Cheshire Local Medical Committee Ltd
A Practice Guide to the GP Contract Changes2022/23

Investment and evolution:
A five-year framework for GP contract reform to implement *The NHS Long Term Plan*

A resource for 2022/23
Version 1: March 2022

This is a Practice Guide to the GP Contract Changes 2022/23 developed and issued by Cheshire LMC. No part of the document supersedes the actual guidance or notes issued by NHS England. It is our intention to update the guide on our web site as the detailed instruction on various sections is released.

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Review of the General Practice Contract Arrangements in 2022/23 (B1375)
Link to NHSE's B1375 is here: https://www.england.nhs.uk/wp-content/uploads/2022/03/B1375_Letter-re-General-practice-contract-arrangements-in-2022-23_010322.pdf

Background
The LMC understands that the GP contract changes described in NHSE letter B1375 were not agreed with the GPC England and therefore this contract is being imposed upon the profession by the Secretary of State

The PCN DES forms part of a 5-year deal, which is due to end in March 2024 and which was negotiated by the previous leadership of GPC England. Full-service specifications for the PCN DES 2022/23 are not yet published. Therefore, precise information is limited to what we can gather from this particular NHSE communication.

The Technical Bit
NHS England's General Practice Contract Arrangement 2022/23 is a summary document from NHSE, ahead of the publication of more detailed specifications and updated regulations which are expected before the end of the month. Whilst the headlines have been published now, as always, the actual contract changes do not formally take effect until the relevant GMS/APMS regulations have been revised and published together with an updated SFE (usually around Autumn) and only once you have been issued with a new contract that includes the relevant contract revisions.

LMC Comments: The Crystal Ball Gazing
The contract arrangements set out in the document signal changes, additions, and delays to different parts of the GMS contract and PCN DES that is due to end 31 March 2024. Thereafter, the default position is that the existing GMS contract will automatically roll forward unless changed. Greater clarity is needed as to whether this marks an intention for PCNs to continue beyond 2024.

The document confirms that NHS England "remains fully committed to discussing any proposals for potential future national changes from 2024/25 with GPC England".
The use of the word 'discuss' rather than 'negotiate' raises deep concern with your LMC colleagues, because this year too - the changes were neither negotiated nor agreed with GPC England. They are therefore seen as being imposed upon the profession by the Secretary of State.

GMS Contractual Changes
Changes to the GMS contract itself are limited to:
• online booking requirements
• AHRA requests for deceased patients
• minor changes to vaccinations and immunization schedules
• funding for Subject Access Requests (SARs)
• digital patient registrations
• a 2.5% increase in the practice baseline
• a move to weighted patient payments

QOF protection lapses, and no new indicators have been introduced. This is a real concern. The QI modules focus on general practice access, and prescription drug dependency. This feels impossible.

We would argue that is there is no access issue within general practice. But there is a problem with capacity. The Weight Management Enhanced Service will be extended for a further year.

PCN DES 'Enhancements'

Extended Hours and Extended Access

The emphasis is on the PCN DES, with the headline being the amalgamation of extended hours and the CCG commissioned extended access into a "single, combined and nationally consistent access offer with updated requirements" (£7.44 per weighted patient) to be delivered by PCNs from October 2022.

We would observe that the shift from a raw payment per patient, to a weighted payment will mean this single 'access offer' may well be better done at scale. We would encourage you to discuss as a PCN **and liaise with your local GP Federation**. Larger practices may find they can manage using their own processes.

We would encourage intelligent and sensitive payments to staff delivering the access offer, to not cause wider instability or volatility to the GP practice team workforce. Any practices requiring some input into their relationships with their local GP federation should contact the LMC for advice and we would be happy to support both parties in the pursuit of mutual agreement.

Other 'Stuff

There are also new asks for Cardiovascular Disease Prevention and Diagnosis; the Early Cancer Diagnosis service requirements; and new indicators in the IIF. Funding commitments to ARRS are to increase to just over £1bn nationally. "PCNs have flexibility to recruit into any of the 15 different roles" it says.

Back in the real world, we know that when recruitment is incredibly challenging and the roles themselves may not be the most suitable for delivering what patients and practices need, let alone achieving the IIF targets, this feels something of an overstatement – but a great headline – designed to make DHSC look generous whilst HM Treasury claws back monies that general practice 'doesn't need'? We'll let you be the judge.

The document also indicates that PCN CD funding will be boosted by a further £43m this year, on top of the £44m that is already committed in the funding formula. We look forward to further detail of how this additional funding will present, and how PCNs can use it.

What Has Been Pushed Into Next Year?

Anticipatory Care and Personalized Care services in the PCN DES will be delayed to 2023/24, making this year "a preparatory year" for the as-yet-unknown requirements. The workload implications need detailed specifications – so they had no choice but to delay. The document does references that the Anticipatory Care Service will be "ICS led". Again, further clarity about what this means in terms of local variation will be required.

