Special LMC Bulletin

Hooray – sort of….our new Contract

So, the new Contract we have been promised for a while has flopped onto the mat. It may feel like it was rather unannounced – kind of, 'here comes publication of the usual annual contract tweaks, nothing to see here, don't brace yourself or anything'. However, it is pretty seismic as a change and if you have a couple of hours (108 pages) you can read the British Medical Association (BMA) release here.

For what it is worth I shall try and give you my initial impressions and then plug the General Practitioners Committee (GPC) Roadshow we are hosting at St Austell Conference Centre on Tuesday, 12 March, when you can come along primed with your questions to put to Dr Mark Sanford-Wood – Deputy Chair of the GPC and therefore pretty informed.

The big news is that state backed indemnity is happening for all staff involved in providing primary medical services (in and out of hours) and after all the ins and outs practice funding is still going to increase by 1.4% in 2019/20. This was better than we expected as this could mean a significant relative pay rise, although we will have to wait and see by how much our Medical Defence Organisation (MDO) subs go down. You will still need your own insurance to cover insurance forms, advice and representation at professional practice hearings, etc. but hopefully that will be hundreds, not thousands. This feels a bit like the bribe!

As expected there are some Quality Outcomes Framework (QOF) tweaks to retire the useless, catch up with evidence and to adjust thresholds to take frailty into account. A new QOF tilt comes with an attempt to introduce some quality improvement exercises with 74 QOF points attached (end of life care and prescribing safety being targeted first) with some sharing of results and actions with adjacent practices in peer review meetings. Exception reporting is to be replaced by a Personalised Care Adjustment to reinforce the idea that QOF must be tailored to the patient.

Also, as expected, there is a lot of talk about IT – patient access to notes, online booking, 111 appointment booking, apps and video consults. This is partly to level the playing field with Babylon, but also because 'it's the future, innit'. Have a look at the proposed asks and the deadlines by which they must be met and then see if your GP IT system can provide it. If not I would suggest you find out when they will or move system. There will be a lot of contracted data sharing.

Nothing too seismic so far – brace yourselves.

Perhaps unsurprisingly, having spent the last 2-3yrs telling us we should be working at scale they have created quite a good vehicle to make it happen. This comes in the form of a new Primary Care Network Contract being bolted on to GMS/PMS/APMS as a Network Contract DES. What is a Primary Care Network you may ask? It is quantified by a number of patients and they are suggesting 30-50,000 is optimum although super-practices up to 200,000 would qualify. A given practice will be paid a Network Practice Participation Payment (£14k for an average size practice) to sign up to their chosen network and 'engage' with its activities. What activities you may ask? The answer is probably all future developments in primary care in the next 5 years. There are two important parts to the last

sentence. The first part was ‘primary care’, which is no longer synonymous with general practice, and the second part was ‘5 years’ – this is the contract for the next 5 years and if it works the next 10 years. Dealing with the second bit first this is properly good news as it allows us a degree of security in developing systems with some certainty on funding. The distinction between primary care and general practice is important because I think it is the secret to our ongoing sanity and survival as GPs.

Primary care networks are going to be asked to coordinate the Extended Hours Access DES and ultimately Improved Access. Both of these are being appraised with an ongoing Access Review. The Networks will be 100% remunerated for employing a specified number of social prescribers and 70% remunerated for employing emergency care practitioners, first contact physiotherapists, physician associates and clinical pharmacists (Additional Roles Reimbursement Scheme). They will be asked to tailor their health provision to their population using data contractually supplied by practices. They will be tasked with improving ‘system outcomes’ like cancer diagnosis rates, anticipatory care, enhanced care in nursing homes, doing structured medication reviews, cardiovascular disease finding and ‘tackling neighbourhood inequalities’. I suspect the days of Local Enhanced Services contracts with individual practices are a bit numbered (unless I am mistaken, they are to be replaced by Supplemental Network Services). Reading between the lines, the wish is for LES’s to go to the primary care network who then decides how to achieve it. (Don’t worry they will still need us to do it). Each primary care network will need a Clinical Director funded for 0.25 whole time equivalent (WTE) by NHS England (NHSE) whose thankless task will be to herd you lot into doing that lot. However, as I said before, the music is not necessarily about you lot. The wish is that some of this new health improvement can be done by allied health professionals and multidisciplinary teams cooperating across the system. Phew, that was hard to say. What is promising is that they are pouring mountains of cash into these structures to make them work and they do have the potential to reduce individual GP’s workload.

Clearly, this is not going to happen overnight and the dream will come to fruition in a staggered fashion over the 5 year period. A cynic might take the view that if we as practices are key leaders in a primary care network and the network is awarded cash to provide a service we could decide to funnel the cash back to the individual practices and ask them to provide the service in their silos. For some things this will probably happen, but I fear if that becomes the norm, insanity will follow and an opportunity will be missed because our current practices do not have capacity for this vision.

Taking a Cornish perspective, if the localities that are already set up became the networks, that might work quite well. However, there is also a compelling business case for any practice with a population over 30,000 to declare themselves an island which may cause some fragmentation for some of the localities. I think there will be a challenge finding the Clinical Directors if we end up with 15+ primary care networks too. If ultimately, Improved Access becomes part of a primary care network’s core business there may be benefits in bigger networks. Each practice will need to have a proper think about these issues. Choose your neighbours carefully!

What is apparent from the contract is that not everything has been worked out yet and there are issues that still need negotiation. What is also apparent is that all this new stuff is being paid for both in networks and direct to the practice – amazing! NHSE is so worried it will send GP’s income soaring that they are going to be naming individuals whose NHS earnings exceed £150K in ‘the interest of transparency’. This is, of course, the usual pandering to the Daily Hate, but is also I think indicative of a significant pay rise. There is a murky mention of a Balancing Mechanism yet to be negotiated that could be used if we all buy Bentleys.

The challenge I would throw at you is this – I know how many practices and GPs in Cornwall are hanging on by the skin of their teeth due to work pressure. We can survive this by seeing it for what it is. This is not money you must chase to stay viable. NHSE are saying they are going to be pushing

money into the global sum as well and they have recognised they need us in our practices doing medicine. You can chase the money if you have strength and capacity or you can see it as a problem for 'the network' to solve with all of their new resources and staff. It may be that with a small income boost from this contract you could ease back on chasing the pennies and concentrate on the bits you enjoy.

It's a long old document and I have left out a heap in order to concentrate on the bigger picture eg £20million going to practices to compensate for GDPR compliance losses, CCG employed Data Protection Officers, opportunities for GP research income for all, 2% pay raise for salaried staff, piloting new contract features in practices before being adopted, primary care fellowships to retain newly qualified GPs, pension contribution hikes covered. Let it bed in and come and grill Dr Mark Sanford-Wood on 12 March, at St Austell Conference Centre, with your further questions.

The agenda is:

6:45-7:15pm	Refreshments and networking	
7:15-7:20pm	Welcome, introductions, housekeeping	Dr Will Hynds, Chair of Kernow LMC
7:20-8:20pm	GPC presentation – new Contract	Dr Mark Sanford-Wood, GPC Deputy Chair
8:20-9:20pm	Q&As	All
9:20-9:30pm	Summing up/local reflections	Dr Will Hynds, Chair of Kernow LMC
9:30pm	Close	

Places are available on a first come first serve basis, as we are expecting a large turnout. Please confirm your attendance to rich@kernowlmc.co.uk

I think if we can start to think creatively we actually have a funded solution to some of our problems and Cornwall has done quite a lot of the preliminary work to make this do-able. So hooray, sort of!

Dr Will Hynds
Chair of Kernow LMC