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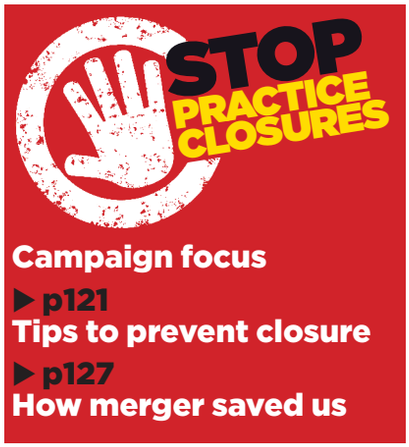
Five steps to campaign against funding cuts

Dr Naomi Beer describes how struggling practices can involve their patients and the media in their fight to survive



Campaign focus

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Tips to prevent closure
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How merger saved us

Our practice serves one of the most deprived populations in the country and after we lost nearly £220,000 in funding this year, because of a reduction in MPIG payments, we had to pay to run our practice from our savings account and were forced to set a 'red-button day' for closure earlier this year.

As we began to realise it would be impossible for us to survive, we held an emergency partners meeting in April and decided to launch a Save Our Surgery (SOS) campaign.

In this campaign we pulled out all the stops, getting our patients involved, organising rallies and speaking with national newspapers and broadcasters. After a hard slog, we have finally seen some movement from NHS England (see page 22). It is early days, but we hope this campaign will provoke managers to give us the support we so desperately need.

As Pulse has shown, there are many other practices in a similar position. By sharing what we have learned, I hope to show in this article the steps you can take to launch a successful campaign to save your practice.

Calculate how big the problem is

1 If you are worried that the viability of your practice is threatened, work out what the funding problems will be long term.

Our practice regularly undertakes one and seven-year financial forecasts and we knew that without MPIG, the practice would not be able to keep operating. But until we figured out what the precise figures would be for this year's cut in MPIG payments we did not know what the damage would be.

For instance, average net remuneration for GPs is around £89,000. We calculated that ours used to be around £79,000 and this year we projected it would fall to £45,000.

We used the BMA's ready reckoner for practice funding to figure this out – for more information, watch the video created by our practice manager Virginia Patania.[1] She has also produced a video specifically for practices that have lost MPIG income.[2]

With estimates of your projected list size for this financial year, QOF income for last year, estimates for maximum income from 2013/4 DESs, global sum, the out-of-hours deduction and net global sum, the tool will estimate what your profits (or loss) will be for 2014/15. Bear in mind that rapid list growth may create a discrepancy that makes you appear to have been overpaid. (Also, the ready reckoner does not factor in the loss of seniority payments.)

Estimate your target income for this year from the ready reckoner, the value of other work (non-NHS income, any enhanced services) and the costs of staffing and cover, expenses and bills. Then work out the difference between estimated target income and estimated costs.

We also run profit margin forecasts for all enhanced services and summarise which work creates the best value for the practice. Some services will subsidise others, but you need to know which ones you might need to cut if you are struggling financially – particularly after this financial year.

It will also help to produce charts in case you need to show NHS managers (the local area team or NHS England) that demand and rates of consulting are going up.

Keep track of true monthly income and costs during the year to check the forecast is accurate.

Show what it means for patients

2 At a meeting, discuss the findings from the forecasts among the partners and decide how you will proceed.

You will probably want to share the information with parties such as the LMC, NHS England, the LAT, patients, the GPC, local MPs and councillors, and journalists. But decide how much information you want to reveal to each one. If you want to see examples of letters we sent to patients, go online to pulsetoday.co.uk/campaign.

At my practice we decided to be completely transparent, but you may decide to save the full picture for the LMC and NHS England, using just details or broad brush strokes for patients and the media. If you can be confident about your forecast and already have examples of how cuts have affected your patients, it may be prudent to be totally frank about the situation.

Prepare simple information explaining what cuts will mean for patients, focusing on access and services or clinics. Be specific about which services will be cut (for instance nursing home support or sexual health services) if possible. Attempt to strike a balance between engaging patients and shocking them. Be clear that the scenario is political and logistical, and has simple funding solutions that could keep the practice in business.

Connect with patients and ask if any of them would be willing to volunteer for the campaign. Ask patients if they have any skills they could lend (writing press releases, for example).

