2022 Special Conference of England LMC Representatives

Sheffield LMC

FRIDAY 25 NOVEMBER 2022

SHEFFIELD LMC EXECUTIVE ATTENDANCE: Alastair Bradley, Krishna Kasaraneni, Gareth McCrea, Danielle McSeveney

This was a full day of discussions in 4 separate Breakout rooms. This was to inform General Practitioners Committee England (GPCE) of opinions around all contract options.

SUPPLEMENTARY NON-NHS OPTIONS BREAK-OUT ROOM

This was to look at fully private provision, offering private services to NHS patients and charging for non-NHS work from private and NHS providers, eg workload dumps from secondary care.

Discussion was because of:

- Reduced number of partners.
- Workload dumps from various sectors.
- Increased risk - financial and clinical.
- Premises issues.
- Reducing values of NHS contracts - core and Locally Commissioned Services (LCSs).

The major problem is defining what is core activity within the General Medical Services (GMS) contract.

Options considered:

- Charging our NHS patients for non-NHS work.
- Charging patients for more convenient appointments, eg evening for working people or sooner appointments than available on the NHS.
- Charging per appointment - nominal fee or as a deterrent - could be means-tested or reclaimed through tax system.
- Charging for letters to private providers.
- Charging for shared care protocols with private providers.
- Charging for data collection.
- Charging other providers for workload dumps.

Having a mixed model of NHS and private provision may put patient pressure on improving NHS services.

Charging may increase health inequalities as patients who can pay will get better services, and GPs may move to more affluent areas where patients can pay. GPs were wary of managing any payment system themselves.

Comparisons were made with Australia, where a payment scheme was introduced over 30 years ago and is still running. Consultations for encouraging patients back to work were funded through a Work Group Scheme as it had a benefit to society.

Comparisons also made with dentists. However, this had led to small practices selling out to larger organisations, who then instigated a salaried service which had driven down salaries. Dentists were doing more cosmetic work as the NHS contract had restricted earnings.

Private work would not be covered by the Clinical Negligence Scheme for General Practice (CNSGP) and was likely to lead to an increase in indemnity fees again.

Note: None of these are policy directives to GPCE. They are discussion points for GPCE to consider during contract negotiations with NHS England (NHSE) and the Department of Health and Social Care (DHSC).

DR ALASTAIR BRADLEY
Chair

NEW CONTRACT BREAK-OUT ROOM

Mindful of the upcoming New GP contract from April 2024, the Conference included a Breakout Group focussed on canvassing opinions of LMC representatives from across England to guide the upcoming negotiations between GPCE and NHSE.

Conference asked for a steer from the delegates on the preferred contract model to pursue in negotiations. The options included:

- Capitation-based funding - this is the basis of the current GP contract, where a fee is paid per patient for unlimited contacts. A degree of autonomy is retained, but workload is potentially unlimited for fixed funding.

- Hours-based payment model - a fixed hourly rate is paid to GP contract holders, providing a guaranteed baseline salary, yet risks unpaid overtime and may not reduce workload.

- Item of Service (IoS)/tariff-based model - a fee is paid per consultation/contact. This may ensure complexity is rewarded with a larger fee, yet with a finite DHSC budget, as activity increases, the unit tariff reduces - potentially leading to a law of diminishing returns.

- Workload-based funding - a model whereby funding is fixed for a defined number of patient contacts per day. Workload above this level could either attract additional funding or be directed elsewhere. The workload would be controlled, but system agreement is required to establish where the overspill would be directed. Effectively there is loss of the GP gatekeeper function.

- Payment by results - essentially a model where everything is in the Quality and Outcomes Framework (QOF). The financial incentives would be clearly defined, however, autonomy would be lost and would risk the stability and viability of practices if all funding were through this type of model.

The consensus in the group was for a mixed approach - based predominantly on a capitation-based model with additional funds obtainable through IoS, ie similar to the current contract with core funding and QOF. There was a clear desire to increase the funding in core and to dramatically reduce the amount of funding in IoS. Indeed, most present believed abolition of QOF and reinvestment of these funds in core contract would be an improvement on the current contract.

