Bedfordshire & Hertfordshire
Local Medical Committee Ltd
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BEDFORDSHIRE & HERTFORDSHIRE LMC

Review of NHSE/I Document *"Our plan for improving access for patients and supporting general practice"*

18th October 2021

As you will be aware, at the end of last week NHSE/I published their "rescue package" for primary care. A copy of the full document can be accessed here. The content of this publication has caused a huge amount of consternation, frustration and anxiety among those who work in general practice. Much of the impact of the directives in the paper will be determined by the way local ICSs/CCGs choose to interpret and implement the plan. We have asked both our ICSs for an urgent meeting to discuss how they view the paper and what plans they intend to submit to NHSEI. There are also ongoing national conversations and meetings about how the GPC/BMA can push back against both this ill-considered publication and the governments general attitude towards general practice.

It should be noted that this publication **does not represent a change to either the GMS contract or the PCN DES specification**. Practices are not being asked to "sign-up" to these new measures in return for funding or other support. These changes are essential being imposed by NHSE/I via the ICSs/CCGs.

The reality of how the proposals put forward by NHSE/I will truly impact general practice will not be known until:

a. There is clarity from the BMA/GPC as to if NHSE/I can employ contractual sanctions for breaches in services which are not defined in the GMS contract (or PCN DES)
b. The local ICSs/CCGs have shared their plans on how they intend to implement and monitor these changes, and what funding will be made available to support their implementation.

We would therefore encourage practices to make no significant changes to the way they currently operate (delivering services in the best interest of their local populations) until there is greater clarity on the two points above.

Below we have broken down the document, identifying the key points we think practices need to be aware of. The section in the blue boxes represent our LMC comments.

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Some (small) Positives

The NHSE/I document has been signed off by the Secretary of State. The document includes statements and commitments:

1. Reaffirming the Government / NHSE-I commitment to general practice, how good patient satisfaction has remained and applauding the work GPs and their staff have done across the pandemic

2. An explanation of the complexity of the access challenge and the need to achieve the best balance of appointment types

3. A zero-tolerance approach to abuse and aggression and a commitment to work with GPC England and others on a zero-tolerance campaign on abuse of NHS staff, including GP teams.

4. £5m fund, through regions, for practice security measures

LMC Comment: These are areas we can largely welcome and are in line with what LMCs and GPC have been lobbying for.

The UK Health Security Agency's independent review of infection prevention control has been published. The significant change is the reduction of social distancing in primary care from 2m to 1m

October Funding

5. Additional funding of £10m for October which is line with the additional funding for September

A new £250m Winter Access fund

This is more than double what we have had over the last 6 months and is for extending capacity of existing workforce, but unlike the previous arrangements this will be for local systems to decide how it should be used. Local plans will need to be developed so it will not go directly to practices before the plans have been approved. It can be used for clinicians and non-clinicians and will be available until the end of March 2022 and will be allocated on a weighted capitation basis to local areas.

LMC Comment: The funding has TWO main uses. One is for improving "access to urgent, same day primary care, ideally from patients' own GP service". But it does say it can be used at PCN level or for expanding extended hours capacity. So, the money does not have to be put into individual practices.

The funding can be used: to fund more sessions from existing staff; to "make full use of the digital locum pool framework, reimbursable at maximum rates set out in guidance"; for extra admin staff; or to employ other physicians, e.g. retired geriatricians.

The other use the funding can be put towards is the urgent care system to expand same day urgent care capacity through other services in any primary and community setting. CCGs have been asked to review capacity and capability of UTCs to match demand. UTC capacity could be expanded as an alternative to patients' own general practices.

CCGs/ICSs will be notified of a maximum indicative amount they will receive from the £250m based on the CCG weighted capitation formula. CCGs/ICSs have to submit a plan by **28 October**. PCN CDs must be involved in developing that plan. The CCGs should also discuss their access plans with the LMC. We have asked for urgent meetings with the CCGs to discuss their plans.

The plans must be "assured by the ICS board" prior to 28th October 2021, which is interesting as ICS boards do not formally come into existence until 1st April 2022.

Funding is due to be released in early November following NHSE approval of the plan. The funding can be reduced or discontinued if "demonstrable progress" is not made by a mid-December checkpoint. This means there will only be a very few weeks in which to make "demonstrable progress".

ICS/CCG Ranking of Practices and Implication for Those Practice Who Rank Poorly

6. ICS/CCGs are required to rank their practices against a number of access measures, including the 20% of practices with the lowest level of **F2F GP appointments** as opposed to whole practice including appointments with other staff. The paper states that in August 15% of practices were offering less than 20% F2F appointments.

LMC Comment: This is making one new NHSE obsession clash with an existing piece of NHSE policy. GP practices have been encouraged to diversify and get more clinicians and non-clinicians in to see patients, under ARRS or not, and now risk being punished for having the diversified workforce NHSE told them to hire. It should be noted that NHSE is still telling them to get a more diverse workforce to see patients in other paragraphs of this document.

