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Cambs LMC Virtual Webinar

Tuesday 23 April 2024

7:30pm – 9:00pm

Agenda

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- Welcome and introductions – Dr Diana Hunter, Chair
- National picture – Dr Katie Bramall-Stainer, Chief Executive
- Local focus – Alice Benton, Interim Chief Operating Officer
- Wellbeing and resilience – Dr James Booth, Medical Director
- Q&A & close

All change!

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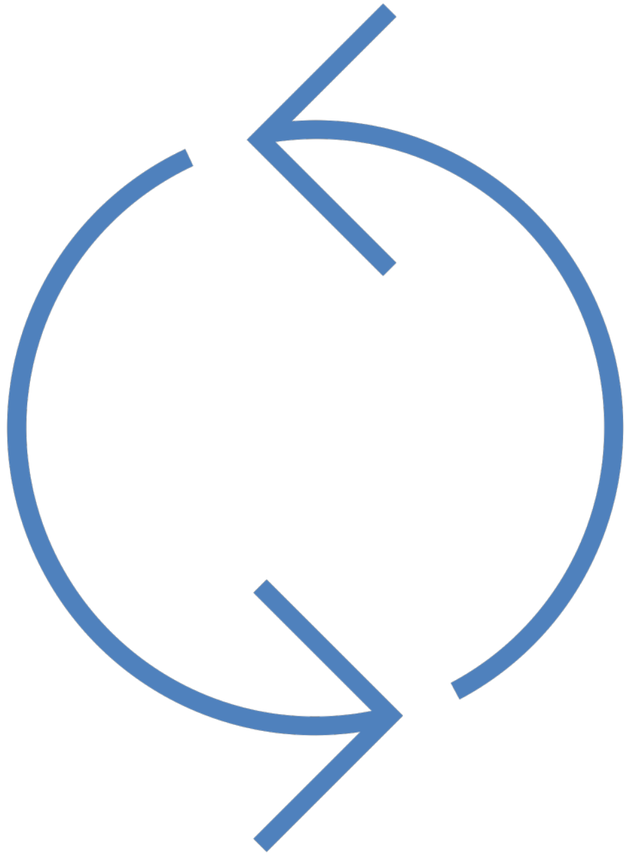
- LMC staffing changes and impact
- Update on communications
- Expectations for the coming year



Your LMC Executive Team

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Dr Katie Bramall-Stainer

Chief Executive

Alice Benton

Interim Chief Operating Officer

Dr James Booth

Medical Director

Emma Drew

Executive Officer

Suzy Stoodley

Executive Officer

Molly Collison

Administrator

Communications update

New website

Changes to the Link

Current WhatsApp groups

Expectations for the coming year

- Regular newsletters and updates
- GPCE roadshow planned – to be confirmed
- Practice Manager conference 3 October 2024
- Further open meetings as required

Your LMC Committee Representatives

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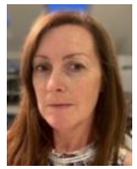
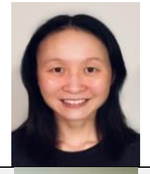
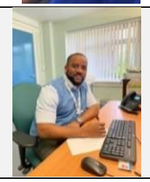
Reem Al-Shaikh *Partner, South Cambs* *Member 2023 - 2027* 	**Stephanie Betts-Masters** *Partner, Peterborough* *Member 2023 - 2027* 	**Duncan Blake** *Partner, Hunts* *Member 2021 - 2025* 	**Eimear Byrne** *Locum, Cambridge* *Member 2023 - 2027* 
Ben Curtis *Partner, Hunts* *Member 2023 - 2027* 	**Francesca Frame** *Partner, Cambridge* *Member 2021 - 2025* 	**Hayley Haworth** *Salaried, Hunts* *Member 2021 - 2025* 	**James Howard** *Partner, East Cambs* *Member 2023 - 2027* 
Diana Hunter *Salaried, Hunts* *Member 2023 - 2027* 	**Lisa Lim** *Partner, Cambridge* *Member 2021 - 2025* 	**Alisdair Macnair** *Partner, Cambridge* *Member 2021 - 2025* 	**Ben Miller** *Partner, East Cambs* *Member 2021 - 2025* 
James Morrow *Partner, South Cambs* *Member 2021 - 2025* 	**Paula Newton** *Locum, Hunts* *Member 2021 - 2025* 	**Daniel Nlewedim** *Partner, Peterborough* *Member 2021 - 2025* 	**Duncan Outram** *Partner, Hunts* *Member 2021 - 2025* 
Jo Pritchard *Partner, Hunts* *Member 2023 - 2027* 	**Jessica Randall-Carrick** *Salaried, Peterborough* *Member 2021 - 2025* 	**Kevin Remedios** *Partner, Peterborough* *Member 2023 - 2027* 	**Caroline Rodgers** *Salaried, South Cambs* *Member 2023 - 2027* 
Jo Scrivens *Salaried, East Cambs* *Member 2023 - 2027* 	**Toseef Sethi** *Partner, Peterborough* *Member 2021 - 2025* 		

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National update

Dr Katie Bramall-Stainer – Chief Executive

2023/24 & NHSE decisions

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- 'Stepping Stone' year post PCN DES ahead of a new government
- July 2023 DDRB announcement '6% uplift' .....2024?
- Imposition of full prospective access to online medical records
- Introduction of the Pharmacy First Scheme
- 'Soft' introduction of Medical Examiner arrangements
- Loss of GP New To Partnership Scheme
- Loss of the GP Fellowship Scheme

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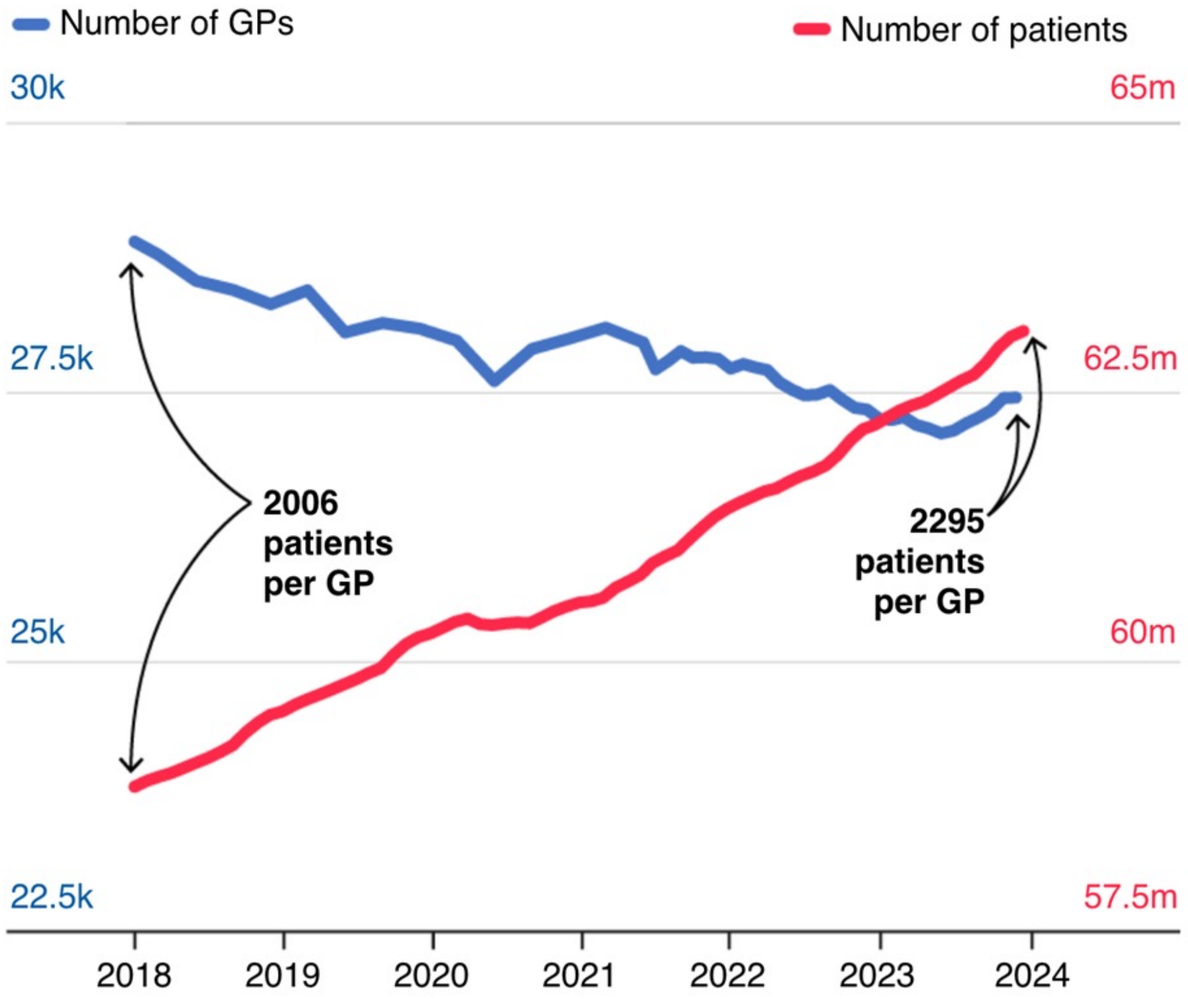
Number of patients registered continues to grow as fully-qualified GPs leave



