Briefing on GP Contract 2022/23

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Key considerations:

- We have been through two exhausting years of this pandemic. This should have been enough for NHSE&I to recognise the need to rebase any five year 'settlement' introduced in 2019, just one year before the pandemic hit.
- The GP contract changes described in B1375 were not agreed with GPC England, therefore this contract is being imposed upon the profession.
- The PCN DES forms part of a five-year deal ending in March 2024.
- Full service specifications for the PCN DES 2022/23 are not yet published.

Opening statements

Page/ section	NHS England text (highlights added)	Comments
Pg 2, para 3a	**Online Booking** It will be 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 via the telephone.	This is unclear. However, practices are advised that they should continue to determine which appointments "require triage", what form that triage should take, and who conducts it. Practices should continue to provide services according to patient need in accordance with their contract.
Pg 2, para 3b	**Patient Records** To require GP practices to respond to Access to Health Records Act (AHRA) requests for deceased patients and to remove the requirement for practices to always print and send copies of the electronic record of deceased patients to Primary Care Support England (PCSE).	This may or may not reduce administrative burden on practices.
Pg 2, para 3d	**SARs** There will also be continuation of funding in Global Sum (£20 million) for one additional year (2022/23) to reflect workload for practices from Subject Access Requests (SARs).	Subject to further detail, this may be positive considering the increased workload of SARs.

Page/ section	NHS England text (highlights added)	Comments
Pg 3, para 1	No new indicators will be added to QOF when the temporary income protection arrangements come to an end in March 2022. The Quality Improvement (QI) modules for 2022/23 will focus on optimising patients' access to general practice and prescription drug dependency.	We have called for QoF protection to remain in place. It is unacceptable that this has not been continued when the profession is in such crisis. Identifying optimised access targets as a metric is unreasonable when the true issue is capacity.
Pg 3, para 2	PCNs have made excellent progress in recruiting to roles under the Additional Roles Reimbursement Scheme (ARRS). The national target is 15,500 FTEs by the end of 2021/22. Based on NHS Digital (NHSD) data and NHS England and NHS Improvement ARRS financial returns we are confident that we are on track to achieving that target.	This statement is counter to evidence shared across London's LMCs and practices. Recent trade press reports based on information sourced from PCNs across England found that ARRS recruitment was falling far short. This was confirmed by the RCGP. Despite national promotion of the ARRS scheme, over 50% of London practices still report clinical vacancies for GPs and nurses (via the 6 monthly Londonwide LMCs workforce survey), alongside issues about recruitment, training and deployment of additional roles, and concerns that workforce and patient demand continue to rise.
Pg 3, para 3	The amount available for PCNs to recruit additional staff will increase as promised by £280 million to just over £1 billion for 2022/23. We continue to encourage PCNs to make full use of their ARRS entitlements.	There is no perceived value in pushing for further ARRS recruitment when staff for the roles either do not exist in sufficient numbers, or at sufficient levels, or do not provide enough benefit.
Pg 3, para 4	The PCN Clinical Director funding for 2022/23 has been agreed as £0.736 per head or £44m nationally as part of the five-year deal. We confirm that this funding will be boosted by a further £43 million.	This is misleading as it suggests that the funding for 2022/23 has been uplifted twice. We presume this is a typo and that "2022/23" should read "2021/22" as this amount of £0.736 was agreed in 2021, to apply to the 2021/22 DES specifications (see page 62). We also presume "£44m" is a typo as this was £43m according to NHS England's own communication from August 2021 (see page 3). We read this section as being a continuation of the previous 2021/22 status quo on CD funding, and that the increased amount will continue for a further year, which is positive.

