Institute of General Practice Management Response to the NHS England & Improvement General Practice Contract Arrangements in 2022/23 Letter Published 1st March 2022

Following the publication of NHS England & Improvement's letter titled "General Practice Contract Arrangements in 2022/23", the IGPM received a large number of contacts from members highlighting their concerns over proposed changes. We canvassed remaining members for their opinions and have produced this document to highlight to NHS England & Improvement (NHSE&I) and other relevant bodies the views of the Practice/PCN Management profession.

General Practice is also keen to "get back to normal" but we must accept that there is a lasting impact from the pandemic on how we run services, how we respond to patients needs and how we also protect our clinically vulnerable patients and staff. We are committed to returning to business-as-usual as much as possible, but also need to emphasise that the pandemic has in many areas been detrimental to our ability to retain and recruit new staff, safely manage our estate in a way that maximises patient access and be able to manage the expectations and demands of patients.

There are a number of elements detailed in the letter which our members have concerns about, particularly in regard to the implementation of some of these requirements.

Core Funding

NHSE&I and the government will continue to honour the 5-year settlement in terms of funding – which equates to a 2.5% uplift to the global sum. Our members are concerned that this does not go far enough. With the planned increase to national insurance contributions and the rapidly increasing rise in cost-of-living and inflation, this will in effect be a real-terms pay cut to many staff. It will also not account for the rising costs of non-staff spend, i.e., consumables, equipment and utilities. We are disappointed to see that no further funding increase appears to have been offered.

Requirement to offer online-bookable appointments

The document states that there will be a "*more targeted requirement that all appointments which do not require triage are able to be booked online, as well as in person or via the telephone. Guidance will be issued on what type of appointments practices are expected to be made available for online booking*". Many members erroneously read that 25% of appointments will be online-bookable (which was in fact the previous agreement prior to the pandemic) – we have clarified this statement to them, but without knowing what the guidance is, there remain concerns that the figure produced could be as high, or even higher.

Issues raised by our members include:

- Feeling that all appointments currently require some level of triage - just to confirm the patient has no Covid-19 symptoms or recent positive test/positive contact. Given the guidance on maintaining Covid-19 security in healthcare currently only lasts until 31st March 2022, and that there has been no confirmation on funding or supply of lateral flow tests for healthcare staff after this date, there is much concern amongst the management community

on how to maintain effective IPC standards. There are also concerns from clinically extremely vulnerable staff who feel without this level of triage they are potentially at risk of coming into contact with Covid-positive patients without knowing. As employers, practices are also concerned about holding the liability for this and potential action being taken by the Health & Safety Executive, as well as threats of disability discrimination from staff and patients.

- Acknowledgement that most practices manage their appointment book differently. Whilst we have all mapped our slots according to GPAD guidelines, these are not activity specific. For example, we may have male patients booking into an appointment for cervical sample taking. We often had patients booking into nursing appointments under the impression they were seeing a GP. Our lived experience shows that regardless of what we call our appointment types, patients will often book in inappropriately leading to either wasted appointments or increased administrative time verifying lists before each clinic. Current systems for online access used in the majority of practices have no mechanism for filtering out Covid-19 symptoms/history or preventing inappropriate bookings being made.
- Who will NHSE&I be engaging with to determine what type of appointment is suitable for online booking?
- Feeling that this could reduce equity of access and increase health inequalities for patients who are unable to use online services effectively. For example, people living in poverty, elderly people, patients with learning difficulties with limited technological skills etc.
- Feedback that practices have spent significant time and resources training reception staff to care navigate, making full use of the multidisciplinary clinical team in their practices. Members feel that online booking overrides this work and also undermines the ethos of continuity of care.

Changes to Access to Health Records for Deceased Patients

Whilst we welcome the opportunity to remove the need to print off whole records to send to PCSE, this change pushes back the responsibility of dealing with requests under AHRA to the practice.

