2023 Special Conference of England LMC Representatives

Sheffield LMC

FRIDAY 24 NOVEMBER 2023

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

A number of breakout groups were held to canvass opinion from delegates to inform the contract negotiations with the Department of Health and Social Care (DH) and NHS England (NHSE) for the General Medical Services (GMS) contract 2025/26:

CONTRACTUALISING CONTINUITY

The evidence for continuity of care improving patient outcomes, quality of care and job satisfaction is well recognised. There is widespread frustration amongst GPs with the push for increased GP access, which fails to recognise capacity in the system - limited by a growing, ageing population and the workforce crisis. Consequently, continuity of care in the system has suffered.

General Practitioners Committee (GPC) England is keen to explore whether there is an appetite amongst GPs for continuity to be protected and incentivised in the new contract.

There was debate about the definition of 'continuity of care' - and that this differs depending upon perspective: episodic vs long-term care, continuity of GP surgery, continuity of doctor.

Conference recognised that patients and commissioners were likely to have a different view of what continuity meant from GPs - and that fundamentally it was the GP definition that would be important to be adopted in the contract.

If continuity became contractual, the definition would be crucial, as an element of 'measurement' (performance management) would likely be mandated by NHSE. Many felt this was unlikely to be useful to patients or GPs, as it was likely to increase bureaucracy without improving clinical care, and that results would not be immediate.

The GPC received a steer from conference that we need to be clear about *our* definition of continuity of care before entering negotiations, that any monitoring of continuity would need to be light touch, flexible to individual practices (rural vs urban / deprived vs affluent) and focussed on high trust on both sides. An interesting suggestion was, rather than incentivising continuity of care in the new contract, perhaps the GPC should consider disincentivising things that negatively impact on continuity of care, such as GP access, working at scale, separation of acute and chronic care.

Teams need to be funded extra to deliver continuity, as it has been shown to improve outcomes.

'SLICING THE PIE' FUNDING BRIEFING

The premise of this breakout group was to canvass opinion on how the Primary Care budget should be spent in General Practice, in the assumption that no additional funding or increase in core contract was secured.

Currently, the Carr-Hill formula dictates how funding is distributed to practices on a capitation basis, and it is widely accepted that this formula is too simplistic, with some practices currently underfunded compared to others.

The GPC was clear that, ideally, they would not want to destabilise any practices, but that in the event of no additional money invested in the core contract, a redistribution of funds would lead to some practices benefitting and others losing out.

An interesting discussion ensued about what factors should be prioritised in any successor to Carr-Hill. Many were suggested, with deprivation, co-morbidity and age the 3 most popular in descending order. Sex, which is a current variable in Carr-Hill was not a popular choice.

A larger number of variables included would lead to more data collection but smoother transitions than fewer variables. The more variables, potentially the less variability in differential funding between practices, as all practices have their unique challenges. Interestingly, irrespective of scarcity of resources, the majority wished to see weighted capitation (89% if no increase in GMS vs 84% if a large increase in GMS).

It was also suggested there should be a review date agreed, but no clarity on how often.

DISSECTING CARE INTO ACUTE AND CHRONIC STREAMS

This was suggested as a possible solution to the current demands on General Practice in an attempt to address workload. Groups were split in two to consider the pros and cons of dissection. It is fair to say there was much more support for the status quo than for any attempt at dissection.

Pros

- Allowing more specialisation within Primary Care for GPs interested in acute or chronic care. Could this lead to better workforce retention?
- Ease of workforce planning, particularly for chronic care streams. Advanced Nurse Practitioners (ANPs) could be utilised primarily in the acute rather than chronic streams.
- Clearer boundaries and job plans for staff.
- Contracting could be block (for chronic care) and variable contracts (acute care).
- Potentially increased continuity of care in chronic care, although this was also a proposed benefit of not dissecting into streams.