Satisfaction rates continue to fall

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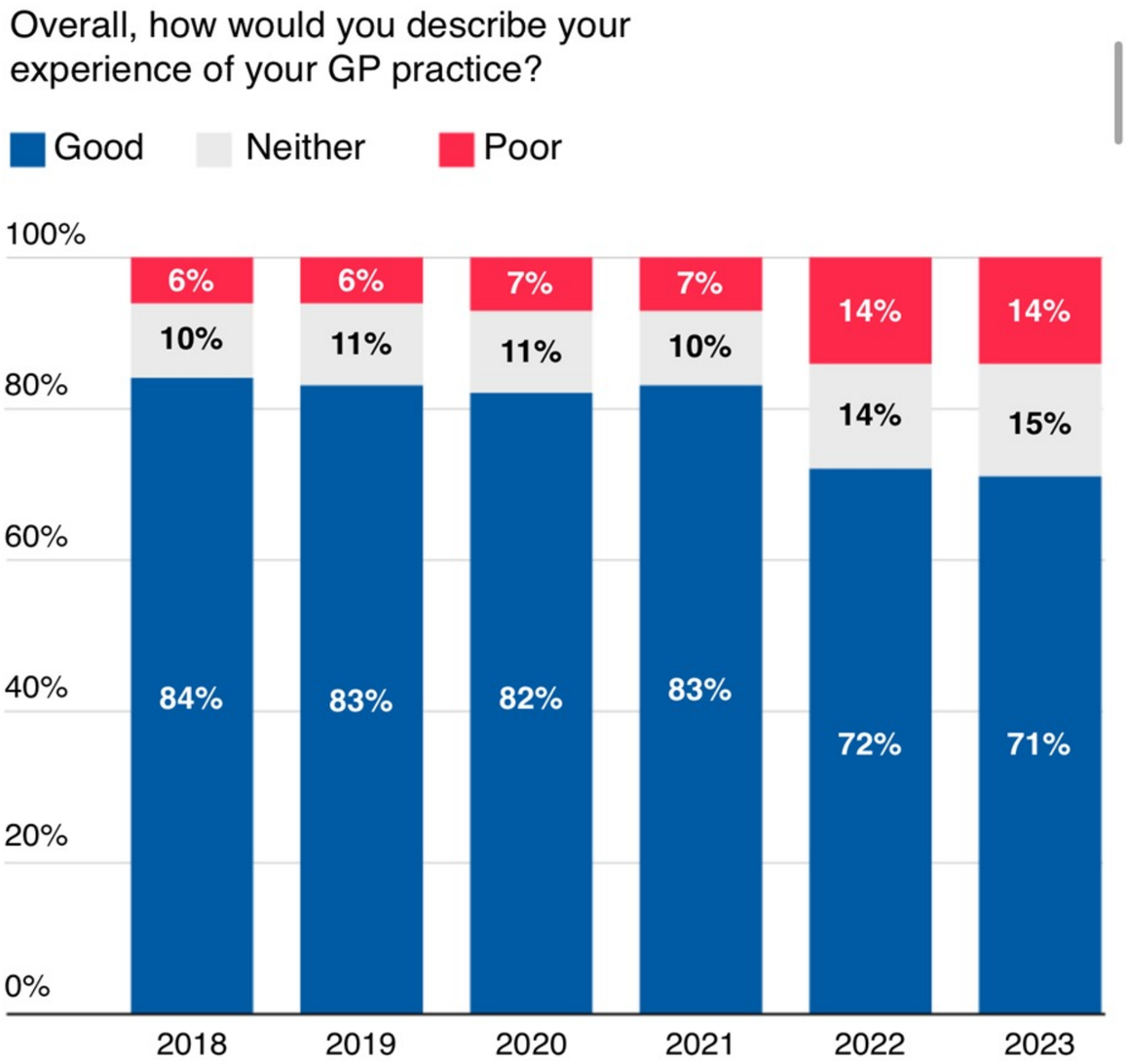

The Contract Timeline

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- Oct 2023 – Jan 2024: NHS England & DHSC formally meet with BMA's GPC England Officer team who produce evidence in a series of papers, with a menu of potential options
- Meetings with the Secretary of State and Ministers throughout
- Evidence: National GP Survey & Practice Finance Survey
- GPC England priorities for 2024/25: Stability, safety and hope
- GPC England unanimously rejects contract draft & mandates officers return to continue negotiations
- NHSE publish contract on 28 February, committing to impose the contract on 1st April
- GPC England holds a national referendum of members 7th – 27th March ahead of the anticipated imposition

GP Referendum: Report of voting

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Report of Voting

BRITISH MEDICAL ASSOCIATION

REFERENDUM FOR GPS AND GP REGISTRARS IN ENGLAND

CLOSE OF VOTING: 12 NOON ON WEDNESDAY 27 MARCH 2024

QUESTION: Do you accept the 2024/25 GMS Contract for general practice from Government and NHS England?

RESULT	No. Votes	% of valid votes
Yes	155	0.8%
No	18,854	99.2%
Spoilt	0	

Number of eligible voters:		31,036
Votes cast online:	19,009	
Total number of votes cast:		19,009
Turnout:		61.2%
Number of votes found to be invalid:		0
Total number of valid votes to be counted:		19,009

Civica Election Services can confirm that, as far as reasonably practicable, every person whose name appeared on the electoral roll supplied to us for the purpose of the ballot:-

a) was sent the details of the ballot and

b) if they chose to participate in the ballot, had their vote fairly and accurately recorded

All voting material will be stored for 12 months.