The letter states "*It is expected that the savings from not having to print and send the electronic record will far outweigh the additional burden of managing a small number of AHRA requests*", but our members have asked why PCSE cannot manage both elements, given this is in their current contract of services? Practices can continue to send the electronic record via their clinical system, and any remaining paper records through the usual method. Was this not considered as an option? The requests that do come in are often incredibly complex cases that require a considerable amount of admin and clinical time in terms of reviewing the notes and redaction of sensitive or third-party information.

It is also not clear whether practices are still required to send any paper-based records back to PCSE for storage. Estates is a major issue in general practice at the moment and we do not have the physical capacity to retain deceased patients records in our premises whilst continuing to register new patients.

Continuation of funding for Subject Access Requests

Our members are pleased to see this continuing. With the introduction from April of full online access to the medical record for new entries, we envisage an increase in the number of SARs from patients who will want to see entries from before this date. We are therefore anticipating an increased workload in this area and feel it is appropriate to continue the funding towards this.

Modernisation of GP Registration

We are also pleased to see this work progressing as we hope it will reduce the administrative burden on our staff. Again, we are happy to engage with this work from a practice management perspective to ensure any new process is fit for purpose.

Quality Improvement Indicators

The letter states, "*The Quality Improvement (QI) modules for 2022/23 will focus on optimising patients' access to general practice…*"

Our members are concerned to know how this will be measured. In 2021 we raised concerns about using patient feedback around access during the pandemic as a performance indicator. During a time when practices were doing the best they could when faced with staff shortages and unprecedented demand, there were many patients and media outlets displaying negative sentiment towards the work that practices were doing. These views are often based out of a lack of transparency into how general practice works, a lack of appreciation of the challenges we faced and a lack of understanding of the priorities that we were given from NHSE&I, which did not always match up to the priorities of individual patients.

If this is to go ahead we would like to see more positive communications coming from NHSE&I and the government around general practice, highlighting the work we do in communities, how we are commissioned to provide services and also highlighting the struggles that we sometimes go through and how patients can help by accessing the right care from the right service at the right time.

Increase to PCN ARRS Budget

Again we are pleased to see this, but our members feel that this is at the expense of an increase to the global sum, which would allow recruitment to other roles not covered under ARRS – but equally valuable – to take place. There are also questions about what will happen to any underspend at the end of each financial year. Many of our members work in CCG areas where there is considerable underspend in the ARRS budget but are not clear on where this gets reinvested, or if it does get reinvested into general practice.

Nationally there also appears to have been a considerable lack of progress into recruitment to the Mental Health Practitioner role. Whilst non-clinical staff are now being included (at Band 4 Level) according to the letter, in many areas Health & Wellbeing Coaches and Care Coordinators have already been employed to do this work, so feedback is largely that this change adds little-to-no benefit.

PCN Clinical Director Funding

Our members are disappointed to see that funding increases for this role, but there is no mention of separate Leadership & Management funding for this financial year. As was recognised in 2021-22,

practice and PCN management is key in the success of PCNs and had not been costed previously, until additional funding became available in this financial year. This situation has not changed, and whilst NHSE&I may be expecting Clinical Directors to cover this as part of their uplift, we are concerned that the letter is not specific enough on how this money should be apportioned. The core funding is also not increasing, despite again the rising cost of living and national insurance contributions for PCN-employed (but non-ARRS) staff (e.g., PCN managers, administrative staff etc.) The burden of activities such as contract management, recruitment, management of staff, estates changes and implementing projects often falls to practice managers who are having to do this work on top of their normal role.

