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Your 2019-20 GMS contract: the changes to focus on now

With the 2019-20 financial year upon us, practices must be fully aware of contract changes and their possible impact on funding and workload. **Deborah Wood*** gives an expert round up and commentary

This year has seen a very different approach to those of previous years with no Doctors and Dentists Review Body (DDRB) involvement - other than to inform rates for GP trainees, educators and appraisers - and NHS England (NHSE) and the BMA jointly agreeing the contract changes as part of a five-year framework.

The agreement reached covers these main areas:

1. Workload issues
2. Indemnity costs
3. Quality and Outcomes Framework (QOF) improvements
4. Primary care network contracts
5. Urgent care services
6. Digital technologies
7. NHS Long Term Plan commitments
8. Five-year funding clarity
9. Test bed programme for future contract changes.

Here I cover the agreement's main financial aspects with specific reference to 2019-20 changes. Other parts of the agreement are covered elsewhere in this issue of *AISMA Doctor Newsline*.

Practice contract funding

The core GP practice contract is to be boosted by £978m a year by 2023-24. The Government has also committed funding to meet the full costs of the 6.3% increase to employer's superannuation contributions from 1 April 2019 (See Table 1).

For 2019-20 this means a 1.4% overall uplift in the contract investment, covering the transfer for indemnity costs, the network participation payment of £105m including the 1% deferred staff pay uplift from 2018-19, and the transfer of the Extended Hours DES to networks.

This funding aims to give practice staff and salaried GPs a 2% rise in 2019-20.

Latest available statistics published last August by NHS Digital for 2016-17 show average expenses in England are rising faster than gross income. They rose by 8.5% while gross income increased by 7.2%. The expenses to income ratio went up by 0.8% to 67.6%.

So it is hoped that the 2019-20 uplift will be enough to cover ongoing inflationary pressures and enable GP principals to also have a 2% (after indemnity adjustment) earnings rise.

Indemnity costs

There is a non-recurrent £60m investment, based on unweighted patient numbers, to cover increased indemnity costs for 2018-19. The payment for 2018-19 is £1.005 per patient.

A new Clinical Negligence Scheme for GPs is in place to cover liabilities incurred on or after 1 April 2019, provided by NHS Resolution and covering all NHS GP service providers including out-of-hours. The scheme covers all staff working in the delivery of primary medical services.

Covered liabilities have to arise from an act (or omission of an act) by a GP or any person working in a general practice where the act (or omission) is connected to the diagnosis, care or treatment of a patient and results in personal injury or loss to the patient.

The cover will extend to contractor and salaried GPs, GP locums, nurses, allied health professionals and GP trainees.

The scheme's full costs will be met by the Government through a one-off permanent adjustment to the global sum representing the current contributions towards indemnity costs.

But practices and individuals including GPs, nurses and some other clinical staff - and note the trainees section below - must still take out separate cover for non-NHS professional or private practice work, advisory

Table 1

	2019-20	2020-21	2021-22	2022-23	2023-24
Contract baseline	£8,116m	£8,303m	£8,562m	£8,748m	£8,985m
% annual increase	1.4%	2.3%	2.8%	2.5%	2.7%

" Further guidance is expected to assist with changing the data extraction process and removing the coding burden."

services, inquests, regulatory and disciplinary proceedings, employment and contractual disputes and non-clinical liabilities. Complaints are not covered.

Vicarious and joint liability claims against GP practices/other organisations

Where a partner, employee, locum or trainee in any GP practice/organisation is covered as set out above, then vicarious liability claims made against the GP practice/organisation will also be covered.

Similarly, joint liability claims brought against a GP practice partnership in respect of the liabilities of one of its partners will also be covered.

Trainees

Comprehensive personal indemnity cover for all GP trainees will be funded by Health Education England (HEE) until qualification.

This vital professional protection includes, for example, support with GMC investigations and hearings, assistance with criminal proceedings, protection for Good Samaritan acts, and free medicolegal advice.

Where a trainee's personal protection is currently provided by a medical defence organisation through a bulk-indemnity agreement, this will continue.

Those trainees who purchase their own professional cover should continue to seek full reimbursement until such time as a future bulk-indemnity agreement is arranged by HEE.

Quality and Outcomes Framework (QOF)

A QOF review was published in July 2018. A sub-group combining NHSE and GPC members worked to implement it and new guidance shows the changes from April.

Some 28 indicators with 175 points value will be retired. 101 of these points will be recycled into 15 more clinically appropriate indicators across five areas.

• Reducing iatrogenic harm and improving outcomes in diabetes care	**43 points**
• Aligning blood pressure control targets with NICE guidance	**41 points**
• Supporting an age-appropriate cervical screening offer	**11 points**
• Offering pulmonary rehabilitation for patients with COPD	**2 points**
• Improving focus on weight management for some mental health patients	**4 points**

Exception reporting will be refocused as personal care adjustments under five different categories:

- Unsuitability for the patient
- Patient choice
- Patient did not respond
- Service unavailable
- Newly diagnosed or newly registered patients.