Alert the media

3 In our campaign, media coverage was crucial to ensure that our voices were heard. The initial article in *The Guardian* that blew the whole story open came via a personal contact (the journalist was the friend of

a friend of mine), but there are lots of ways of alerting the media to your story.[3]

National newspaper journalists read the medical trade publications – such as Pulse – for stories, so do make sure you are alerting them to your plight (you can email the editor privately at editor@pulsetoday.co.uk).

We also circulated press releases to the major newspapers' news desks, whose email addresses are on their websites. We kept details of anyone who rang us or emailed and included them in any subsequent press releases. That way we built up quite a contact list.

You can use press releases to announce some important piece of news in the progress of the campaign. Think about the main points of information you want to convey. Always explain how the developments affect patients, and make sure it's simple – ask a few patients to read it through to check they understand what's happened or changed. If you are taking action, say what you want to achieve by it.

If relevant, mention who is supporting your action (such as local MPs, councillors or community figures). You might want to include a standard paragraph on 'Background' – summarising what's threatening your practice, when you started your campaign, and what your main aims are. Keep it simple and give a name, number and email where journalists can reach you if they need more detail.

We contacted local radio (regional BBC stations, for example) and London TV stations (we were bold and assumed that everyone needed to hear our story).

Then the TV crew from BBC London came down, and so we invited London Live and ITV too. As the story grew, other channels including BBC One and Channel 4 contacted us to do short and more laterally-extended pieces, featuring our practice.

We have a fantastic group of patients – passionate, articulate and ready to be interviewed on camera. Our readiness to be available and our ability to galvanise patient support made us quite media friendly. We only turned down one interview and that was because of time constraints.

Our campaigners took their message to 10 Downing Street

'If your neighbouring practice is in crisis, watch out'

For more stories about practices facing closure and advice about fighting the threat, go to **pulsetoday.co.uk/campaign**

We gave journalists as much information about our situation as they asked for. As already discussed, we took a decision to be open with our accounts and our services, as we had nothing to lose, and we wanted to rebuff the usual gripes about GPs lining their own pockets at the expense of quality care. It was a risk, certainly, but being honest gave our story credibility.

Very early on we made plans for how information should be shared quickly and appropriately to other members of the partnership and also to the practice staff. This has kept everyone on board, feeling part of it and able to offer valuable contributions.

Running a petition on the 38 Degrees website also attracted interest and support.

Get politicians to fight your corner

4 We wrote to our two local MPs, Jim Fitzpatrick and Rushanara Ali. After Mr Fitzpatrick saw the article in *The Guardian* and discussed the issues with a local Labour councillor, he offered to raise parliamentary ▶

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questions about our situation. This is done by ballot, but luckily, his was chosen. He and Ms Ali then had the opportunity to question health minister Dr Dan Poulter directly in a televised debate. At this debate, Mr Fitzpatrick also secured a meeting with health minister Earl Howe. We attended that meeting on his invitation, and also went to a meeting of the House of Commons Health Committee where NHS England chief executive Simon Stevens was appearing for the first time. We handed him our position paper with a request that he review it and the MPIG funding decision.

If you know a local councillor in the same party as the MP, they are usually a little more approachable and will hopefully offer to raise your situation with the MP on your behalf.

That said, there has been an awful lot more publicity around the issue recently so a direct approach to the MP should now ensure a response, especially if a few GPs put in a request for a meeting together. Look to see if Pulse has already contacted your MP at pulsetoday.co.uk/campaign.

If an MP is raising a question in the House of Commons on your behalf, they will want a full briefing about what threats you're facing, as well as suggestions of what questions to raise. After that, keep them on the mailing list as a courtesy.

You can also campaign at a local as well as a national level. Although you cannot take part in debates and discussions at county council meetings, you can ask to make a presentation on any issue that is within its 'terms of reference'. You may also make a presentation to any committee or panel of the council, to cabinet or when individual cabinet members make decisions, on your own or as part of a group. This is known as making a 'deputation'.

A deputation can comprise up to four people and each of them may take part. Write to the chief executive stating the meeting you want to attend and the issue you would like to cover. You usually have 10 minutes to state your case and raise a question. You can also propose a motion that the council members can debate and decide to take up if they deem it important enough, which ensures they will take action. For example, the motion may move the council to take action to examine the impact of GP funding cuts on local health services and to request a meeting with the health secretary.

We made a presentation at a local council meeting and proposed a motion. Our presentation informed local councillors of the issues and the impact that cuts might have on their constituents. After the deputation we kept all councillors informed of the actions we were taking and gave them the opportunity to join rallies and marches.