Enhanced Access Arrangements

Issues raised by our members include:

- Staffing – members report that staff are feeling burnt out from the last two years and willingness to work over and above contracted hours is at an all-time-low. The availability of locums and agency staff has also reduced considerably. General feeling is that in order to staff additional hours – especially Saturdays – this will be from moving sessions from within core hours, which will not increase appointment numbers. We also acknowledge that many clinical staff choose to work in general practice because we are not normally open on weekends and bank holidays, and this is beneficial for their work/life balance. To enforce weekend working on staff would require potential large-scale consultation which may lead to staff leaving.
- Patient willingness to travel – for PCN's located in more urban settings this may be less of an issue if closely geographically located, but for most rural practices this will be a considerable barrier for patients who will be unwilling to travel for appointments, thus increasing inequity of access. Many of us experienced this through the vaccine programme in our PCN hubs. The letter states "*The new enhanced access arrangements aim to remove variability across the country and improve patient understanding of the service*" – however our members are concerned that this will actually create more of a problem than it solves. It would also be helpful to clarify what NHSE&I's "understanding of the service" is. Further in the letter it states appointments must be "*in locations that are convenient for the PCNs patients to access in person face-to-face services*" – however for example in rural Cornwall, practices could be more than 20 miles apart. Is the expectation that PCNs would then need to offer appointments out of a "neutral" location e.g., another premises, in which case are practices likely to be funded for the increased cost of this?
- Lack of detail on the finance element for this – currently practices receive a combined amount of £7.44 per head. The letter does not confirm whether this level will continue or will in fact – as many members anticipate – be reduced. If a reduction occurs, this makes the impact of what is essentially "unsociable hours" working even more expensive, as staff working during these times are often eligible for enhanced rates of pay. With reduced funding, and no further increase to the global sum, this may be unaffordable for some PCNs to deliver.
- Allowing 111 to book into unused appointments in these clinics – many members have raised that their practices have reduced funding to pay for an Out-of-Hours GP service in their area. They feel that anything triaged by 111 as needing to see a GP outside of core

hours is the responsibility of that service and not something practices should be providing, as well as paying for.

- The need for this service – given recent analysis[1] has shown no measurable impact on patient access to appointments, so our members have asked why is this service being extended further?
- Logistics of booking and legalities – the letter states "*PCNs will be required to provide bookable appointments during the Network Standard Hours which are available to the PCNs registered patients*". PCNs do not have registered patients – individual practices do. Our clinical systems are separate and whilst cross-organisational booking is possible in some areas, it is a laborious process that often results in IT failure. It also states we must *"make same day online booking for available routine appointments where no triage is required up until as close to the slot time as possible*". The concerns regarding online booking are already listed above, but we also are not aware of a technological solution that would allow a non-registered patient to do this, in which case we would not be providing access for patients registered with another practice in the network. Our members are concerned that the wording of the letter implies that it is the responsibility of the PCN to ensure systems are functioning to allow this, when our IT infrastructure is often out of our control and managed by the CCG/CSU.
- Logistics of services – if we are expected to provide routine services will the infrastructure be there to support this. For example, blood and sample collections, IT support in the event of technical problems, community teams able to see patients urgently etc.

Changes after 2023/24

Members have expressed concern that this contract letter was not agreed by GPC England and since then many GPC and BMA representatives have spoken out against it. The letter states "*NHS England and Improvement confirms that it remains fully committed to discussing any proposals for potential future national changes from 2024/25 with GPC England*". Our members have expressed a lack of confidence in this assertion given the manner in which this contract letter was delivered. As always, the IGPM would welcome the opportunity to discuss the logistics and potential implications for staff and patients on any changes to services and we very much have an open door to NHSE&I if they would like to utilise our expertise in these areas.

Overall Viewpoint

Our members feel that overall this document constitutes an increased workload for practices, who are still trying to deal with the fallout from Covid-19 and the very real threat that this still poses to how we manage our day-to-day operations and our business continuity. It poses a number of logistical, financial and staff challenges that we are concerned are not feasible or sustainable. We ask NHS England & Improvement to consider the points we have made and look to whether any changes can be made that make the business of "getting back to normal" something that we can return to successfully, with a workforce that feels supported, engaged with and resilient enough to continue to provide the excellent service that they strive to do.

[1] https://bjgpopen.org/content/early/2022/02/18/BJGPO.2022.0013

Kay Keane Robyn Clark Nicola Davies Jo Wadey

Directors of the Institute of General Practice Management

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