

**Cheshire Local Medical Committee Ltd**

**A Practice Guide to the Parliamentary Committee Looking into the Future of General Practice**

A resource for practices

29 November 2021

This is a Guide developed and issued by Cheshire LMC.

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**Briefing Headlines**

You may have just heard or read the news regarding the announcement that the House of Commons health and social care committee has launched an inquiry into the future of general practice, declaring that it is ‘in crises! It goes on to say “general practice has seen significant changes in recent years, such as the development of Primary Care Networks, and during the pandemic the way in which many patients interact with their local practice has changed substantially. This inquiry will explore specific issues including regional variation in general practice, the general practice workload, and the partnership model of general practice.”

<https://committees.parliament.uk/work/1624/the-future-of-general-practice/>

For those in a hurry here are some of the basic headlines –

* Published on 16 November
* No consultation with the BMA
* This review will impact every GP, their staff and practice development irrespective of contract status
* A stated aim is “making general practice more sustainable in the long term”
* It also mentions “the sustainability of the traditional partnership model given the

workforce crisis, prioritisation of integrated care, and the move towards salaried GP

posts”

* It will look at whether or not current GP contracting and payment structures support ‘proactive, personalised, coordinated and integrated’ care’
* It will consider whether or not PCNs have improved this kind of care and reduced the admin burden on GPs
* It will also ask of general practice can work in effective partnerships with other job roles in primary care and beyond to free up more GP time for patients, and to what extent

In short it will look at the key challenges facing general practice over the next five years as well as the current and ongoing barriers to access to general practice by patients.

Whilst your LMC will be reviewing the detail individual GPs and practices are encouraged to do likewise.

Evidence can be submitted here

<https://committees.parliament.uk/work/1624/the-future-of-general-practice/>

Written evidence should be no more than 3,000 words.

Former health secretary Jeremy Hunt, will chair the committee.

**William Greenwood**

**Chief Executive Cheshire LMC**

[WGreenwood@cheshirelmc@org.uk](mailto:WGreenwood@cheshirelmc@org.uk)

**LMC View**

Over recent months Cheshire LMC has ben discussing, and reacting to, the current workforce and workload issues impacting our practices and PCNs. Whilst we have had some local successes negotiating changes and funding this is a national crisis.

What would you wish to see happen to improve working in general practice and the care that you can provide patients? We really want to know your alternatives to, or in addition to industrial action (as currently being considered by the BMA), and what you want to see from Cheshire LMC next - whether you agree with the LMC or BMA/GPC approach. This House of Commons announcement is your opportunity to provide comments and thoughts but please do try to include some constructive suggestions and actions amongst any barriers!

Things that have been considered by Cheshire LMC or mentioned to us following the recent BMA/ GPC communications: -

• Reduce negativity/increase positive voice and media (#MAKEGPGREATAGAIN!)

• Better leadership from GPC and LMC empowering people to say no

• Support for PCNs (range of views but positive outweighing the negative with call to

assist with NHSE control/burden work to allow PCNs to flourish and be maximised)

• Ability to use ARRS staff better and broaden their use but recognise some patients

want GPs!

• Reduce admin burdens and data collections (e.g., stop QOF for this year)

• Reduce financial dependency on over burdensome little value specifications

• Locally little appetite for industrial action

• Educate patients….and government!

• Define (and properly cost) general practice role, define what is primary and

secondary care for patients so they understand roles, and define capacity/cap on

safe practice/daily consultations (requires overflow). Stop bucket style approach to

commissioning

• Mixed views on online consultations

• Patients first/ no desire to compromise patient care

• Talk to us (jobbing GPs)!

• Reliable IT support

• All practices working together/consistent approach in media messages (national)

• Stop workload shift from secondary care and/or ability to return if workload too

much

**This review is a call for evidence, and anyone can respond. Deadline is 14th December.**

You should consider enlisting commentary from your **patient participation groups** about why they like and need the continuity that is provided by the independent contractor model; and from salaried GPs as to why they would prefer to work for a GMS partnership of GPs than a Primary Care Organisation or commercial organisation, and from GP locums as to what kind of environment would bring them back into a substantive practice role.

We need to spell out the financial and clinical efficiency plus the patient safety aspects of the kind of practice NHSE (and Dept of Health and Social Care) are trying to break.

**Some Interesting Conversations**

**Here are some thought pieces currently circulating between Cheshire LMC members. Why not send us your thoughts, view, and suggestions?** (Colours relate to different inputs, questions or replies)

1 Legislate to make PCNs legal entities thereby enabling them to employ staff, receive resources directly and hold contracts. ​

Could be a significant threat to the practice partnership model?