CIVICA ELECTION SERVICES

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Where are we now?

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- Last week: ⇨ Letter to NHSE formalising dispute
- This week: ⇨ Letters to ICS leads advising risk register entry
- Now ⇨ Purdah until after May elections Premises Cost Directions
- May/June ⇨ GPCE's and Political Parties' Manifestos
- July ⇨ DDRB followed by Parliamentary Summer Recess
- Sept ⇨ Seasonal Vaccs Programme & Political Conferences
- Oct onwards ⇨ General Election amidst Winter Crisis in the NHS
- Jan 2025 ⇨ New Government, new mandate, 25/26, new contract…

What's our leverage? When can we act? How do we act

Context of wider action

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- Backdrop of unprecedented BMA Industrial Action
- Consultants' new offer
- SAS Doctors have rejected their pay offer by 62%
- Junior Doctors: no obvious progress, continuing strike action
- For GPs – impact of diagnostic waits and elective backlog recovery, outpatient wait whilst GPs deliver more appts to more patients having taken no action then given this offer….

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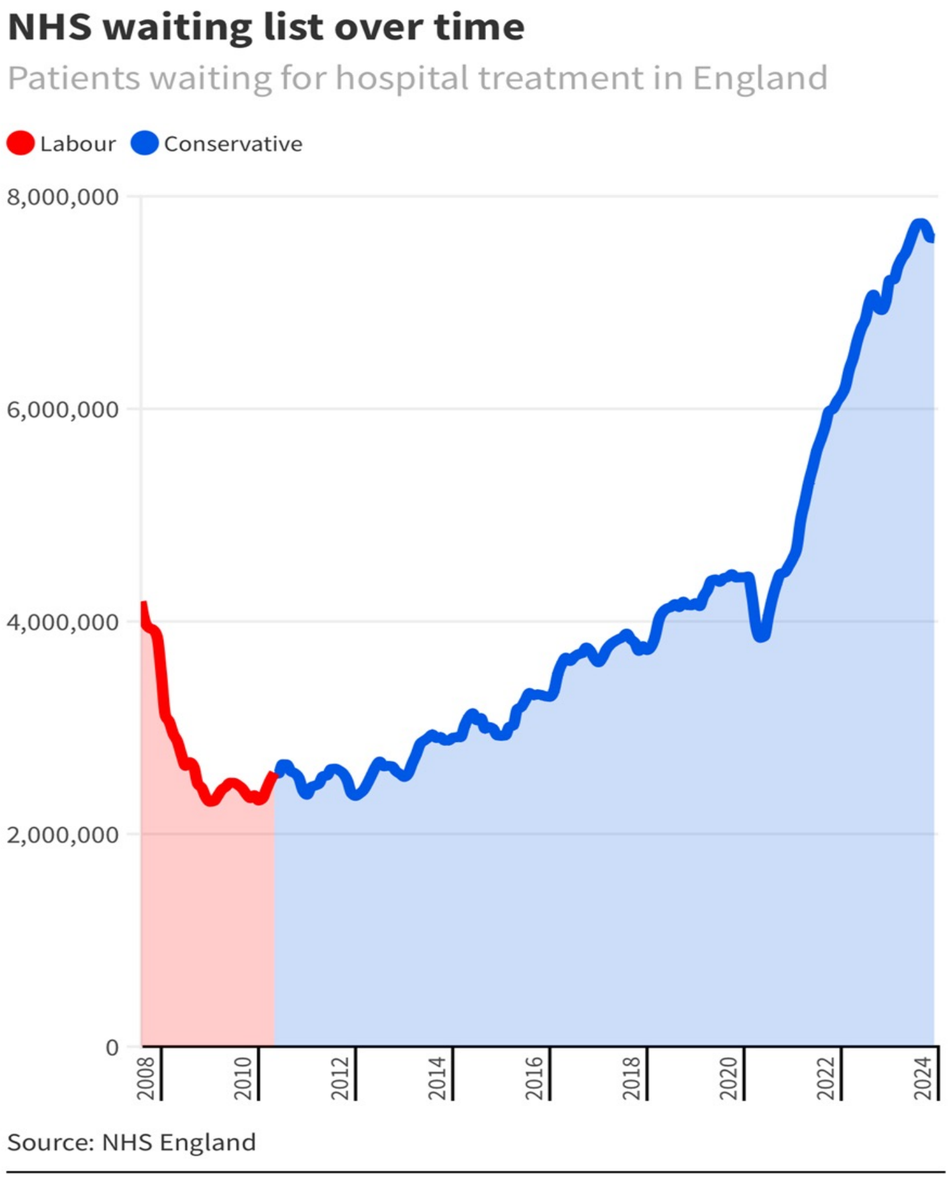
This is our leverage:

We need to learn from Trusts

We need to control the speed of our own hamster wheels



The Status Quo – if we do nothing

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- 17.4% attrition of GP Partners from Practices (March 19 – 22)
- Loss of >1,300 Practices since 2015 & 1000s of GPs
- LTWP figures suggest 4% more GPs, but 49% more Consultants
- 6,000,000 more patients registered compared with 2015
- 1st April: increase in National Minimum and Living wage from April 2024 (9.8% for those under 21)
- Cost of living pressures for ALL practice staff; Utility costs; Inflation
- Increasing competition from other high street employers
- **Constructive dismissal on a national scale**
- **ARRS replacement by stealth**
- **No funding to hire GPs/PNs or recruit additional partners**
- **Starve core and only fund PCN**
- **“Integrated Neighbourhood Team” – Assimilating ‘Primary Care’ into Community Trusts**

GP Contract Dispute

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- GPs are different
- What is TULRCA and why does it matter?
- What is ‘industrial action’ vs ‘collective action’?
- What are our collective demands?
- What are we prepared to risk?
- Who are we negotiating with?
- What strategic leverage do we need?
- What organisational capacity do we have?
- What will work for the majority?

Small actions to protect your daily practice, will lead to impacts at a system, and national level…

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What about DDRB?

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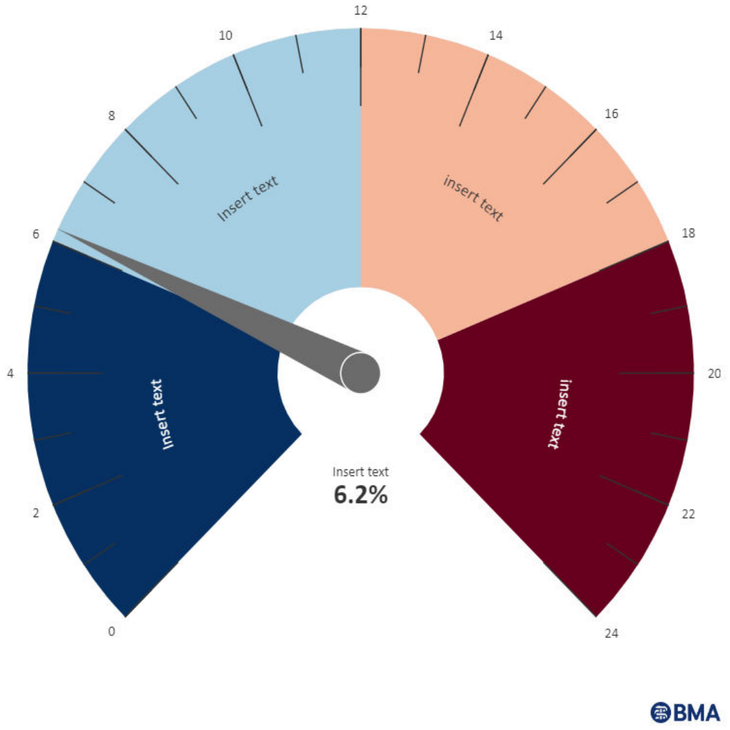
- **Since 2019**
  - CPI inflation increased by 21.2%
  - But Global Sum investment increased by only 12.5%
  - DDRB would need to offer a **full Global Sum uplift of 6.8%** to match the funding practices received in 2019
- **In 2023**
  - DDRB uplifted the ‘other staff expenses’ element (44% of funds) of the Global Sum by 6%, which was then capitated through Carr-Hill
  - This was not enough to fund a 6% payrise for most staff
  - Practices that did were either very fortunate, or took the financial hit themselves
  - We know that comparing Winter 2023 with Winter 2022 partners reported income cut of average 23.5%
  - Money from Covid vaccs Programme has ‘filled the funding gap’ in GMS essential care since 2020 but it’s now run out
- **Reimbursed tariffs have not increased at all, so need a 21.2% uplift to match 2019 funding:**
  - Vaccs & Imms tariff from £10.06 to £12.19
  - Sickness and parental leave reimbursement from £1751.52 to £2122.84