Specific Changes in More Detail

Online Booking

The 25% of appointments being available for online booking target has been replaced with a "more targeted requirement" that all appointments "which do not require triage" are able to be booked online (as well as in person, or on the telephone). We would advise that it remains up to practices and their triage models as to which appointments don't require triage. We might suggest planned care, e.g., long term condition annual reviews; invitations to attend national screening programmes; or predicted vaccs/imms that may not require triage. One model might be an extended appointment in the patient's birthday month to deliver elements of bespoke planned care, leaving other appointments to require triage – so this may be helpful.

Patient Records

There will be a requirement for GP practices to respond to the Access to Health Records Act (AHRA) requests for deceased patients. Practices will no longer have to print and send copies of the electronic record of deceased patients to Primary Care Support England (PCSE). LMC Comment: This may be helpful, but we don't yet know what the number of requests will look like, and arguably PCSE are better placed to respond to such requests themselves, given they are contracted to do this. Time will tell.

SARS

There will be continuation of funding in the Global Sum (£20 million) for an additional year (2022/23) to reflect workload for practices from Subject Access Requests (SARs). We welcome this continuation of funding in acknowledgement of the increased workload.

Enhanced Access

Primary medical services will need to be delivered at times that fall between (note, not across) the hours of 18:30-20:00 weekdays and 09:00-17:00 on Saturdays. We have concern around the introduction of the term 'network standard hours' that overlaps with the OOH opt-out period which GMS contracts are already adjusted for. There needs to be a minimum of 60 minutes of appts per 1000 PCN weighted patients per week. But there is also some latitude around meeting the needs of the PCN population where e.g., early morning appts would be more popular, or 'by exception' during core hours, where demand is regularly high. (LMC Comment: This is everywhere, right?) The appointments offered will need to be a practical mix of team and mode – exactly how they are now.

LMC Comment: If 'network standard hours' are going to be delivering routine services, this is a slippery slope which may de-stabilize staffing. We will also need to ensure that the CCG/ICS is going to be able to support blood/sample collections and IT support for GP providers at enhanced access hubs.

Investment and Impact Fund (IIF)

Three new indicators will focus on DOAC prescribing (a pricing deal has been done for the NHS (LMC Comment yet more prescription switching); and FIT targets for all lower GI 2ww pathways. We know practices haven't always timely access to FITs, which will need to be sorted. The additional work will come with an additional £34.6million funding (about 63p

per patient). IIF remains optional for PCNs, and you can still pick and mix which bits of the IIF you wish to deliver as a PCN too.

[Note1: The "Enhanced Access" referred to in this communication is the new combination of the following two separate services, which as of October 2022 will become a single network obligation under the DES:
• What has been previously referred to as "Extended Hours" which prior to 2019 was a practice level DES but was later rolled into the PCN DES at network level
• What is referred to as names such as "Improved Access" or "Extended Access" and is a CCG commissioned service delivered in various way

Note 2: The BMA has confirmed GPs will be funded £7.46 per patient to deliver the new PCN extended hours scheme]

Early Cancer Diagnosis
In addition to FIT, the use of tele-dermatology "to support skin cancer referrals, where available and where appropriate" – but that is not mandatory. There is also a need to implement a plan to "increase the proactive and opportunistic assessment of patients" for a "potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-Pandemic baseline". This could pose a significant workload issue – but we will need to await further details. Finally, there is going to be a review to the Non-specific symptom 2ww pathway. We will work with the CCG/ICS to push for improvements and remove any real or perceived obstructions for GP teams.

LMC View: What Is Missing?
• No ARRS flexibility
• No pandemic recovery plan reflecting secondary care's position
• No funding to cover the increased Employers' NIC from April and rising inflation (LMC Comment: We have raised this with Cheshire CCG)

LMC Comment: Next Steps
These contract changes have been imposed, there has been no agreement by GPC. The ramifications are being discussed nationally, as is the legality of imposition of what NHSE consider routine contractual amendments. Despite general practice pulling out all the stops to deliver the lion's share of the covid vaccination programme and the Omicron booster scheme over Christmas, not to mention delivering more appointments with fewer staff than ever before, these changes provide no concession of support and merely intend to pick up where we left off two years ago, as if nothing had happened in the interim. But everything has happened.

It is clear, that we are going to have to craft our own solutions to workload, and safety in the workplace, to avoid further loss of our workforce. We intend to help you do that in the coming weeks.

In the meantime, we advise that you work in your PCNs within the constraints of this contract, in a manner which works best for you and your patient population. In particular, with regard to the enhanced access/extended hours 'offer' we recommend exploring the

option of subcontracting services, and **if you do not already do so, to work closely with local Federation colleagues where this makes sense**.

In the interim, your LMC will work with the CCG and emerging Integrated Care Board (that part of the ICS likely to hold GP and other NHS contracts) and Place (e.g., Cheshire East and Cheshire West) to press for as much flexibility and autonomy as possible, so practices are free to make this contract work in the way that suits their patient populations best. We will always support you to interpret the requirements of a contract in a way which is as flexible and pragmatic as possible, in the best interests of the sustainability of your business and the wider primary care community of Cheshire.

W.Greenwood
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Cheshire LMC

15 March 2022