LMC SECRETARIES CONFERENCE

THURSDAY 24 NOVEMBER 2016

SHEFFIELD LMC ATTENDANCE: David Savage Margaret Wicks

ADDRESS BY GPC UK CHAIRMAN

The Conference opened with Dr Chaand Nagpaul's address. He outlined the current negotiations with the Government and NHS England (NHSE). This was a good overview of the current state of Primary Care. The main points of note were:

- The GP Forward View (GPFV) would see £2.4b recurrent investment in Primary Care; the target being that Primary Care should have at least 10% of the NHS budget by 2020/21. This was the first recognition by NHSE of the workforce crisis in Primary Care.
- £500m of the £2.4b would be allocated to supporting extended GP access by 2020/21.
- There was £508m of non-recurrent funding which should have been charged to various areas of Primary Care development. Part of this was £40m for the GP Resilience Programme. This is an area that we are seeking clarification on from Sheffield Clinical Commissioning Group (CCG) and NHSE to understand Sheffield's allocation.
- There is a £30b funding gap in NHS budgets, with a target of £22b efficiency savings.
- All authorative opinion, including the Kings Fund, was that NHS funding was inadequate in its current form, and this was not helped by post Brexit paralysis.
- Funding is available to cover the indemnity fee increase, which will be reimbursed to practices.
- The Care Quality Commission (CQC) expenses rise will also be reimbursed.
- Changes to standard contracts were highlighted, particularly with regard to hospital Trust DNA policies and inappropriate transfer of Secondary Care work to Primary Care.
- Evidence suggests that 27% of GP appointments are avoidable and initiatives to reduce this figure were outlined, such as online consultations, promoting self-care and stemming inappropriate requests from secondary care. There is a move to encourage hospital Trusts to use FP10s and electronic prescribing, rather than filling up GP appointments unnecessarily.
- Workforce solutions were touched on, such as optimising skill mix and moves towards practice based pharmacists and Physician Associates.
- Shared Care arrangements should be considered voluntary, and should be appropriately funded.
- The GPC was in favour of encouraging GP networks and federations with access hubs to avoid practice closures, as well as sharing back office functions, managing urgent appointment overspill in hubs and better patient triage models.
- Considerable work had been undertaken with NHSE to develop various stages of multispecialty community provider (MCP) contracts, particularly highlighting the first 2 phases, which allow GPs to retain their General Medical Services (GMS) contracts. The difficult and uncertain logistics of a return ticket to GMS were acknowledged.

MEET THE GPC ENGLAND EXECUTIVE

For the first time there is now a separate GPC England Executive comprised of Chaand Nagpaul, Richard Vautrey, Mark Sanford-Wood and Gavin Ralston. The number of GPC meetings has been reduced and the GPC sub-committee structure is going to be changed to one of policy leads.

SESSIONAL GPS AND LMC ENGAGEMENT

Zoe Norris, Chair of the GPC Sessional Sub-committee and Sessional Doctors Regional Representative for Yorkshire gave a presentation:

- The difficulty of trying to track sessional doctors, particularly those not based in one GP practice for any length of time was acknowledged.

- A paper has been produced *Sessional GPs and LMCs – working together more effectively*, which suggests ways of identifying sessional doctors in the area.
- Zoe had been informed that Primary Care Support England (PCSE) had supplied each LMC with a list of doctors on the Performers List in their area, including contact details (Sheffield received an out-of-date list with no contact details).
- Concerns were expressed regarding the development of MCPs and how the contracts would work for sessional doctors, noting that the BMA model contract outlined the minimum terms and conditions that should be offered.
- A new Retainer Scheme is due to come out in 2017.
- Sessional doctors had significant issues with PCSE, in particular with regard to pension contributions, and had demanded a 6 monthly pension statement.

The presentation was well received and Zoe offered to visit LMCs or attend already scheduled LMC meetings.

UPDATE FROM THE GPC REFORM TASK GROUP

Hamish Meldrum, Chairman of the Implementation Group gave a brief overview, highlighted the creation of GPC England and noted that a new constitution had been written. There was also a move towards Regional LMC Liaison Officers being encouraged to undertake LMC visits and for LMCs to visit the GPC. Proposals for the GPDF to move from a GPC based company to an LMC based company with transparency, ownership and accountability were under review.

SUPPORTING PRACTICES IN UNDERSTANDING THE PROCESS OF WINDING UP / HANDING BACK THEIR CONTRACTS

Justin Quentin, BMA Law gave a good presentation on issues to consider prior to a decision being made to hand back a contract:

- potential expenses and liabilities;
- trigger the dissolution of Partnership Agreements;
- terminating the practice's core contract;
- notifying the CQC, CCG and the Information Commissioners Office (ICO);
- winding up the business.

There followed a discussion with regard to leases and mortgages:

- Extortionate early redemption penalties were highlighted, which are causing problems for practices on cost rent. There was a view that practices could, particularly if in positive equity, negotiate a compromised solution.
- GMS contracts have a 6 month notice period during which the practice has responsibility for the patients. Personal Medical Services (PMS) practices have a 3 to 6 month notice period.
- When handing back a contract with a lease, the lease period needs to be looked at, as liabilities continue unless there is a right to resign.
- In cases where the lease document is missing, an original lease should be stored with the Land Registry. If this is not the case then an implied tenancy agreement based on lease payments would be put in place.
- Many practices also had hire purchase agreements, practice loans, outstanding monies to locums and professional fees, all of which would need to be settled.
- There was obviously the issue of staff redundancy costs. If the staff had been employed for more than 2 years then they would be entitled to redundancy monies, unless they could be TUPEd to be employed by another provider.
- It would be helpful if practices gave the CCG notice of their consideration of shutting down. The CCG still has the ability to make discretionary payments.
- It is vital that Partnership Agreements are up-to-date, as they would be considered void if there was no signed agreement of adherence. If this was the case then the Partnership Act of 1890 would fall into place. GMS practices would have the right for their contract to continue if the Partnership Agreement was dissolved, but this is not the case for PMS practices.