    (currently £1143.06 & £1385.39)

What about DDRB?

- **6.8% (8.7 – 1.9) on everything?** Matches 2019 Funding, but *doesn't lift V&I or SFE*
- **6% on 'other staff expenses'** would be equivalent to 2023
- **2% uplift** is NHSE & DHSC's recommendation
- **Reality - somewhere in between?**
  BUT THAT WILL NOT BE ENOUGH
- We need ***at least 12%*** to safeguard practices' viability this financial year



What do we need from the next Government for 2025/26

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- Maximum flexibility and autonomy in ARRS spend allowing recruitment of **additional GP Nurses & additional GP roles**
- Allow EA appts in core hours for own registered patients to **encourage continuity at a practice level**
- **Ringfence GP supervision** of ARRS staff repurposing funds from elsewhere
- **Restore the core** – transfer CAIP funds & QOF funding into GP Core Contract (cost neutral)
- Increase QOF Aspiration payments to **95%** (**cost neutral**)
- Bring back the **New to Partnership Programme** & **GP & GPN Fellowships**
- Provide ringfenced funds for GP Nurses to have paid parental and sickness leave
- **Occupational Health Cover** provided by Host Trust at ICB level (cost neutral)
- Permit practices to hold **Limited Liability Partnerships** (cost neutral)
- Amend Personalised Care Adjustment (Exemption) rules to allow informed dissent (e.g. MMR) & **not financially penalise deprived/specific communities** perpetuating health inequalities
- Uplift SFE and V&I IOS Tariffs by CPI gap since their inception
- Uplift Global Sum by double % points to provide pay uplifts for staff and Salaried GPs and protect practice viability

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And a new contract?

Cloud-based Telephony Data Sharing

- call volumes
- calls abandoned
- call times to answer
- missed call volumes
- wait time before call abandoned
- call backs requested
- call backs made
- average wait times

From October 2024 data will be used to:

“Provide insight into patient demand and access trends”

“Better understand patterns of demand and surge to inform commissioning of local services”

PCN DES Service Requirements

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This is Year Two of *Supporting transformation towards 'Modern General Practice'* and *Supporting the PCN role within Integrated Neighbourhood Teams (INTs)*

Enhanced Access specification is not changing

Weight Management Service is not changing

The other eight specs replaced by "*one simple overarching specification with greater outcomes-focus*" which allegedly:

- Supports resilience and care delivery
- Improves health outcomes
- Reduces health inequalities
- Targets resources to deliver proactive care

Other changes

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- **Registration:** Introduction of a combined on-line registration process and new paper form will be imposed by October 2024
- Using **Digital Tools for Catchment Areas** - a compulsory digital version of your practice boundary to be maintained
- **Armed Forces Veterans** must have "*due regard for the requirements, needs and circumstances of Armed Forces Veterans when offering services and making onward referrals*"
- **Continuity of care** to be considered when determining the appropriate response when a patient contacts their practice - *think about how you can use this as an exception reporting tool*
- Quarterly submissions to the **National Workforce Reporting Service** (NWRS) for both practices and PCNs ***"rEdUcInG bUrEaUcRaCy!!"***
- **Performers' List Regulation Changes** Covid emergency amendments to allow doctors not on the Medical Performers List (MPL) to undertake primary medical services now being made **permanent.** SAS/Consultants offered within ARRS!
- Any SAS/Consultants in GP setting *"cannot see undifferentiated patients" and "must continue to practice within their sphere of professional competence"* – compare and contrast with Physician Associates..?

Emperor's New Clothes

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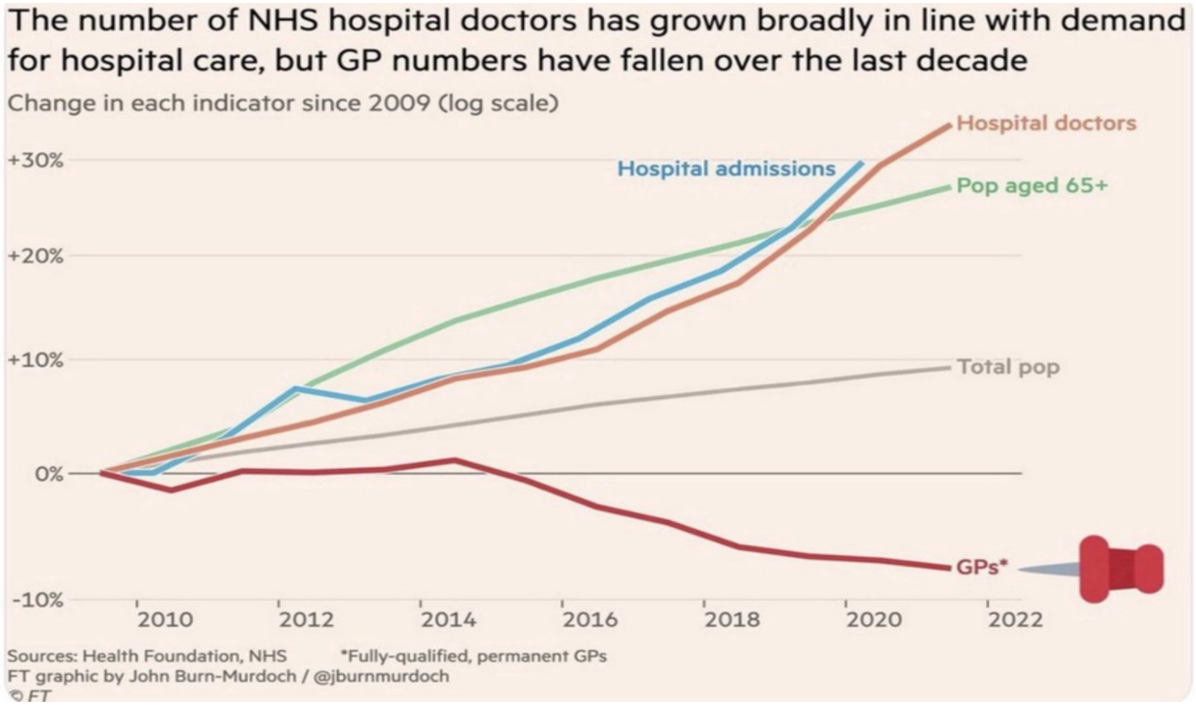
- This is their future – it's not GP-led.
- It is GP-supervised delivery of an integrated primary care model where access trumps continuity.
- Where care is primarily delivered by associate roles.
- Where a primary function of the primary care setting is to absorb work overflow from Trusts.
- It is not evidence-based. It is not what we were trained to deliver.
- We need to fight to protect our specialty, our profession and our future.