In the plenary session, all delegates were polled on their preferences. A capitation-based model was the favoured model, with the payment-by-results model being least popular. The Agenda Committee felt this was very helpful in giving GPCE a steer from the profession to guide contract negotiations with NHSE prior to 2024.

DR GARETH MCCREA
Executive Officer

ALTERNATIVE ACTION BREAK-OUT ROOM

This was to inform GPCE of opinions around what alternative actions (industrial action or collective action) the profession would be willing to take if the contract negotiations for 2024 onwards are not favourable.

The discussion was broad ranging and could be split into seven main areas:

1. Patient care: Whilst some expressed the view that any action will have to have an impact on patient care for the government to listen, the overwhelming majority of the group felt that they could not support any action that negatively impacted on patient care.

2. Legal risk: The second main barrier to taking any form of action is the worry of potential legal issues, such as breach of contract/loss of contract.

3. Financial loss: Any withdrawal of voluntary activities, such as withdrawing from the Primary Care Network (PCN) Directed Enhanced Service (DES), would result in a financial loss that practices will not be able to absorb in the current climate.

4. Regulatory risk: Representatives expressed concerns about potential problems with practice regulators such as Care Quality Commission (CQC) and personal regulators such as the Medical Practitioners Tribunal Service (MPTS) and the General Medical Council (GMC).

5. Impact on colleagues: Potential impact on the rest of the NHS was seen as a barrier to some forms of collective action.

6. National/professional reputation: Wide-ranging views about whether to pay attention to the professional reputation aspect. Some felt that sections of the press would always criticise general practice, and it was futile to try to address that. The majority felt that we must not support action that damages professional reputation.

7. Local/personal reputation: This was obviously topical as the national appointment data was published and there was already press coverage and league tables emerging. Representatives felt that this was more important than national reputation as it is one's patients who will be influenced by this and could significantly affect doctor-patient relationship.

The discussion then moved on to what type of actions the profession could support. Again, there was no consistent theme that representatives got behind. Wide ranging views were expressed which ranged from strike action to selective workload controls/limits.

DR KRISHNA KASARANENI
Executive Officer

BEST ALTERNATIVE TO CURRENT PCN DES BREAK-OUT ROOM

In this section of the breakout debates we discussed what is working within the PCN DES and potential alternatives. Unsurprisingly, the debate was very mixed, with a big divide between those for which the DES is working well and are seeing the benefits of the collaboration and new roles, and those for which the cumbersome micromanagement, difficulties recruiting and significant supervision required for Additional Roles Reimbursement Scheme (ARRS) staff outweighs tangible benefits.

Types of Collaborative Work Beneficial to Practices

This mainly included additional services such as sexual health services, minor ops, and joint injections. Some suggested items which would, in theory, increase practice resilience such as cross cover for absence. However, this was met with some opposition. It was felt non contractual items which cannot and should not be delivered at practice level such as spirometry and dermatology clinics should not be included. Overall, the message given was that flexibility was key both in funding and services provided.

ARRS Roles

There was a strong feeling this money should be moved into core funds with more flexibility of roles claimable. Supervision time is currently unfunded, and this should be looked at and built in - a suggestion that this could come from the significant underspend was proposed. Richard Van Mellaerts, Deputy Chair, GPC England, made assurances that the funding would continue for these roles beyond 2024.

Solutions to the hidden costs: Training hubs for ARRS staff across an area. Again, the running theme with this debate was funding, flexibility and less micromanagement.

Red Lines with the DES

Appointment data being collected and released to the public was felt to be unreasonable and unhelpful at best, destabilising and potentially threatening for practices and individuals. Many expressed the loss of the funding through the DES would be the tipping point which would make some practices unsustainable, this must be addressed in negotiations.

Separating acute and chronic care was discussed during this debate, with strong feelings expressed on either side.

Estates planning must be part of the discussion around ongoing collaboration.

The PCN DES must not be used as a plan B for various failing services, the example given being mental health.

DR DANIELLE MCSEVENEY
Vice Chair