A local mayor also has the right to take up any matter they choose, even without a deputation. We approached the mayor of Tower Hamlets directly to inform him of the issues and he wrote to the health secretary.

You can also write directly to the local health scrutiny committee to inform them of local problems. The more GPs are involved in this letter, the more they can see that constituents are affected and the more they are likely to listen.

We are due to have a separate meeting with local councillors soon to decide on what further co-ordinated action we can take together.

5 Connect with other local campaigners

We kept the story rolling by collaborating with other like-minded campaigns. Apart from our practice campaign we have been part of the Save Our Surgeries campaign in Tower Hamlets and UNITE. The latter has given the campaign fantastic practical support in terms of resources and advice as its leadership took a decision this year to support any action to stop more cuts to NHS services.

We were lucky because our area, Tower Hamlets, has a long history of protest and of collaboration. The combined support and interest of virtually every practice in the borough, and of the CCG, has ensured that we have people who can tweet and use social media to promote the campaign widely. But you can get support for your campaign wherever you live.

Join a wider campaign by connecting with your CCG, LMC, unions and the Keep Our NHS Public campaign. For example, a march was organised locally by someone from a union, which got great coverage in the local press for our campaign. Several local councillors attended. If you feel isolated locally – for instance if you are the only practice facing cuts in your area – Pulse is collecting stories from around the country. Go to pulsetoday.co.uk/campaign to connect with others in the same position.

> Recent publicity means that a direct approach to an MP should ensure a response

References

1 YouTube, George Farrelly. Virginia Patania on MPIG Ready Reckoner. youtube.com/watch?v=BkSaQcxXyqc

2 YouTube, James Stewart. A presentation on the MPIG losses calculator by Virginia Patania. youtu.be/w_IiiWPRwc8?t=1s

3 *The Guardian*. GPs braced for shutdown after 'toxic mix' of loss of funds and high demand. April 2014. theguardian.com/society/2014/apr/16/gps-surgeries-shutdown-loss-funds-high-demand-nhs

Dr Naomi Beer is a GP in Tower Hamlets, east London

Online resources

As part of Pulse's campaign against practice closures, Dr Beer has provided resources that GPs can use to inform their own campaign. Go online to see her letters and videos at pulsetoday.co.uk/campaign

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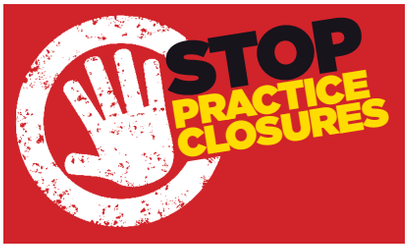
Safeguarding your practice's future

Experts advise on how to cope with three scenarios that threaten your practice



Can't close list

My practice has been denied permission to close its list to new patients as we cannot cope with our current list. Can we appeal this decision? Is there anything else we can do to avoid taking on new patients?

Is your problem shared by other practices across the locality and, if so, how are they responding?

Liaise with NHS England (or your primary care organisation in the devolved nations) and make managers aware of your concerns about the viability of the practice if the list continues to grow. Invite representatives to the practice to discuss the issues to ensure they see the problems first hand.

Ultimately, if the practice is sinking to the point of becoming unviable and managers refuse your request to close the list, you could discuss a merger with a neighbouring practice. If NHS England or the PCO does refuse then appealing is likely to have little impact.

In the meantime, review your workload and decide what services can be stopped, especially if they are not resourced (for example, enhanced services and private medicals). Then review your system for appointments and consultations and assess whether there is a more efficient way to address the increasing patient demand. You might consider telephone triage; would a local out-of-hours provider be willing to triage patient calls for the practice?

Work out how patients can safely be triaged and redirected appropriately to other local primary care services, for example, opticians, pharmacists, self-help groups and charities.

See if any of your back-office functions, such as payroll or audits, can be devolved to other agencies in order to free up staff time to meet patient demands. Do you need to engage locums to help you to gain control of existing workload? If so, estimate how many more sessions you will need them for.

Dr Mohammed Jiva is the secretary of Rochdale and Bury LMC and a GP in Manchester

The practice's next step should be to talk to the LMC. If the decision has been made by a relatively junior staff member at the local area team or PCO, a call from the LMC chair to the director may solve the problem. If not, the LMC can pursue the matter through formal channels. As this may take time, it is worth seeking help when the problem is first recognised and before it has become intolerable.

The last thing the area team or PCO wants or needs is to have to find primary medical care at short notice for several thousand unsettled patients.