Near retirement? Even more reason – you will need a GP as you get older.

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GP Action

- Different to other branches of practice
- Public-Facing Narrative - Build on Trust, Repair the Toxic damage
- Impact NHSE and Government, not our Patients
- Bring the Profession with us - ICBs, CQC and risk
- Marathon not a sprint
- Must be Partner-led, involve the whole practice team & PPG

All sorts of possibilities open to us which would not pit us against our patients, and which, if undertaken under the legal protection of the BMA, would not lead to contractual action eg:

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- 👉Who/how we admit
- 👉Who/how we refer via eRS
- 👉Whether we engage with A&G
- 👉Whether we switch off data sharing agreements
- 👉Serve notice on all shared care agreements - no capacity to deliver
- 👉No proformas - just write a letter
- 👉Stop rationing and risk holding patient requests for referrals
- 👉Give a platinum level of service to the max 25 pts you see a day

- If we did this 👆imagine the impact.... 1.39million patients a day

NHS waiting list over time

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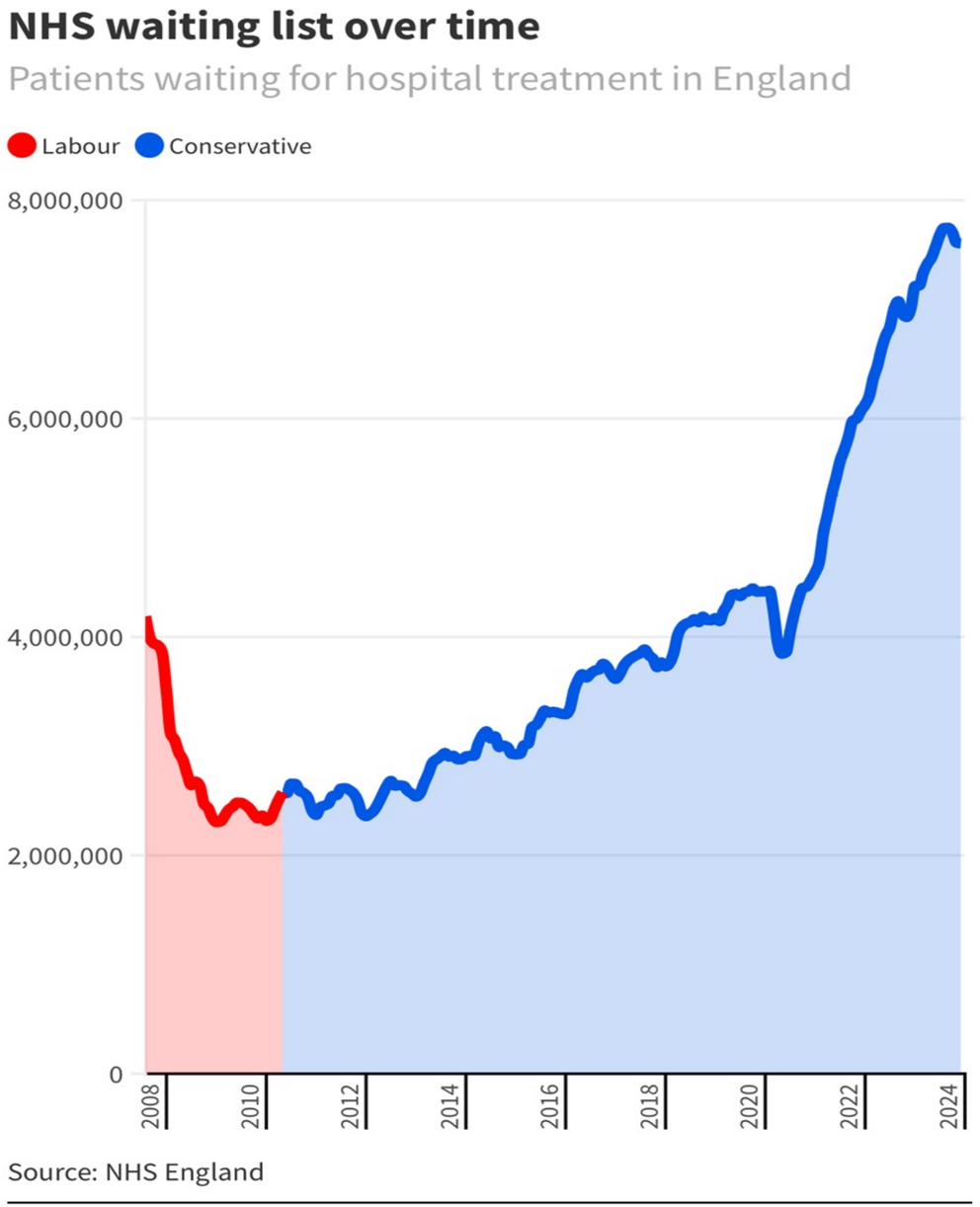

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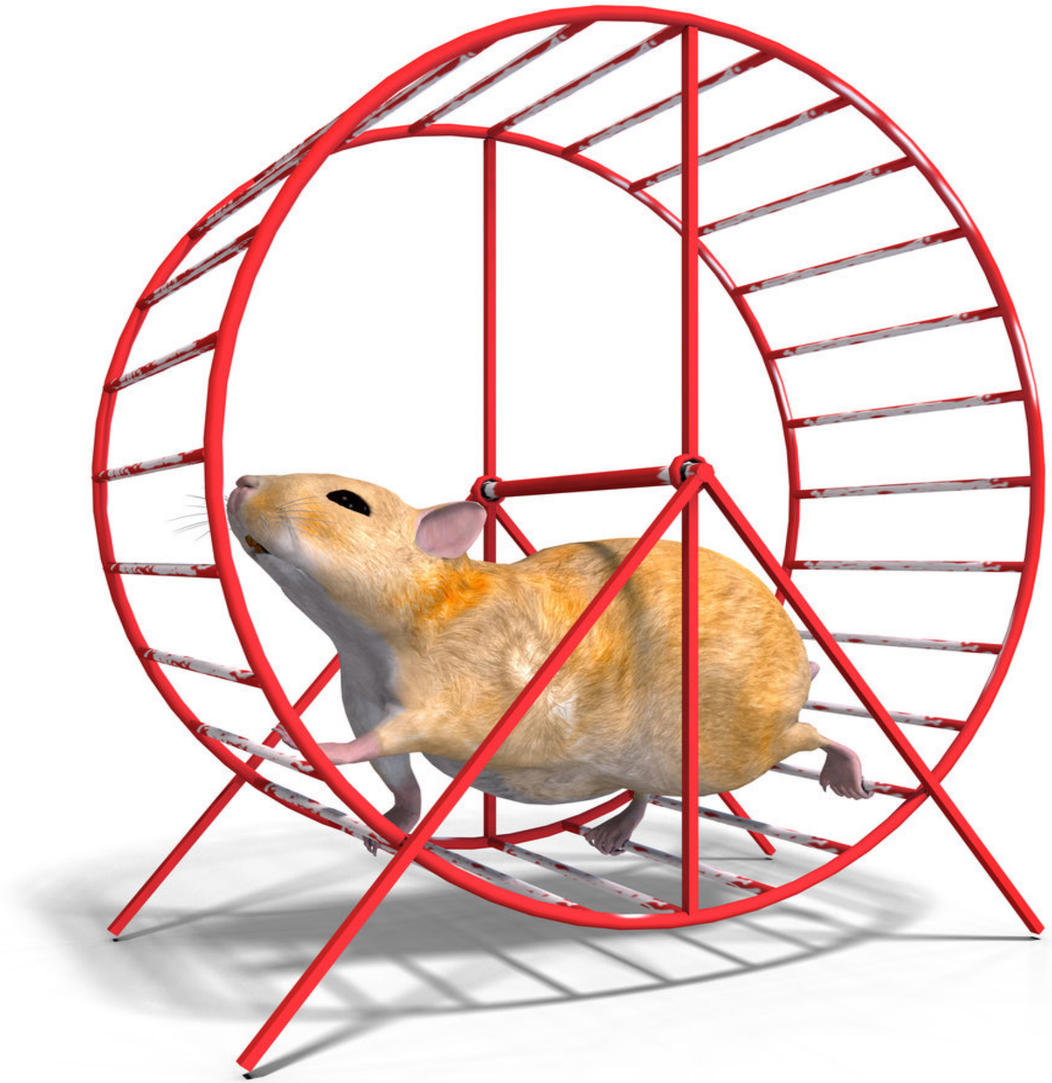

