LMC England Conference breakout group summaries - 24 November 2023

Dissecting care breakout group

The purpose of the breakout group was to raise awareness of the issues surrounding the separation of planned and unplanned care. Discussion focused on the impact of this separation on the patient, the GP, and the system. The issue was debated in Motion 17 (i-iv – Lost, v – Carried)

Motion by 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 GPCE negotiates a separate service for the provision of on-the-day acute care for patients currently seen by GPs.
(iv) Requests that GPCE 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 GPCE negotiates a new GMS contract which focuses on continuity of care, care of long-term conditions, preventative healthcare and end of life care.

Strengths/opportunities	Weaknesses/threats
• Better continuity • More flexibility • Safer - improve quality / consistency of care • Better chronic disease management • Reducing health inequalities • Resourcing for acute care • Workload – quantifiable and improved • Choosing what to do and develop own interest • Morale, job satisfaction and wellbeing • Workforce – recruitment/retention • Better job planning • Camaraderie / team working • Estates - reduce pressure • Allied roles – better use • Better quality acute care • Integrate new technology / AI • Less decision fatigue	• Loss of continuity of care • Patient safety and safeguarding • Undermining wholistic care • Overmedicalisation and antibiotic resistance increase • Rural areas • Sustainability and climate change - travel • Workforce – retention/recruitment • GP dissatisfaction – more stressful and burnout • Deskilling • Widening health inequalities • Less cost effective - costly home visits • Training and education • Defining acute • Estates • Medico legal liability • Missed opportunities to educate staff and patients

Contractualising continuity breakout group

The purpose of this break-out group was to discuss how to include continuity measures within any new contract. It will focus on the principles of defining, measuring and incentivising continuity.

Key themes

- Risk / concern of measuring being used against GPs
- Funding / investment in practices is required (key incentive)
- Use of "micro-teams" to provide continuity of care (episodic vs continuity with same doctor)
- How can this be measured meaningfully is a key concern?
- Stratification to group patients for continuity
- Trust between patient and GP

What does "Continuity of Care" really mean?

- Continuity of teams and workforce stability.
- Continuity of information and records (data sharing).
- Continuity from a patient's perspective/experience.
- Continuity of care is individualised. It does not fit all.
- Importance of retention of staff.
- Is continuity of care needed for everybody or vulnerable patients only?
- Can change over time/second opinion.
- Continuity of care is coordinating care.

Do we think Continuity of Care should be measured? If so, how?

- Continuity and family groups.
- Measuring it is difficult and do we want to measure it at all?
- Quality of improvement, is it re patient satisfaction/patient survey?
- Focus on outcomes as a way of measuring continuity of care.
- Underlying problem is the contract.
- No further tick boxing needed.
- Increase funding to recruit and retain staff instead.
- Access vs continuity of care.
- Showing through policies that continuity is prioritised.

What should Incentivisation of Continuity look like?

- Stop incentivising demand.
- Disincentivise continuity of care, or things that obstruct continuity of care.
- High trust and low bureaucracy.
- Increase number of GPs through retention and have a stable workforce.
- We don't want to tick more boxes.
- Suggest a quality improvement project.
- Ring-fenced pot of money for GPs.
- Focus on outcomes instead.
- Be careful that we are not destroying access nor continuity of care.
- Could discriminate against staff working LTFT or could marginalise some practices (inequalities).

Slicing the pie breakout group

The purpose of this break-out group was to discuss how to achieve an equitable formula for patient funding, pros and cons of the current funding formula, and which patient factors may be important when negotiating funding within a new GP contract.

- 89% of reps wants to see weighting of any new capitation-based funding in a new GP contract
- Over 1600 variables for calculating weighting were out forward, the highest ranking of which were deprivation, age, and co-morbidities (to include mental health).
- Rurality, sex, list turnover and ethnicity i.e. variables reflected by Carr-Hill were not ranked as highly. This gives some context as to why conference policy is that Carr-Hill is not fit for purpose.
- Any new funding formula should have its methodology reviewed at set intervals, and a practice's weighting should also be reviewed at set intervals – future conference motions would be useful for firming this up
- A majority voted for an element of weighting depending on patient/practice factors.
- Some concerns that a new contract will create a lot of uncertainty, with winners and losers, which risks destabilising the profession, so may be better to stick with Carr-Hill.
- There is much more data available now than when Carr-Hill was devised, but some practices are not coding all the work they are currently doing.
- Important to define what an appointment is, especially with the development of online appointments, that don't always get coded.
- Carr Hill doesn't reflect the ageing population and multi morbidity
- How do we encourage people to work in under doctored areas?
- We need to make the pie bigger, otherwise it doesn't matter how we slice it.
- Is there a risk we will move away from a national contract? Is a level playing field possible considering the history of general practice?
- Need to guard against complexity, we need a formula that practices understand.