You and an LMC representative should also arrange to sit down and talk to the director of primary care about how to make sure that the practice can continue to provide safe care for its existing list. And there may be solutions without closing the list. But the practice needs immediate support as well as longer-term help in exploring all the options.

Don't forget that your patients can be your greatest allies. Tell them and all your staff that the practice is struggling to provide a full service, why this is, and what you are doing to make things better. Many will be able to offer support if you need to make your argument public.

It is clear if workload is not controlled then it is only a matter of time before both GPs and staff begin to run into serious difficulties, and in the current climate there is a real risk that once one domino falls the rest will follow.

Dr Harry Yoxall is the medical director of Somerset LMC

Singlehander retiring

I am a singlehanded GP nearing retirement, but have struggled to find a candidate to take over my surgery. What should I do?

The main option if you are retiring and have not taken on a partner is that you resign your practice contract. NHS England or your PCO would then have the choice of putting the contract out to tender or dispersing the practice list, meaning the practice's patients would have to re-register with other local practices. ▶

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The problem with dispersion is the impact on other local practices, especially when general practice is under such pressure. This approach would also mean the retiring GP would be responsible for the redundancy payments for the practice staff and also for any issues related to premises.

If the practice went out to tender then the winner of the tender would be responsible for the staff under TUPE regulations.

If you don't want to take this risk, you could look to merge with a local practice. If you are GMS, you could take on a partner from the practice you wanted to merge with so that, when you retired, there would be a partner remaining in the practice.

Remember, you could merge contracts with the permission of the area team or you could create an organisation that runs two separate contracts.

Talk to the LMC as soon as possible, as its leaders will be able to help and advise you.

It is also important to involve the area team or PCO to ensure that the process is as straightforward as possible, and inform them and your CCG (in England) of your plans (whatever they are) and seek their support at an early stage.

Dr Nigel Watson is chief executive of Wessex LMCs

What advice would you give in these situations? To see more responses to all three scenarios and add your own, go online to **pulsetoday.co.uk/campaign**

If I were a singlehander I would be considering joining a partnership where possible as this protects all your patients from list dispersal – perhaps to less convenient practices. It also protects you from the real risk of being left with unsaleable property or negative equity – particularly if the property is purpose built. My first point of call would be the LMC, then direct approaches to fellow local practices.

Careful consideration should be given to whether you amalgamate the practices. This might have implications for correction factor and also invite a challenge from the area team or health board who might consider it a new contract. The alternative is a looser federation where the same partners run both contracts, but the contracts remain separate. This allows economies of scale, but protects against reprocurement. It can be done in a single partnership, holding separate GMS contracts.

Postponing retirement would be a last resort as there are tax disincentives for many GPs to continuing in the pension scheme and many are considering retirement anyway in the face of unmanageable workload.

Dr David Bailey is a GP in Wales and a former chair of GPC Wales

Local closure

One of our neighbouring practices, which has a large elderly population, is closing. What can we do to prepare to accept its patients?

Your area team (or health board) is responsible for what happens to patients when a practice closes and in determining whether to put the practice contract out to tender or disperse the list. In doing this they are supposed to consider the impact on neighbouring practices.

If NHS England or your PCO takes the decision to close a practice, it is unlikely to simply allow you to close the list. The rules on list closures are vague but restrictive and, anecdotally, many requests are refused.

If you expect a large influx of new patients you could, with your LMC, make a case to managers for one-off funding as short-term financial relief to cover the cost of undertaking an exceptional number of new patient health checks, for example, or urgent note summarisation that may be required. Your CCG (in England) may support that request, especially if several practices are involved. There is no requirement for managers to provide such relief, but they may use discretion, especially if you can demonstrate a potential financial detriment (for example, on QOF targets).

You should aim to maximise income from DESs or locally commissioned services by identifying relevant patients as soon as they register. Where care home patients are involved, it would be sensible to discuss with the area team or PCO, CCG, neighbouring practices and the homes itself what registration arrangements should apply.

Chris Locke is chief executive of Nottinghamshire LMC

Being under-resourced is not considered a valid reason to refuse to register new patients. Area teams or PCOs can override even justifiable refusals and allocate patients to a bulging list. Adopting an 'open but closed' list status is not possible any more.

Consider carefully before informing managers that you would struggle to provide essential services. They may advise list closure which could bar you from participating in extra-contractual work. If you're facing destabilising forced allocations, closing your list temporarily may be the most reasonable option but it's a procedural minefield. Present a convincing case for closure to the LAT or PCO (over 50% of London applications failed in 2013). Managers can appeal and overturn a 'successful' closure application. Practices can counter-appeal under the NHS dispute resolution process. Ask your LMC for advice.