I do not want PCNs to become legal entities with employing ability- anymore than the Confederation should be. That would lead to the rapid demise of GP practices.

There are too many layers between patients and government as it is- let’s not ask for another.

2 SoS to make a Direction that would allow PCNs to be the preferred provider for any GMS contracts that previous partners want to relinquish.

Could help retain GMS contracts (in perpetuity) APMS/PMS were/ are all expected to have end dates i.e., 3/5/10 years etc. APMS allows non-GP contract holders such as Acute Trusts or private sector to hold the contract.

3 Develop a premises strategy similar to that in Scotland whereby the system absorbs partners’ risks.

If GPs do not own the premises they are largely at the mercy of the owner (i.e., NHS Property Services). Capital is not the real issue impacting improvements it is the revenue consequences. In Cheshire at present the tri-annual rent reviews add £2m to the Cheshire baseline cost every 3 years.

4 Facilitate mergers of PCNs (where they wish to do so) allowing them to strengthen their position in the emergent ICS world.

Whilst I don’t know if the Government would legislate to make PCNs legal entities (I think unlikely for a few years yet – if at all) but they could issue a Directive, via SoS, to increase the ‘normal’ PCN size i.e., 100k – 200k population.

​Points 1,2, 4 - Choice and flexibility are important with these points. I recognize that further integration/expansion of PCN responsibilities could be seen as a threat but currently locally at least PCN's seem to be in favour. I think we should be guided to a degree by what members want. The pending BMA indicative action results will be insightful.

I agree we should go with member wishes but I think the LMC should be more proactive at getting out messages to inform members of options/ possible consequences more often. Perhaps we need to be more active at the Place based membership for a in future? Might need more active involvement by LMC members too.

Point 3 - I would be interested to know from colleagues how they feel about the estates risk and is it such an issue for them? Many will have a vested interest in keeping their estates (assuming its profitable). As I am in leased premises, I would probably prefer to not have the risk, but am uncertain what level of control I would lose if the system had more control over it.

Largely risk is around last ‘man’ standing issue. There is also something of an issue where former partners or their families own leased premises and decide to sell them (subject to some protection in landlord/ tenant legislation)

5 Facilitate management and leadership training specifically aimed at new GPs in order to produce a new wave of Clinical and Medical Directors with system wide ambitions.

Probably something the Enhanced Training Hub will lead on anyway. Funding from NHSE and NW Leadership Academy.

6 Develop a career pathway for GPs within the ICS allowing part time and portfolio working and support through mentoring and coaching.

I think ICS structure will have a life span of maybe 5-7 years. Already it is starting to feel remote from front line GPs. Largely driven by NHSE/Dept of Health and Social Care agendas i.e., target driven. Will want action plans from Place Based Commissioning structures – who in turn may look to PCNs (PCNs will need to understand the big picture asks).

Do enough GPs have an idea what sort of leadership roles there might be? Will such GPs become remote from their colleague’s day to day issues?

7 Develop a career pathway for PMs and GPNs to do likewise (including the portfolio element).

I think there is a growing gap in who speaks for PMS/GPNS and the ARRS staff. No one seems to be addressing this issue. I don’t sense our LMC is inclined to do so but I think (and always have) that we should have one or two PMs and GMNs on the LMC even if in a non-voting capacity. We have offered ‘leadership’ training to both groups in the last 2-3 years but we don’t have the staffing resource to do much on an annual basis unless we team up with other organisations i.e., C&M LMCs or Enhanced Training Hub (our current preferred option).

​5,6,7 - yes

8 Underpin the partnership model to promote greater continuity of care.

​The partnership model seems to come in many different guises, I am not sure all of them promote greater continuity of care.

Agreed but continuity of care was the single biggest basis for complaints against GPs in the 12 years I either managed it or had oversight of complaints. It is one of my biggest concerns as a patient.

9 Create an appropriate support offer for patient groups to play a wider role within PCNs in terms of their population’s health.

​Patient representation within the population health can and should add value, CDs may caution this due to the potential increase in workload.

Agreed – likely a central plank in future DHSC thinking and it would most likely increase workload unless GPs come up with a ‘work smarter not harder’ approach.

10 Create an offer to encourage the establishment of new GP practices (not mergers or the like).

​This has the potential to cause conflict, caution would be required. Is there a workforce?

No, there is no short-term workforce fix unless you up skill (and supervise) other groups which has its own workload issues. I can see some villages and small towns ending up with only one or zero practices in a few years’ time. That would cause problems with allocations as a knock-on impact.

11 Re-establish the national Medical Practices Committee model to establish ‘designated areas’ which would attract additional practice level investment (designated area allowance)

12 Create a new Group Practice Partnership Allowance scheme at practice level with suitable criteria

​11, 12 - I don't have experience with these and will have to do some background reading to be able to comment further.