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Check BMA website for FAQs and updates

- Regional Roadshow Peterborough July
- Webinars
- Membership Offer
- bma.org.uk/gpcontract

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Local focus – funding & commissioning

Alice Benton – Interim Chief Operating Officer

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Tracking allocation & spend

- Role of LMC in tracking recurrent and non-recurrent funding for general practice
- Variety of sources
- Budgets are often drawn from multiple allocations
- Clearer picture of funding disparities, uneven distributions and underspends

ICB allocations 2024/25

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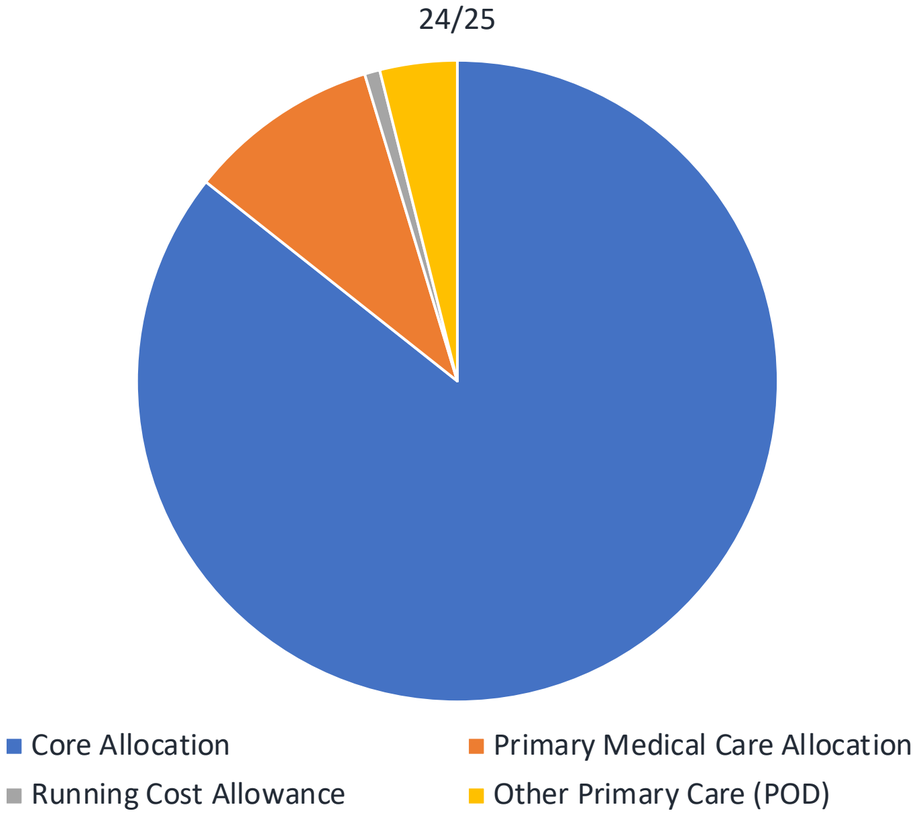
ICB Allocations	24/25	£ per head
Core Allocation	£1,568,049,000	£1534
Primary Medical Care Allocation	£177,043,000	£173
Running Cost Allowance	£14,098,000	£14
Other Primary Care (POD)	£71,317,000	£70
	£1,827,886,000	£1791
Baseline population	1,022,196	
Primary Medical Care Allocation as a % of total allocation	9.69	



Source: https://www.england.nhs.uk/publication/allocation-of-resources-2023-24-to-2024-25/

ICB allocations 2023/24 comparisons

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23/24	£/head (core)	£/head (GP)
England	£1643	£171
East of England	£1585	£169
Cambridgeshire & Peterborough	£1484	£165
Norfolk	£1730	£191

24/25	£/head (core)	£/head (GP)
England	£1,732	£180
East of England	£1,672	£177
Cambridgeshire & Peterborough	£1,534	£173
Norfolk	£1,820	£199

C&P population adjustment, weighting factor of 0.884 reflects measures of lowest need in England and contributes to ongoing and historic low funding

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Sources of funding for General Practice

- Delegated primary medical services budgets
- Local ICB discretionary investment
- NHS England Programme budgets
- Place-based investment
- Public health / other system partners
- Capital

General Practice budgets

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Primary Medical Services budget

- Core contract payments (GMS, PMS, APMS)
- PCN Payments
- Other DES and enhanced services
- Premises reimbursements
- QOF
- Dispensing and prescribing fees
- PMS re-basing

ICB direct allocation

Local budgets

- Locally commissioned services
- Quality initiatives
- ICS funding to offset delegated commissioning budget shortfalls

ICB Core allocation

Programme budgets

- Primary care IT
- System Development Funding investments

Separate programme funding

Public health

- NHS Health Checks
- LARCs

Local Authority Budget (wider ICS)

Place-based investment

- e.g. integrated neighbourhood initiatives, high intensity user programmes

From ICB Core allocation

Local commissioning

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Local budgets (23/24)

- Locally Commissioned Services (£10,634k- £6,183k= £4,451k)
- ICS funding to offset delegated commissioning budget shortfalls (£4,243k)

Reinvestment of funding released through the PMS rebasing exercise

Discretionary investment of c. £4.5m

Rolled over for 6 months into 24/25, pending review

Impacted by insufficient delegated funds that need to be topped up from ICB funding. Gap gets wider year on year.

The LCS Roll-Over 2024/25

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- Commits funding for the first six months of 24/25
    - Core +
    - Medicines Optimisation
    - DVT (Peterborough only)
    - Diabetes
    - Complex dressings
    - Nursing home beds
    - Safeguarding
    - *NEW* COVID-19 Pharmacological Treatments in General Practice
    - Total = £9.64m (FYE)

  Investment relating to Population Health Management projects (£1.00 per weighted patient or £0.98m) – not commissioned at this stage but investment is promised later in the year

What is in the LCS Framework?