- Justin felt that handing back a contract was the "Armageddon option" and it was always better to talk to the LMC or the CCG when considering closure. It would be far better to look at an alternative option, such as taking on a new partner, finding a private provider, or preferably a local federation or provider organisation to take over the contract.

THE ROLE OF LMCS IN MCPS AND LOCALITY MODELS

It was suggested that the LMC's role is to:

- Inform practices about local and national proposals and discussions.
- Explain the options, benefits, risks and threats to practices.
- Ensure all parties are aware that any proposal is voluntary, although no change probably is not a viable option.
- Encourage practices to get involved and shape the evolving new structures.

A number of issues were discussed:

- It was reported that in some areas commissioners who are also providers enter in to commissioning negotiations and are either conflicted or do not adequately seek independent provider opinion.
- There appears to be no Plan B if some practices want to sign up to a particular model, but some do not. It is not clear how this could work.
- There were concerns around an assumed progression along the different stages of the MCP model. It was felt that there needed to be absolute clarity as to what a practice was signing up to and that any progression remained voluntary.
- There was a suggestion that sessional GPs might not want to work for independent contractors, but would favour an entirely salaried model.
- Many LMCs did not feel adequately involved or informed, with CCGs consulting federations or private companies when they wanted a GP opinion.
- It was suggested that the patient registered list and a perpetual contract should not be undervalued, and should be retained. Sub-contracting should be used rather than major contractual changes and a move away from GMS.
- The guarantee of a return to GMS was little comfort when there can be no guarantee of who would hold the contract and what it would comprise several years on.
- There was agreement that there needed to be more focus on the value of General Practice and a clearer understanding of what needs to change, before being able to determine whether MCPs are the best way of achieving the changes.

SUPPORTING GENERAL PRACTICE

Ros Roughton, Director of NHS Commissioning, NHSE gave a well presented overview of NHSE's view of the current workforce/workload crisis in General Practice:

- It was acknowledged that for the first time NHSE had got evidence of the dire situation in Primary Care.
- There had been a lack of investment in previous years, and from 2009 to 2015 there had been a workforce of three times as many Consultants as GPs.
- There had been a 2.5% increase per year since 2009 in annual consultations. On average GPs are undertaking 14% more consultations today.
- NHSE is trying to encourage recruitment and retention and has increased the number of GP training places.
- A bursary scheme for under doctored areas has been set up, with good take up (162 returners since January 2016).
- An extra £33m has gone in to the Primary Care Budget for 2016/17 to cover increased costs, such as indemnity fees.
- £31m has been invested in pharmacy schemes, with 493 pharmacists being employed in more than 700 practices.
- £15m has been put aside for Practice Nurse Development.
- £6m had been allocated for Practice Manager Development.

- £13m was being invested over 3 years in the GP Practice Development Programme, which was looking at models of access hubs run by practices, where patients can be seen as urgent extras outside of their own premises.
- General Practice Resilience Fund monies had been allocated to 1000 practices.
- The new GP Health Service would be set up in 17 areas, which should offer GPs and trainees struggling with stress or other mental health issues access to a confidential helpline.
- Funding is available to help practices on leases with CHP with Stamp Duty and to compensate them for VAT, although this was non recurrent.
- Ros apologised for PCSE's unacceptable service levels, which obviously was not helpful in the current crisis in General Practice. She gave assurances that urgent work was being undertaken to resolve these issues.

ADDRESS BY THE DEVOLVED NATION CHAIRS

There followed presentations by the 3 devolved nations. It would appear that Scotland has made significant progress and has now had all Quality and Outcomes Framework (QOF) and Locally Commissioned Services (LCSs) put in to a core contract. The situations in Northern Ireland and Wales appear to be worse than in England. In particular, in Northern Ireland 97% of GPs had agreed to sign undated resignation letters.

ASK THE GPC

Chaand Nagpaul was asked about the £2.4b recurrent money being invested in Primary Care, and why this could not simply be added on a £s per capita basis to the global sum. He pointed out that £500m was put aside for access monies. Also NHSE wanted the funds to be assigned to specific Primary Care projects, as some considered that a per capita uplift could just be used to increase GP profit.

Concerns were raised regarding contracts handed back to CCGs and Area Teams being put out to tender as Alternative Primary Medical Services (APMS). Chaand felt that this was a problem in Procurement Law in England alone, as it was for some of the LCSs, such as Sexual Health Services. The only exception is when it would be prudent to be dependent on a patient list based system.

Chaand suggested that the GPC had taken legal advice and there was no such thing as an informal list closure. There are areas in the country where practices were declaring themselves closed and were being supported by the CCG, but in other areas breach notices were being issued. He felt that each list closure had to be looked at on an individual basis and that GPs would have to prove that they were closing on the basis of patient safety.

DR D SAVAGE
Secretary