Cons

- Reduced continuity:
  - Potential for misdiagnosis in repeated presentations, eg cough in lung cancer, recurrent UTIs in bladder cancer.
  - Safeguarding issues may be harder to identify.
- Rural challenges - poorer public transport links making it more difficult for patients to access different sites for acute and chronic care.
- Fractured/siloed care:
  - Duplication of workload, including need for home visiting service for both acute and chronic streams.
  - Medicolegal risk of patients with long-term conditions who only present to acute hubs, or presenting acutely ill at a Long-Term Condition (LTC) clinic.
  - Potential inappropriate transfer of workload from chronic to acute streams and vice versa.
- Issues in defining acute care - who is triaging/deciding if patient is acute or chronic?
- How much flex can be achieved? Pandemic response depended upon the ability of General Practice to flex overnight to acute care. This is unlikely to be possible in future if split into acute and chronic streams.
- Deskilling of registrars - how do we ensure they receive adequate training if GPs are not providing both acute and chronic care simultaneously?
- Splitting the GMS contract:
  - Facilitating further underfunding of General Practice as government can remove at least one stream from core contract/facilitating government to sell off practices to private providers.
  - Does this facilitate the government selling off acute care (more profitable aspects of General Practice) to private providers?
- Less cost effective:
  - Larger workforce required with mix of skill sets.
  - Increase in referrals and risk of over-investigation/over-treatment.

    - Less experienced staff, riskier environment, less/no facility to follow-up patients/use time as a diagnostic tool.
- Poor antimicrobial stewardship as a consequence of over-treatment.
- Estates issues - already insufficient estates in England.
- Impact on GP wellbeing - many enjoy generalist role, continuity of care - may impact recruitment / retention.
- Loss of opportunistic healthcare, eg inviting for screening when presents with acute issue.
- Widening health inequalities - in areas of deprivation, patients less able to travel to different sites for acute and chronic care.

MOTION 17: SEPARATION OF PLANNED/UNPLANNED CARE

WALTHAM FOREST: That conference believes that the current workload for general practice is unsustainable, and:
(i) believes that the time has come to separate acute on-the-day care from planned general practice care
(ii) insists that the separation of care be an essential component of a new GMS Contract
(iii) requests that GPC England negotiates a separate service for the provision of on-the-day acute care for patients currently seen by GPs.
(iv) requests that GPC England stipulates that a new GMS contract clearly indicates the situations when a patient would benefit from moving between acute care services and planned care services and the mechanism to enable this
(v) requests that GPC England negotiates a new GMS contract which focuses on continuity of care, care of long-term conditions, preventative healthcare and end of life care.

i-iv on separating the workstreams were all lost by at least 80% against.
v was a request for GPC to negotiate a new GMS contract based on continuity, care of LTCs, preventative healthcare and end of life care. It was passed with 61% voting in favour.

MOTION 18: APPRAISAL

WEST SUSSEX: That conference believes that GPs should not have to bear costs associated with mandatory annual appraisal and implores GPC England to insist that these costs are reimbursed in full.

The free MAG4 form was clunky and superseded by better platforms at a cost to the appraisee. Conference agreed that the cost of being appraised should not be met by the appraisee.

MOTION 19: REAFFIRMING CONTRACT POLICY

AGENDA COMMITTEE TO BE PROPOSED BY KENT: That conference calls on GPC England to:
(i) include in its negotiations with NHSEI / DHSC that existing conference policy of an activitybased contract is part of the new contract 21
(ii) include in its negotiations with NHSEI / DHSC that existing conference policy of PCN into core is part of the new contract
(iii) include in its negotiations with NHSEI / DHSC that existing conference policy of more flexibility for private services the NHS cannot provide is part of the new contract
(iv) include in its negotiations with NHSEI/DHSC that existing conference policy of the removal of home visits from core contract work is part of the new contract
(v) formally ballot members once the outcome of negotiations for the new contract with NHSEI / DHSC are known.

This motion was brought because conference felt that some aspects of policy that had been agreed as business in the past, were not being actively negotiated.

Most parts were passed: investing Primary Care Network (PCN) monies into core, including activity-based elements in core, more flexibility for private work.

The last 2 were more controversial. Conference had previously asked GPC to negotiate home visits out of the core contract, but this was lost 47:53. Conference did, however, request a ballot of the profession on any new contract.

DR ALASTAIR BRADLEY
Chair

DR GARETH MCCREA
Executive Officer