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Core Plus

- ✓ Minor Injury
- ✓ Anti-Coagulation/DOAC initiation & monitoring
- ✓ High Risk Drug Monitoring
- ✓ LHRH Analogue Injections
- ✓ Denosumab Injections
- ✓ Phlebotomy
- ✓ Treatment Room
- ✓ Depot Antipsychotic Injections
- ✓ 24 hr ECGs Monitoring
- ✓ 24 hr BP Monitoring
- ✓ Medicines Optimisation Objectives

Separate services

Using ICB local discretionary funding, the services included in this section are listed below:

- ❖ Diabetes Management
- ❖ Complex Dressings
- ❖ DVT (Peterborough only)

GP Practices will receive a single fixed guaranteed income budget for 6 months, based on 2023/24 budgets.

Separate funding arrangements

- ❖ Nursing home beds
- ❖ Safeguarding reports
- ❖ Covid-19 Pharmacological Treatments

What the review will likely cover

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Focus on:

- Higher cost services
- Services with greatest geographical variation
- Services with activity changes
- Wider system impact
- Funding from other parts of the system
- Commissioning gaps

Variations in funding

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	GMS (21/22)	
	Average price per registered patient £	Average price per weighted patient £
Highest	304.19	293.58
	337.12	288.51
	100.41	127.28
Lowest	88.24	127.36

Average across 71 GMS contracts = £179.69 / weighted patient

31 practices under £165, 40 practices over £165

LCS Earnings (22/23)
Range of £4.23-£18.34 in income / pt
Average £8.34/pt
20 practices earned <£6/pt
5 practices earned > £12/pt

Average income per practice was £97,134, with highest practices at almost £400k and lowest at less than £20k.

Impacted by list size, age of population and prevalence

Leaving no stones unturned…

- Review 24/25 budgets
- Monitor impact of changes to Locally Commissioned Services and how this will inform in-year review and beyond
- Prepare for levelling up discussions – based on population health
- Confirm mapping of allocations and track spend against programmes
- Continue to work with LA and Place commissioners to better monitor existing budgets and track potential funding opportunities
- Continue to scrutinise NHS E allocations, ICB reports, wider system planning and investment.

Practice considerations

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Know what you are commissioned to provide

Know what you are paid

Know what it is costing you to deliver

Know if it is financially viable to continue

What does the ICB say?

"GP Practices are encouraged to explore alternative models of delivery that makes best use of their workforce and skill mix. This approach will also support some services to remain financially viable for practices to make available to their patients, as it presents an opportunity for practices to consider whether a service is best delivered at either Practice, PCN or GP Federation level, with the opportunity for any efficiency savings to be reinvested back into practice(s)."

Help us to ensure that the local commissioning works for local practices.

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Wellbeing and resilience & how the LMC can support you

Dr James Booth – Medical Director

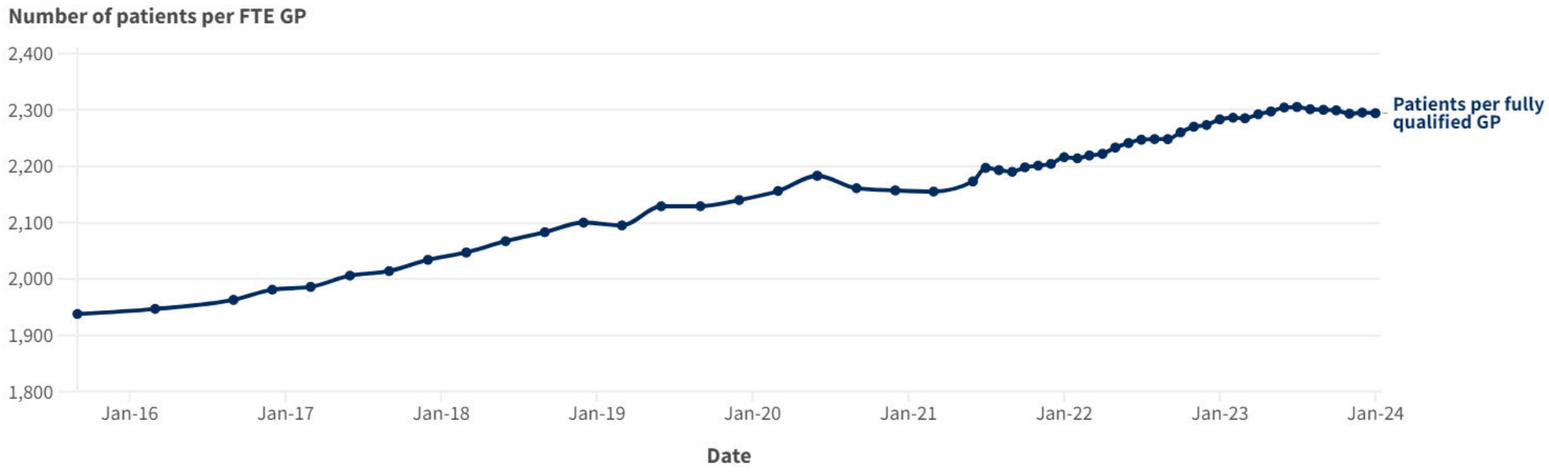
GPs are in distress

We are working harder, for more patients, with fewer doctors

- This is a downward spiral
- We are working in a system that feels like it is collapsing

The NHS has lost the equivalent of 1,862 full-time fully qualified GPs since 2015.

Source: BMA analysis of NHS General Practice Workforce data.



3.5 Million Patients…

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This is how many patients in England have lost ‘their’ GP going by the ratio of a decade ago…

That’s a combined population of Cambridgeshire & Peterborough **three times over.**

We experience moral injury

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Moral injury can occur when

- *someone engages in, fails to prevent, or witnesses acts that conflict with their values or beliefs.*
- *when they experience betrayal by trusted others especially when this is perceived as avoidable, or they are powerless to change it.*

- **We make constant compromises when providing care**
- **We pick up the pieces when the system fails**
- **We act as a “capacity sponge,” and a risk-sink**

We feel overlooked and under recognised

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We each go to work to do our best for our patients

- **But we work in a local and national context that feels indifferent or hostile to us**
- **Doing our best takes longer, requires more effort**
- **Our own sense of personal responsibility is challenged by factors outside our control**

The imposed model of working worsens this

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We are pushed increasingly into new ways of working:

- The Fuller Stocktake
- The PCN DES
- Modern General Practice Access

- We are being moved away from our traditional, valued role
- We are losing continuity of care
- We are seeing the personal connections with patients be diminished and that impacts on patient trust and experience

And patients do not want it!