Page/ section	NHS England text (highlights added)	Comments
Pg 3, para 5	As agreed in the 2019 deal and subsequent updates, we will bring together, under the Network Contract DES, the two funding streams currently supporting extended access to fund a single, combined and nationally consistent access offer with updated requirements, to be delivered by PCNs.	The reference to "updated requirements" is concerning as this indicates increased workload/demands whilst the original funding envelope remains static. Further detail on this aspect is annotated below in comments on Annex A.
Pg 4, para 2	There will be a limited expansion of the Cardiovascular Disease Prevention and Diagnosis service.	The paperwork is lacking detail of the referenced "limited expansion". No detail appears in the annexes.
Pg 4, para 3	We are now further re-phasing published plans in two ways. First, PCNs will have an additional year to implement digitally enabled personalised care and support planning for care home residents. 2022/23 will now become a preparatory year, with implementation of the requirement required by 31 March 2024. Second, there will be an extension of the period that PCNs have to develop their anticipatory care plans until December 2022. The Anticipatory Care service itself, which will be ICS led, will start in 2023/24.	It is welcome that Anticipatory Care services will not start until April 2023, and Personalised Care will not be a requirement until the end of 2023/24. However, it remains to be seen how much workload this will require and we await details in the service specifications.
Pg 4, para 5	Three new Investment and Impact Fund (IIF) indicators focused on Direct Oral Anticoagulants (DOAC) prescribing and FIT testing for cancer referrals will be introduced in 2022/23.	Making FIT testing an IIF target for all lower GI 2ww referrals could undermine agreed cancer pathways which state that FIT testing is not mandatory, especially where it will delay referral.
Pg 5, para 1	The current five-year framework of GMS contract changes, agreed by GPC England concludes at the end of 2023/24. The default position is that the existing GMS contract will automatically roll forwards unless it is changed.	This defines the whole five year agreement introduced in 2019 as the "GMS contract" and states the intention that this will "automatically roll forwards unless it is changed." This is concerning as it marks an intention for PCNs to continue beyond 2024.

Page/ section	NHS England text (highlights added)	Comments
Pg 5, para 2	In considering options for any future potential changes to the national GMS contract, NHS England and NHS Improvement and DHSC will engage with a range of NHS organisations including the new Integrated Care Boards who will be responsible for commissioning primary care services; and patient and professional representative groups.	It is concerning that NHS England list a wide range of other organisations before mentioning consulting the profession itself on GMS contract changes. It is unclear whether similar broad consultations are intended for contracts/ contractual changes for other providers and services across the health landscape. It is also unclear why this section references GMS contracts and not PS or APMS contracts.
Pg 5, para 3	NHS England and NHS Improvement confirms that it remains fully committed to discussing any proposals for potential future national changes from 2024/25 with GPC England.	In light of the contract imposition in 2022/23, the word "discuss" instead of "negotiate" or "agree" with regard to contractual changes for 2024/25 is concerning.

Annex A – enhanced access:

The "Enhanced Access" referred to here is the new combination of the following two separate services which, as of October 2022, will become a single network obligation under the DES:

- "Extended Hours" (prior to 2019 this was a practice level DES; later rolled into the PCN DES at network level).
- "Improved Access" or "Extended Access" (a CCG commissioned service delivered in various ways).

Section	NHS England text (highlights added)	Comments
1	From 1 October 2022, PCNs will be required to provide Enhanced Access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays.	This would appear to be open to interpretation as provision of service within these hours as opposed to across these hours.
2	To prepare for delivery of Enhanced Access from 1 October 2022, PCNs must work with their commissioner to produce and agree an Enhanced Access Plan. This plan will need to set out how the PCN is planning to deliver Enhanced Access from October.	Reflecting the diversity found across, and even within, London's LMC areas, these plans should be formulated at a local level under a light touch approach, rather than the one-size-fits-all checklist that NHSE&I gives from 2 (i) to (vii).
3	PCNs must submit their draft Enhanced Access Plan to their commissioner by 31 July, with a final iteration agreed by 31 August. Commissioners will need to ensure the PCN Enhanced Access Plans form part of a cohesive ICS approach.	Producing a joined-up ICS service will be a challenge for commissioners but is not the responsibility of practices or PCN CDs to plan/ coordinate beyond their respective areas.