For the 15% of practices said to be offering less than 20% of F2F appointments in August, there is a lack of confidence of the dataset being used to derive these calculations.

7. ICSs/CCGs will be required to produce a list of no more than 20% of practices where it will be taking immediate further steps to support improved access. This list is to be submitted to NHSE by **28 October** with the Winter Access Fund plan.

LMC Comment: The document does not say if a list of 0% of practices is acceptable or what the lowest percentage is that is acceptable. We will ask the CCGs about this when we meet them.

8. CQC are planning a revised rapid inspection methodology for appropriate actions once practices "which are not meeting people's **reasonable needs**" have been identified.

LMC Comment: There is no definition of "the reasonable needs of patients" in the contract. "Reasonable needs" can be different in different contexts. They are the "needs" of patients not their "wishes" or "desires". If any practice is identified by commissioners as not meeting the reasonable needs of their patients, the LMC is ready to offer whatever support we can to such a practice.

9. The document suggests that "smaller practices offering unacceptable access may be expected to partner with other practices, federations or PCNs".

LMC Comment: It is outrageous to make specific reference to smaller practices in such a document when patient satisfaction services often show smaller practices with the highest satisfaction rates. It is not clear how the expectation of partnering with another organisation would be achieved. It is not clear what contractual levers the commissioners might have to bring around any such partnering. And, of course, other practices, federations and PCNs are each independent organisations and would need to make their own decisions about who they would want to partner with.

10. There is the threat of "contractual action" where practices do not engage with support and are in breach of their contractual obligation to meet the reasonable needs of their registered patients.

LMC Comment: It is difficult to see how a CCG could in fact take contractual action as there is no definition of "the reasonable needs of patients" in the contract (see comment below point 8 above).

11. The Winter Access Plan must, among other things, aim to: increase overall appointment volumes in practices by the full deployment of ARRS staff AND increase the proportion of F2F appointments with GPs.

LMC Comment: The increase of the number of ARRS and other appointments increases the absolute number of GP appointments. The first requirement increases the size and difficulty of the second requirement. And there are not enough GPs in the system to do the work.

There is also a clear prioritisation of quantity over quality in NHSE's plans. A patient being seen by three clinical professions in separate appointments before a correct diagnosis/treatment can be reached seems to be viewed as preferable to a single GP appointment reaching the same conclusion.

Recommit to expansion of the GP and wider primary care workforce

12. The document admits that existing GP schemes have not been as successful as hoped against the Government manifesto commitment of 6,000 new GPs – so there will be renewed efforts to those and a new advisory group on workforce measures will be established (starting with GP recruitment and retention but could go wider). This is a national target/commitment.

LMC Comment: It is possible that the apparent upturn in GP numbers (1,200 more FTE GPs in June 2021 than June 2019) might include a number of GPs who returned to practice during the pandemic. However, one of the main differences between the numbers that NHSE are using and the BMA are using is that NHSE are including the numbers of trainees and estimates of locum numbers (adding these in changes the data from a decrease in the number of qualified GPs to an increase in the number of GPs).

13. There will be an increased priority on GP workforce measures nationally, regionally and locally.

LMC Comment: This is primarily about ARRS roles. CCGs are required to achieve their share of the 15,500 target by March 2022. We will be asking local CCGs how they are doing against this target and what their plans are. We recognise that it is not always possible to find suitable ARRS staff and that there is also a time-lag if people have to leave other jobs to join PCNs.

14. The document says that "Pharmacists joining PCNs will automatically be trained to prescribe, lifting workload from GPs".

LMC Comment: The document does not address how the training will be funded; whether there will be backfill for the ARRS pharmacist while they are on this training to for someone to do their other ARRS work; or what while happen if an ARRS pharmacist fails to pass the training. The prescribing workload will only be lifted from GPs once a pharmacist is appropriately qualified to prescribe. The document does not address whether existing ARRS pharmacists will/should also be trained to prescribe.

Cloud-Based Telephony

15. **Commitment to enable and encourage a greater use of cloud-based telephony** (currently used by about 24% of practices); looking to provide this for practices immediately (possibly via a short-term national solution – subject to value for money), with a longer-term strategic review and the development of supplier framework.

LMC Comment: Concerns have been raised about what the procurement process might be for a "short-term national solution", given the criticism of Government contracts awarded during the height of the pandemic, and whether this might tie a large number of practices nationally into a monopolistic supplier.

It is unclear if such a procurement would be funded separately or has to form part of the ICS/CCGs spending plan.

Mandatory Sign-Up to Community Pharmacy Consultation Scheme

16. Community Pharmacy Consultation Scheme (CPCS) to increase to apply to all practices (currently only some 800 nationally are signed up to this); **access to the Winter Access fund will be on the basis of having signed up to CPCS**.

