompli. Once we have collated all responses we will decide whether to formally request a closure of Polruan branch surgery. If this were approved we could plan on making the changes over a period of a year as our notice to relinquish the lease runs out. This period of time should allow us to manage many of the difficulties that ensue.

You have been really helpful in highlighting your concerns and some potential solutions to some of our issues and that is hugely welcomed. However, we are concerned that with an uncertain time ahead, that we, and the wider PCN, need to be in a strong position for the future of our business and your practice.

Thank you for taking the time to read this very long reply to the issues you identified. We do not think a reply without providing the background and context we have would be as useful.

Yours sincerely,



Dr Richard Cockshott



Dr Paula-Jane Marrett



Dr Jan Knobloch