Section	NHS England text (highlights added)	Comments
4	PCNs will be required to provide enhanced access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (known as "Network Standard Hours").	The phrase "Network Standard Hours" suggests a direction of travel towards the return of OOH provision (even if on a shared basis) which the 2004 contract removed, at a negotiated financial deficit to practices. We are clear that there is a distinction between standard hours across the network, and core contractual hours within general practice.
5 (i)-(iii)	PCNs will be required to provide bookable appointments during the Network Standard Hours which are: i. available to the PCN's registered patients ii. are for any general practice services iii. for bookable appointments, that may be made in advance or on the same day, regardless of the access route via which patients contact their practice, and the PCN must a) make the appointments available a minimum of two weeks in advance, with the PCN's Core Network Practices utilising appropriate triage and/or navigation as required to book and/or offer patients available appointments b) make the Network Standard Hours appointment book accessible to its practices to enable efficient patient bookings into slots following patient contact c) make same day online booking for available routine appointments where no triage is required up until as close to the slot time as possible d) operate a system of enhanced access appointment reminders	(ii) The appointments should be for "any general practice services" which the practice feels are appropriate/necessary for their patients. (NB: "any" does not mean "all".) (a) The requirement for appointments to be "bookable" and "utilising appropriate triage" is contradictory. We interpret this as "bookable" by the GP/clinician/practice following triage, where the practice thinks an appointment is appropriate. (b) Each practice in the PCN should be able to access the appointment book. (c) Where appointments are available, they should be available to book online. Where there are on-the-day slots [bearing in mind 5 (iii), a) requires all appointments to be pre-bookable rather than on-the-day] and they remain unused, they should be made available to 111.

Section	NHS England text (highlights added)	Comments
	e) provide patients with a simple way of cancelling enhanced access appointments at all times a. in line with published guidance, make available to NHS111 any unused on the day slots during the Network Standard Hours from 6.30pm on weekday evenings and between 9am-5pm on Saturdays, unless it is agreed with the commissioner that the timing for when these unused slots are made available is outside of these hours b. have in place appropriate data sharing and, where required data processing arrangements to support the delivery of Enhanced Access between the PCN's Core Network Practices and where applicable a sub-contractor.	

Section		NHS England text (highlights added)	Comments
5 (iv)	iv.	delivered by a multi-disciplinary team of healthcare professionals, including GPs, nurses and Additional Roles Reimbursement Scheme workforce	The staff delivering these services at various times must include the wider practice team.
	v.	within Network Standard Hours and are:	
		a) a mixture of in person face to face and remote (telephone, video or online) appointments, provided that the PCN ensures a reasonable number of appointments are available for in person face-to-face consultations to meet the needs of their patient population, ensuring that the mixture of appointments seeks to minimises inequalities in access across the patient population	(a) In order to provide a "mixture" which includes a "reasonable number" of different modalities and types of consultations which "minimise inequalities in access," we advise practices to use their discretion and provide a mixture not dissimilar to their mid-week services.
		b) in locations that are convenient for the PCN's patients to access in person face-to-face services; and	(b & c) Delivered in sites and locations no less numerous or local than how they have been delivered by CCG commissioned services.
		c) delivered from premises which are is as a minimum equivalent to the number of sites within the PCN's geographical area from which the CCG Extended Access Service was delivered.	
5 (vi)	vi.	providing a minimum of 60 minutes of appointments per 1,000 PCN adjusted patients per week during the Network Standard Hours, calculated using the following formula: additional minutes* = the PCN adjusted population** ÷ 1,000 x 60 *convert to hours and minutes and round, either up or down, to the nearest quarter hour **PCN adjusted population is based on the CCG Primary Medical Care weighted population as at 1 January 2022	For a sample 50k patient PCN: 50,000 ÷ 1,000 x 60 = 3,000 minutes (50hrs) per week.