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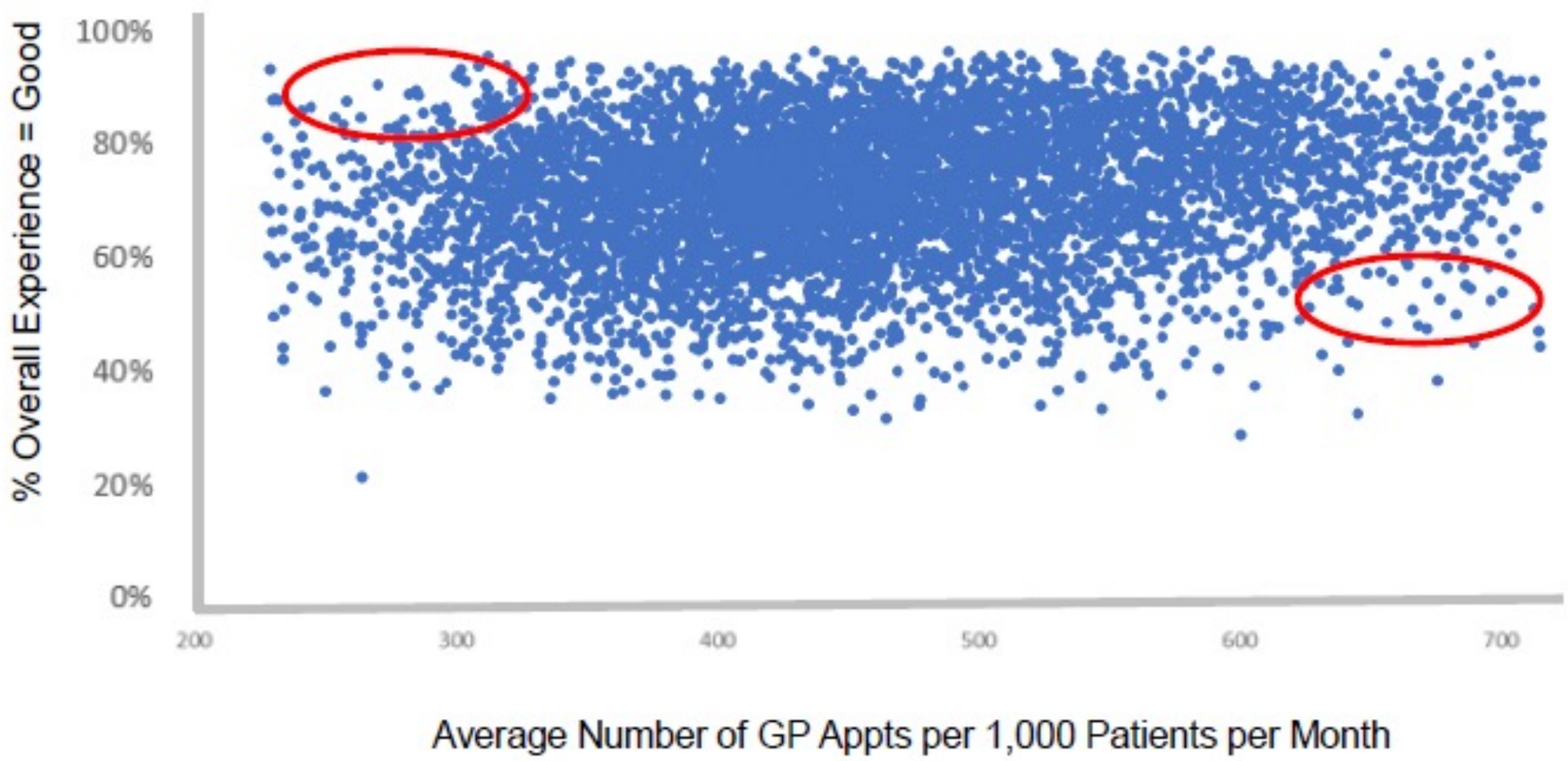

Source: Beds & Herts LMCs

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New ways of working…

Where is the evidence?

Where are the outcomes?

- Access
- Prescribing
- Apathy
- Moral injury
- Stress/burnout
- Tasks
- Errors

- Curiosity
- Care
- Outcomes
- Continuity
- Patient satisfaction
- Professional satisfaction

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What does the LMC do?

Represent

- Your voice to the wider NHS
- Negotiating on your behalf
- Liaising with LMCs regionally and nationally

Support

- Confidential pastoral care and burnout
- Partnership/regulatory issues
- Complaints

Advise

- Service provision & interface management
- Contracts/local commissioning
- PCNs

How can we help?

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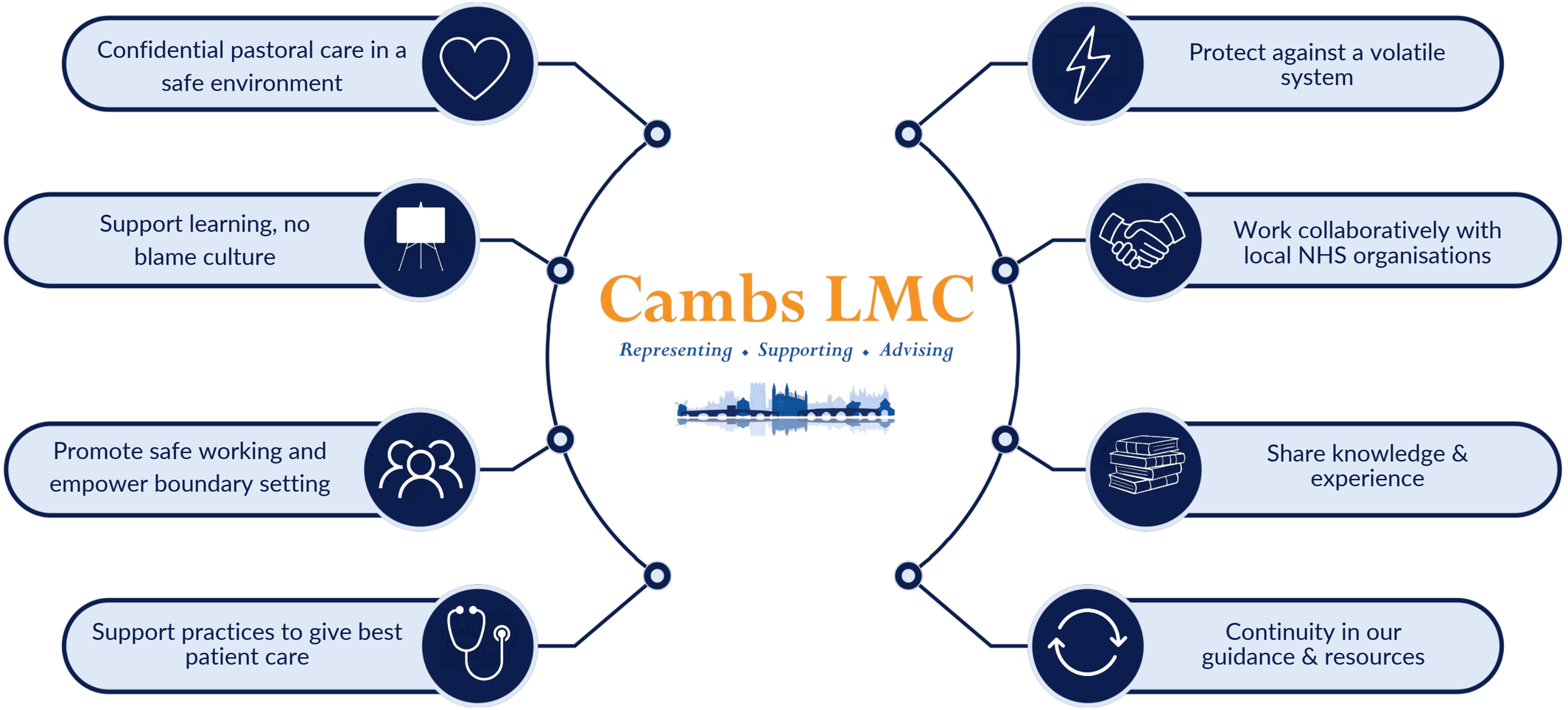

How can we help?

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- When an aircraft is in trouble, the advice is always put your own oxygen mask on first.

- The LMC is there to hand you the mask, the tank, and say **‘STOP, breathe’**!

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Questions?

Thank you

Close

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