Unlikely to happen but this was a national panel (made up largely of GPs) which regulated the establishment of new practices and also controlled the entry to the (what is now) the local Performers List in areas which were seen as over doctored. Likewise, they could designate some under doctored areas as ‘Designated’ (type one and two) which attracted a premium for each GP in that area of several thousand pounds. I think there were several classifications from memory –

Open – any doctor could apply and approved automatically. The majority of England.

Closed – no extra doctors needed so likely entry refused. This was largely applied to areas such as central London.

Intermediate – neither under or over doctored so each application treated on merit. This was a band between the first two. Not very many of them at any one time.

Designated (type 1 and 2) Under doctored and would attract one of two levels of extra payment for each and every doctor in the area. In the 70s and 80s much of NW England fell into these bands.

The main criteria was average list size of GPs in that area (areas were often 100k population size and there was a suggest 1800 patients per wte GP).

**General Thought Pieces**

The inquiry into general practice will cover a range of issues (you can find the full terms of reference [here](https://committees.parliament.uk/call-for-evidence/632/)), but it includes regional variation in general practice, general practice workload, and the partnership model of general practice. Key questions include

* **Is the traditional model of general practice sustainable given recruitment challenges, the prioritisation of integrated care, and the shift towards salaried GP posts?** and
* **Has the development of PCNs improved the delivery of proactive, personalised, coordinated and integrated care and reduced the administrative burden on GPs?**

The Inquiry has come at a point where there has been considerable media and public attention to the challenges around access to general practice, and is also hot on the heels of the announcement of a ballot for industrial action of GPs by the BMA in response to NHS England’s recent publication on improving access and support for general practice.

The Chair of the Health and Social Care Committee is Jeremy Hunt.  Jeremy Hunt appears to be enjoying his role as a backbench GP, able to chair this committee from a position of considerable knowledge, particularly in terms of how he can make life as uncomfortable as possible for the government.

The more cynical will assume this is a back door attempt to end the independence of general practice and shift practices into the main body of the NHS, or conversely to privatise things further by shifting all remote and telephone consultations to digital first providers to “reduce pressure” on practices.  Finally, it does seem odd to want to look at the partnership model of general practice only a few years after the [**2019 review by Nigel Watson**](https://www.gov.uk/government/publications/gp-partnership-review-final-report), the cross party nature of the committee, along with the methodology of collating evidence from as wide a group of experts as possible, does make this seem unlikely.

**We would encourage you to submit your views direct to the Inquiry by 14 December (see how to in the text). Please consider Sharing your views with the LMC at** [**WGreenwood@cheshirelmc.org.uk**](mailto:WGreenwood@cheshirelmc.org.uk)

**Related Reference List**

**House of Commons Announcement**

**NHSE/I Our plan for improving access for patients and supporting general practice**

[BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf (england.nhs.uk)](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/10/BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf)

**BMA Workload Control in General Practice**

<https://www.bma.org.uk/media/1145/workload-control-general-practice-mar2018-1.pdf?utm_source=The%20British%20Medical%20Association&utm_medium=email&utm_campaign=12741476_GP%20ENEWSLETTER%202>

**GP** **Partnership Review (NHSE/ Dr Nigel Watson)**

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf>

**Understanding Pressures in General Practice (Kings Fund)**

<https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf>

**Pressures in General Practice (Kings Fund)**

<https://www.kingsfund.org.uk/projects/pressures-in-general-practice>

**Measuring General Practice Productivity (Kings Fund)**

<https://www.kingsfund.org.uk/publications/measuring-general-practice-productivity>

**Primary Care Networks (BMA)**

<https://www.bma.org.uk/advice-and-support/gp-practices/primary-care-networks/primary-care-networks-pcns>

**Primary Care Home: Evaluating a New Model of Care (Nuffield Trust)**

<https://www.nuffieldtrust.org.uk/research/primary-care-home-evaluating-a-new-model-of-primary-care>

**Primary Care Estates Guide (NAPC)**

<https://napc.co.uk/pcnestatesguide/>

Cheshire LMC is a member- based organisation, independently funded by its member practices. It is the only representative voice in the local NHS that is recognised by statute. We exist to represent and support you. To do that we always welcome your views, ideas and concerns.

Cheshire Local Medical Committee Ltd

The Weston Centre Weston Road

Crewe Cheshire

CW1 6FL

Tel: 01244 313 483 Email: [WGreenwood@cheshirelmc.org.uk](mailto:WGreenwood@cheshirelmc.org.uk)

Website: [www.cheshirelmcs.org.uk](http://www.cheshirelmcs.org.uk)

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