Section	NHS England text (highlights added)	Comments
6	If agreed with the commissioner, a proportion of the Enhanced Access minutes may be provided outside of the Network Standard Hours, where it is evidenced by the PCN that such appointments would better meet the needs of the PCN's patients. For example, this could be through the provision of a morning clinic between 7am to 8am, or by exception a proportion of capacity may be used to support management of demand during core hours, where this is regularly high.	Where there is demonstrable need (eg. where it has already been happening) PCNs may, in agreement with the commissioner, provide a proportion of these required services outside the "Network Standard Hours," including (where demand is "regularly high") during core hours. As demand is demonstrably regularly extremely high throughout the week, the LMC will support practices in calling for some of these hours to be at the busiest times of the week, as defined by practices.
7	PCNs must ensure GP cover during the Network Standard Hours, providing in person face-to-face consultations, remote consultations, leadership, clinical oversight and supervision of the multi-disciplinary team (MDT).	The GP member of the MDT should provide a variety of consultations, no different to how they do during in-hours practice.
8	PCNs must actively communicate availability of these enhanced access appointments to their patients, including informing patients how they can be accessed, what and when specific services are available (for example vaccinations and immunisations, screening, health checks, PCN services etc) and what and when different members of the MDT are available, through promotion and publication through multiple routes. This may include the NHS website (nhs.uk), the practice leaflet, the practice website, on a waiting room poster, by writing to patients and active offers by staff booking appointments.	As per the GMS contract, practices should meet the reasonable needs of patients who are "ill or believe themselves to be ill" and should use their own discretion in utilising these appointments according to need, in a manner to be determined by the practice in consultation with the patient.
9	PCNs must ensure, when available, appropriate telephony and IT interoperability will operate between the practices of the PCN, as well as any other parties involved, such as sub-contracted providers.	In much the same way that practices currently communicate and data share in their PCNs.

Annex B – Updated Early Cancer Diagnosis service requirements 2022/23

Service specifications for Early Cancer Diagnosis have already been introduced for 2021/22. The communication B1375 by NHSE&I updates these requirements, however this is pending formal updated service specifications. We summarise below what appears to have been added.

Section	NHS England text (highlights added)	Comments
1	Review referral practice for suspected and recurrent cancers, and work with their community of practices to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas where early diagnosis rates are lower.	There is a new emphasis on reducing inequalities, which was one of the targets set out in the original 2019 five year deal.
2	Work with its core network practices to adopt and embed: i. the requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer; and, ii. where available and appropriate, the use of tele-dermatology to support skin cancer referrals (tele-dermatology is not mandatory for all referrals).	As mentioned in comments on Pg 4, Para 5 above, FIT tests are already part of the agreed process in some areas but are not mandatory. This spec appears to undermine that process, as well as adding it to IIF. Tele-dermatology to be introduced but we emphasise this is not mandatory.
3	Focusing on prostate cancer, and informed by data provided by the local cancer alliance, develop and 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 increase in "opportunistic assessment" has potential to cause a further large excess of workload. We await further details in the specifications.
5	Review use of their non-specific symptoms pathways, identifying opportunities and taking appropriate actions to increase referral activity.	Londonwide LMCs will work with commissioners at pan London, ICS and local LMC level in our interface meetings to push for an improvement in non-specific symptom pathways to remove 2ww obstructions which currently exist.

Annex C – Investment and Impact Fund (IIF)

Thresholds, points, and maximum payment per average PCN for the three new indicators are summarised below (based on 1,250 PCNs in England). Note: that the Access and SMR IIF indicators were announced in the August 2021 contract update, but with no detail on thresholds.

Indicator	Requirement	Thresholds	Points	Max funding
CVD-12	Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	Upper: 95% Lower: 70%	66	£11,840
CVD-15	Number of patients that were prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2-VASc score of 1 or more for men or 2 or more for women and who were prescribed a DOAC.	Upper: 60% Lower: 40%	66	£11,840
CAN-10	Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the 14 days after the referral. *Comment: We interpret this as meaning that FIT testing does not need to delay referral and indeed can be requested but not completed when the referral is done.*	Upper: 80% Lower: 2022/23 = 40% 2023/24 = 65%	22	£4,000

Indicator	Requirement	Thresholds	Points	Max funding
ACC-02	Number of online consultation submissions received by the PCN per 1000 registered patients (per week).	5 per 1000 patients (25 in avg. PCN)	18	£3,280
SMR-01	Percentage of patients eligible to receive a Structured Medication Review who received a Structured Medication Review.	Upper: 62% Lower: 44%	53	£9,600

With thanks to our colleagues at BBO LMC for their assistance and analysis of the contract documents. As always, please do not hesitate to contact us for support, advice or assistance of any kind on the challenges within this contract, or if you have any questions, at info@lmc.org.uk.