Special Conference of England LMC Representatives

Sheffield LMC

WEDNESDAY 11 MARCH 2020

SHEFFIELD LMC ATTENDANCE: Alastair Bradley Mark Durling

BACKGROUND

Following NHS England's (NHSE's) publication of their proposed specifications for the 2020/21 contract, including the Primary Care Network (PCN) Directed Enhanced Service (DES) on 23 December 2019, there was universal condemnation of the document. This led to many LMCs across England recommending the proposal be rejected. In January 2020 the General Practitioners Committee (GPC) rejected the contract and called a Special Conference in March.

In the meantime, NHSE heavily revised their proposals, which were subsequently accepted by the GPC, but the Special Conference had already been agreed. Although the contract for 2020/21 appeared more acceptable, the direction of travel indicated by the initial proposals has raised significant concerns about future workloads from extended hours, new specifications and "left-shift" from hospital. Proposals beyond 2024 were also uncertain.

The conference, therefore, received a significant number of motions on all parts of the contract, which are highlighted below.

MOTIONS

Contract Negotiations
Conference approved that the contract agreement has been "mis-sold" as a 5 year deal when it is in fact still an annually negotiated settlement, and a vote 74-62 confirmed conference did not feel the GPC should have agreed the contract knowing they had called the Special Conference. However, conference still supported the GPC as the sole negotiator.

Pay Transparency
Conference was told that the contract proposal to name GPs earning more than £150k was an NHSE negotiating RED LINE. As this has nothing to do with patient care conference considered this to be anti-GP rhetoric and proposed that publication of earnings anonymously by age, gender and Health Education England (HEE) area would provide more useful information.

Partnership Incentives
Conference asked the GPC to negotiate that the £20k was also made available to returning GPs, tax free, although practices need to be careful of the 1995 pension control total.

Quality Access Scheme
There was debate as to what this actually was but conference supported longer consultations, valued continuity of care and should refuse further access requirements until new capacity is in place to meet this demand.

Extended Access / Out of Hours
The GPC made it clear they wanted conference to support a motion that said it was a red line for us that PCNs should not have responsibility to deliver out of hours care. Conference duly obliged.

PCN DES vs Core Contract
Conference made it clear that the PCN DES should always remain a DES, separate from the core contract. There needed to be a financially viable option for practices who did not want to partake in the PCN DES and any changes to the DES must not negatively impact core GMS funding. Conference called for the priority area for investment to be in the core contract, not the PCN DES.

PCN Opt-out

Two clauses of the new contract raised concern:

1. **Clause 9.5:** *To ensure that the whole of England benefits from the investment and service improvements that PCNs offer, CCGs must ensure 100% population coverage of PCNs. Existing practices have guaranteed preferential rights. But where they choose to opt-out,* ***arrangements for alternative provision of core GMS with network services will automatically apply.***

   Conference asked that this was reviewed urgently to ensure there was no link between Core contract and the PCN DES, and there was no possibility of removing core contract elements from practices who opted out.

2. **Clause 9.7:** *Where agreement between a practice that wishes to sign up to the Network Contract DES and a PCN is difficult to secure, CCGs, with their LMC, will, as has been the case this year, support the parties involved through mediation to come to agreement on the practice joining the PCN. We will introduce from April 2020* ***the ability*** *for CCGs, in the unlikely circumstances that agreement cannot be secured through the mediation process,* ***to assign such a practice to a PCN****. This will require the CCG to work closely with the LMC on the decision given its sensitivity.*

   Although the GPC said this was to ensure a practice wishing to take on the PCN DES could do so, conference felt this was too damaging to existing PCNs and could potentially destabilise a whole PCN.

PCN Workload
Conference asked the GPC to remind NHSE that the new workforce being recruited is to support current workload and not to manage a shift of workload onto PCNs. Clinical Directors (CDs) are already struggling with the primary care workload.

Care Homes
It was recommended that this part of the contract be renegotiated to increase the premium. The contract should cover per patient not per bed and consideration should include managing the frail elderly at home.

PCN Modelling
Concerns were raised that PCN modelling had not been carried out prior to the implementation of the DES and so we had little knowledge of how they would progress and workload implications. Conference felt that sign up to the DES should be extended until October 2020 to allow for modelling to be carried out and published. There was also concern that many specifications were dependent on new recruitment and so should be delayed for 12 months until new staff were in post.

Investment and Impact Fund
This is a PCN level monitoring rather than practice based. This raises the problem of practices within a PCN performance managing each other. It was considered this was better done at a practice level with the PCN agreeing how to split the funds dependent on results. However, the funding could only be used on staff recruitment with CCG approval anyway.

Additional Roles Reimbursement Scheme (ARRS)

This was a themed debate with many contributors. The themes were similar to those raised across Sheffield and the recent PCN CDs Conference:

- It is extremely bureaucratic and time consuming.
- There is no time allocated for training.
- It creates considerable extra time to supervise staff and train them.
- There is a lack of workforce to recruit.
- Sick leave and parental leave have not been resolved for ARRS roles.
- Some staff may have qualifications but not training in primary care. An example was given of taking 2 years to train a Physician's Associate (PA) in primary care.
- Baseline staff are already employed doing this type of work but are not reimbursed and can create problems for PCN funding if they leave.
- It was felt that many of these roles did not reduce workload due to the supervision required and limitations compared to GPs or Advance Nurse Practitioners (ANPs).
- One solution is to use ARRS funds to employ staff at practice level rather than across the network.
- Premises - where to house all these new staff?

There was also a resolution passed to demand that ARRS underspend cannot be passed into CCG baselines and that funds identified for each PCN should remain for that PCN to use. London weighting for ARRS roles was passed.

Tax Advice

There was unanimous agreement that the confusion around tax and VAT was hampering progress and should have been resolved before PCNs were approved. The conference particularly wanted proper tax advice and clarity for PCNs to be funded centrally by NHSE. It should not be left to PCNs and £1.50 per head was inadequate.

PCNs as NHS Bodies

A motion proposing consideration be given to enabling PCNs to become NHS Bodies was defeated as this would create problems for practices within PCNs - direct commissioning with PCNs by-passing practices could occur.

Future of PCNs

The final motion was the most debated as it considered the threat posed to the independent contractor model of the current PCN DES. Again concerns were raised about the impending workload transfer from secondary care and the need to invest directly into core funding of general practice. There were also worries over CCG wishes to transfer all Locally Commissioned Services (LCSs) and DESs from practice responsibility to PCN responsibility. Conference asked the GPC to urgently survey the profession on intentions around the PCN DES sign-up.

The final part of the motion stated: *(v) the profession should reject the PCN DES as currently written.* This was passed 83 for, 53 against.

SUMMARY

The whole tone of the conference was one of major concerns for implementation of the PCN DES and the extra workload that will be incrementally passed to PCNs. It was considered this was not how we were sold the contract. The final motion did not reject PCN working outright but did mandate the GPC to go back to NHSE, highlight all our concerns and negotiate a different PCN DES that the profession could actually deliver and did not pose threats to practices or core contract activity.

DR ALASTAIR BRADLEY
Chair