Update to the GP Contract Agreement 2020/2021 – 2023/2024

There are a lot of useful summaries of the GP Contract agreement already available, therefore rather than focus on what is included in the contract I wanted to concentrate on the likely impact on Practices, PCNs and GP Federations (or Networks of Networks).

To start with, it is worth considering what the Contract Agreement actually is:

- The annual amendment to the GMS Contract
- The year two plan PCN DES Specification
- The delivery plan for the NHS Long-term Plan

Looking at the three elements my observation is:

GMS Contract - For practices there are some significant new obligations (such as sharing their activity and workforce data) and some new service requirements. Interestingly on their own the incentives may not be sufficient to make the changes and requirements acceptable.

PCN DES - The contract is much more attractive to PCNs and removes lots of the significant barriers in the last version, most of the financial benefits are for the PCNs and some of these are required to be re-invested in services rather than in practices.

The NHS Plan – Some of the requirements have been set out as aspirations in previous documents (on-line access) others are new (50 million more appointments), and there is a mix of national and local actions (training more GPs etc).

Putting the three elements together my main observation is that there are some significant new obligations for practices whilst most of the financial benefits are for the PCNs, and some of these are required to be re-invested in services rather than into practices.

Making the new contract work for PCNs and Practices – What PCNs need to deliver

Interestingly there is for the first time an explicit statement as to reasons why the Additional Roles Reimbursement (ARR) scheme is in place:

1) To support practice sustainability
2) To improve access – deliver more appointments
3) To deliver NHS Plan goals

This is important as these 'reasons' have not been clearly spelt out before. Clearly the delivery of 2) and 3) could be seen as additional staff for additional work and therefore not contributing to 1) however it is an interesting debate if increasing capacity to improve access is practice sustainability or additional work. The paradox in these statements is that the Additional Roles are PCN roles but the objectives 1) and 2) are practice based objectives, unless PCN solutions are put in place (i.e. PCN based services).

If we assume that the PCN practice participation payment (included in the GMS uplift) is not enough to persuade practices that the PCN model is worthwhile, then the key challenge is how PCNs make the ARR scheme and the other PCN incentives improve the sustainability and resilience of practices as well as delivering the PCN requirements, providing the answers to the following questions:

- Do practices recognise and welcome the opportunity to work with the other practices in the PCNs? I.e. Are practices taking the opportunity to share back office functions? Are relationships improving within the PCN?
- Do the additional roles provide real practical support to practices? I.e. Is access to Social Prescribing reducing the practice workload? Can each practice effectively use First Contact Physiotherapy appointments?
- Are practices clear how they would wish to use any future resources delivered through the incentive scheme? I.e. Have the practices developed a list of service priorities?
- Are PCNs looking to develop 'At Scale Solutions' to meet new service requirements? I.e. Is there a PCN Care Home Plan? Is there a PCN solution for ensuring that practices can work together to deliver Local Enhanced Services?
- Are PCNs preparing schemes which will enable practices to benefit from the provision of Extended Access and Extended Hours?

If the answer to some or all the above questions is "yes", then it is likely that the PCN model will be welcomed by the practices and the contractual changes will be recognised as a key element of changing the way practices work together; if the answer is "no" then there is a danger of the following refrain: "What has the PCN ever done for us?"

Making the new contract work for PCNs and Practices – How PCNs can deliver

In my view there are a number of do's and don'ts that are key to prevent practices from questioning the value of the PCN.

1) Do work at a higher scale than the PCN. Unless your PCN is large then you will need to work as a Network of Networks to maximise opportunities and to negotiate the right deals. Challenge your local Federation to deliver what the PCN wants / needs or look to create a new Network of Networks.
2) Do keep an absolute focus on the benefits to patients and practices, keep asking the question as to how any proposal will benefit patients and practices – it can be easy to be driven by the CCG / NHSE agenda and this may not be your priority.
3) Do try to understand where the PCN fits with the changes to the way Health Systems are organised – recognise the PCN role must represent General Practice as a provider.
4) Don't overly focus on the PCN Board meetings – these meetings will not be the best place to formulate plans – the Board needs to sign off decisions but the work to determine the right options / recommendations needs to go on outside the Board. Making the Board work effectively remains the biggest challenge for PCNs.
5) Do understand the three key requirements of your PCN management / administration:
    a. To effectively manage the Board – making sure the agenda and papers work effectively, making sure the minutes and action notes are circulated within a couple of days of the meeting etc.
    b. To effectively communicate / engage the practices – this needs to happen outside the meeting and can't be delivered solely by E Mail or newsletter.
    c. To deliver on projects. Making things happen remains the biggest challenge – the trick is to ensure your project management resource is really focussed on delivery.

Is the new contract the 'tipping point' in respect of practice recognition that PCNs are here to stay?

Everyone is well aware that the reaction to the original version of the contract (December 19) put the future of PCNs as a part of the NHS architecture in serious doubt. The revised offer addresses all the criticisms of the original, and is likely to be seen as the tipping point in respect of the acceptance of PCNs by practices, however, there remains two key challenges:

1) Ensuring Practices feel the benefits – as pointed out earlier the contract offers significant incentives to PCNs, but these need to translate into practical support to practices.
2) The ongoing challenges of the organisational model. The PCN structure provides practical difficulties – PCNs are Unincorporated Associations and as such they can't employ staff or take on contracts etc. This is continuing to cause some tensions particularly around taxation and the employment of PCN Clinical Directors – these tensions may yet affect the resilience of PCNs.

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- Developing and delivering Extended Access services
- PCN practice benchmarking and data analysis
- IT training and support
- Project Management
- Practice Resilience and Sustainability
- GDPR
- Implementing innovative solutions.