Dr Eleanor Scott is a medical director for Londonwide LMCs

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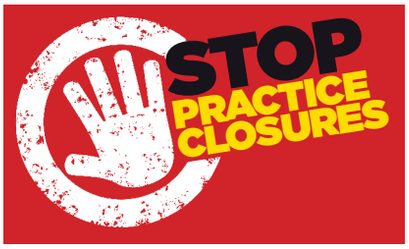
How a merger saved our practice

Dr Joe Firth explains how a practice with no space and a practice with no partners merged to protect their businesses



The problem

Our practice, Chestnut House Surgery, was an average-sized practice in Thorne, near Doncaster. We had historically enjoyed excellent rates of satisfaction – well above average according to our 4,500 patients and the NHS Choices website. However, our practice was crammed into the back of a LIFT building in a premises designed for a single-hander and a registrar. As our list grew, so did our staff; before the merger we had three partners, plus a registrar, two nurses and two healthcare assistants to meet the needs of our population – and we were forced by space constraints to consult in our back office and the storage room. We had nowhere to see patients. Permission to extend the premises was denied and we knew that closing our list would be financial suicide.

Our neighbouring practice, Moorends (3,500 patients), had lots of space but was struggling to find staff. It had been a two-handed practice, but one partner had retired and the other was about to go on maternity leave, meaning the practice would have to be staffed by locums for six months – an untenable situation.

What we did

At the start of 2012 the senior partners at Chestnut House and Moorends initiated the merger. We began the process in July 2012 by trying to manage everything ourselves and sharing the work, but ended up hiring a management accountant with a 'change management' background for half a day a week. We drew up a Gantt Chart with time in months across the X axis and a list of areas of the business such as premises, IT, phones and staff on the Y axis. We then had partners' meetings on a weekly basis during the 12-month run-up to formal merger on 1 July 2013 and continued to meet weekly until last April.

The practice manager at Chestnut House left in September 2013, but having a consultant overseeing the merger was very helpful. She had a non-NHS background, which was refreshing as she was less naïve than some NHS managers.

The key task was to complete due diligence, ensuring there were no issues outstanding in either partnership. We formed a new partnership with a new partnership agreement to indemnify each other for any issues that may arise from the individual practices.

More online
Accountant Bob Senior advises on managing finances before a merger
pulsetoday.co.uk/merger-advice

The challenges

The merger was very time consuming; on average, I have spent an hour a day on it since we embarked on the project.

It has also been expensive for the four partners involved. Drawings had to be reduced for the first nine months, our QOF score suffered, falling from 100% to 98%, and differences in coding clinical activity caused confusion over searches for LES and DES payments.

Although we were well prepared, we felt blind-sided by a number of issues we had thought would be straightforward.

First, we took nine months to establish which NHS organisation was responsible for our phone system. After the PCT closed, no one would accept responsibility. We struggled to merge the two practice telephone accounts (and lines) into one and some patients were able to 'play the system' if they were struggling to book an appointment.

Second, we had switched both practices onto SystmOne before the merger, but it was time consuming to deal with the paperwork and the process for merging the computer systems has not been straightforward. Allow plenty of time if you undertake this type of switch.

Third, given that Chestnut House already had a good reputation, there were some complaints from patients after the merger. When we explained the space issues we had faced (which are also detailed in a patient leaflet) patients were generally sympathetic to the challenges of the newly merged practice. Patients at Moorend now have better continuity of care so seem happier than before.

Although we made no redundancies, another concern was that staff morale fell after the official merger date. We managed this as well as we could by running fortnightly staff meetings and trying to keep everyone informed.

Finally, the premises owners want to charge almost £6,000 to change the names on the two leases for the two surgeries. We have a quote indicating it should only cost us £750 and we are still making the case to reduce this bill.

Results

We are now all in a much better position than we were before.

The list for the merged practices is growing at a manageable 20 to 30 new patients a week. We have been able to recruit two new full-time equivalent GPs and have delegated specific areas of practice business to each of the four partners, making us better organised. We haven't had any redundancies, although some staff have retired or moved on, and morale is now better than before the merger.

We now have a centralised call and administrative centre, which has freed reception staff to handle all face-to-face requests for appointments and prescriptions without having to field calls at the same time.

Dr Joe Firth is a GP in Thorne, Yorkshire

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