LMC Comment: A requirement to be participating in CPCS is a bizarre limiting step for access to the Winter Access Fund. There is no equivalent limiting step for Winter Access Fund plans for urgent care. It is not clear if all pharmacies are ready for CPCS; it is not clear how CPCS will work in urban settings where practices relate to a number of pharmacies; it is not clear if CCG systems are in place to be able to sign all practices up to CPCS. Practices are encouraged to sign up to CPCS by 1 December but the Winter Access Fund plan has to be submitted by 28 October so, presumably, practices have to be signed up before 28 October for the Winter Access Fund plan to be approved.

Covid Vaccinations

17. Practices involved in this will need to be able to deliver all other services. The document says that where face-to-face appointments with GPs in practice are low, commissioners should consider alternative provision for COVID vaccination such as community pharmacy.

LMC Comment: The requirement not to drop anything else when a practice takes on COVID vaccinations is a standard line from NHSE but it is still another example of more and more being piled on general practice. The argument that low GP face-to-face appointments should mean that alternative COVID vaccination is considered is clinically and contractually illiterate. It makes no sense to alter and jeopardise an essential public health vaccination campaign where 70% of vaccinations have been delivered via general practice groupings because of demands for face-to-face appointments when these demands may not even be clinically appropriate. Contractually, access is a practice issue. Practices are working in (usually PCN) groupings to deliver COVID vaccinations. We will be asking the ICS/CCGs:

- What level of face-to-face appointments by individual GP practices in a grouping is enough to trigger reconsideration by the CCG of the PCN's COVID delivery?
- How will the CCG balance practices with lower F2F rates in a PCN with practices with higher F2F rates in a PCN?

It is not clear if pharmacies are immediately ready to take on more COVID vaccination – or how long it would take to transfer from a practice/PCN to a pharmacy model.

Admin Burden

18. There has been little progress on enabling others other than doctors to complete fit notes but the document says this is still NHSE intent. There is a similar commitment to reduce the burden for the DVLA certification processes by increasing the scope for patients to self-declare stability for an increasing number of conditions.

Secondary Care Workload Shift

19. The document highlights the steps already within the standard NHS contract. These include the requirement for hospitals to agree with CCGs plans, covering amongst other things, to eliminate the redirection of activity to general practice, such as organising investigations, prescribing medications etc.

LMC Comment: The LMC is awaiting reports and plans from local hospitals and CCGs on this. We will continue to pressurise our local commissioners for these.

GMS and PCN Contractual Targets (QOF, IIF, Pay Transparency)

20. Despite recognising the pressure general practice is under, and asking practices to take on more work, there are **no changes to QOF, IIF, or pay transparency declarations** this year.

21. NHSE will commissioning a QOF QI module for the future on optimal models of Access (presumably for 2022/23). NHSE will work with research partners on an analysis of the impacts of remote versus F2F consultations, and the role of continuity of care in the GP/patient relationship.

22. The PCN Investment and Impact Fund will incentivise individual practices to improve their patient satisfaction rates for 2022/23 and 2023/24.

LMC Comment: The IIF for 2022/23 incentivises ease of making an appointment, number of online consultations, patients waiting less than two weeks for a general practice appointment, and referrals to CPCS. It **does not incentivise F2F appointments**. The incentivisation of online consultations might be thought to be disincentivising F2F appointments.
IIF operates at a PCN level so it will average out differences between member practices. IIF is not a clear mechanism for incentivising individual practices.

Delay in Extended Access Move to PCNs

23. PCN Extended Access arrangements remain as before - delayed until April 2020 **-** CCGs can transfer to PCNs earlier (if PCNs want this).

Addressing Variation in Appointment Modality

24. Nearly all practices will have been reflecting on balance of appointment types. The document says that this is not a contractual or an expected arrangement, but NHSE encourages all practices to further reflect on this to optimise services to patients. RCGP have been asked to provide guidance to practices on this by the end of November (particularly looking at the balance of remote/online and F2F in GP appointments)

Real Time Monitoring of Practice Satisfaction Data

25. A real-time measure of patient reported satisfaction from as early as April 2022. Patients will automatically receive a message following their appointment with a series of questions about their access to care.

LMC Comment: NHS data solutions don't often come in on the dates they are forecast for. It is not clear if a similar real-time measure of patient satisfaction is to be rolled out for other parts of the NHS. There are clear problems of the digital divide here with regard to those patients who do not have a smartphone, email, or social media presence to receive such an "automatic … message". It is also not clear how any real time data would be used, e.g. will a practice receiving four bad reviews in a row trigger an alarm in the CCG HQ?

26. Data transparency – working with NHSD to move to practice level publication of appointment activity.

LMC Comment: This is a dangerous move as the datasets are published on the NHS Digital website. It will give any individual or newspaper the ability to identify specific practices and single them out for abuse.

Expanding the Access Improvement Programme

27. Expanding the Access Improvement Programme by more than 200 more practices from the 900 that it is working with now. This is a programme that works on reducing waiting times, optimising workflow, improving patient experience, and improving the working lives of practice teams. It is not clear from the document how practices can access the programme if they want to, or whether practices will be enrolled on the programme by the CCG.