Further guidance is expected to assist with changing the data extraction process and removing the coding burden.

The remaining 74 points will be used to create two quality improvement modules under a new quality improvement domain. Each module is effective for one year and will then be replaced with a different topic.

Table 2

	2019-20	2020-21	2021-22	2022-23	2023-24
Additional role	£110m	£257m	£415m	£634m	£891m
£1.50 per head	£90m	£90m	£91m	£91m	£92m
Clinical director	£31m	£42m	£43m	£44m	£45m
Extended hours	£66m	£87m	£87m	£87m	£87m
Improving access			£367m	£376m	£385m
Investment/impact		£75m	£150m	£225m	£300m
Total	£296m	£552m	£1,153m	£1,457m	£1,799m

For 2019-20 the modules cover:

- Prescribing safety
- End of life care.

The new domain aims to improve patient care, be valued by practitioners, be a smart investment, and - in this first year - to assess if QOF is the right place for this type of quality improvement investment.

The QOF point value will be adjusted in 2019-20 to reflect population growth and relative changes in practice list size using data at 1 January 2019. Based on the data then, compared to January 2018, an average list size has risen from 8,096 to 8,479. This means the value of a QOF point will rise from £179.26 to £187.74.

There are no changes to QOF thresholds in 2019-20.

Enhanced services: network contract DES

Under this DES general practice takes the lead role in every Primary Care Network (PCN).

The Network Contract is effective from 1 July 2019 with funding set over a five-year period to reach £1.799 billion by 2023-24, equivalent to £1.47m for a typical 50,000 patient network.

This investment includes £1.235 billion of new funding, the existing enhanced access and extended hours DESs, and £1.50 per patient cash support (see Table 2).

Local CCG investment for integrated primary and community care should be added to this.

The improving access monies previously available through CCGs will be used as planned for 2019-20 and 2020-21 and will not be expected to contractually transfer into the networks until 2021-22.

CCGs and LMCs will need to review their locally agreed services to ensure local enhanced services are directed to outcomes beyond that of the Network Contract.

This DES is an extension of the GP core contract and must be offered to all practices holding GMS/PMS or APMS contracts with 100% geographical coverage expected to be in place by 30 June 2019.

It has three main parts:

- Network service specifications
- Network financial entitlements
- Supplementary network services.

Eligibility requires submission of the registration form to the CCG by 15 May 2019 showing:

- Member practices
- List size at 1 January 2019
- Map of agreed network area
- Named provider that will receive funding on behalf of the network
- Named accountable clinical director for the network.

Once approved, network funding starts from 1 July 2019 comprising:

- Additional Role Reimbursement Scheme (see below)
- Support funding for the clinical director, 0.25 WTE per 50,000 patients £0.69 per patient per annum (75% payable for 2019-20)
- £1.50 per registered patient (25% will have been paid to practices for the first quarter with the remaining 75% to networks from July).

Practices signing up with a network will get a network participation payment of £1.761 per weighted patient.

There will be a manual claims process for 2019-20.

Each network is expected to serve a 30,000 minimum population and will tend not to exceed 50,000. Its area will be aligned to local requirements including consideration of other community-based providers, governed by a network agreement. A national template agreement was due to be published at the time of writing.

Additional Role Reimbursement Scheme

There will be an Additional Role Reimbursement Scheme established within the new Network Contract DES starting from 1 July 2019. The reimbursement will be recurrent funding and will be £110m for 2019-20 rising to an expected £891m for 2023-24.

Based on an average PCN covering 50,000 patients this is equivalent to £92,000 rising to £726,000 over the next five years.

This funding will create additional posts for clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics.

The model role specifications and additional guidance were due to be published as this article was being written.

For 2019-20 the funding will be available to every network of at least 30,000 patients at 70% for one additional WTE clinical pharmacist and 100% for one additional WTE social prescriber based on Agenda for Change scales. The funding is for two WTEs for networks over 100,000 patients, and an additional WTE for every additional 50,000 patients beyond that.

The maximum reimbursable amounts for 2019-20 are:

- Clinical pharmacist £38,810
- Social prescriber £34,113.

The funding becomes available from 1 July 2019 on an actual salary claims basis at the point of confirmed recruitment into post.

Practices and networks need to agree who will employ the new staff members. Consideration needs to be given to:

- Overall employer liability
- Where the funding sits relative to the costs
- Any potential VAT implications for possible cross charging between practices and the network
- Auto enrolment and entitlement to the NHS Pension Scheme.

Practices and networks will this year need to plan for their 2020-21 additional staff requirements when the network will receive a single combined share based on weighted capitation.

IT and improving access

The new global sum includes £20m annually for the next three years to support practices to manage Subject Access Requests (SARs) under GDPR.

All newly registered patients will have full online access to their prospective data from April 2019.

All practices will offer and promote electronic ordering of repeat prescriptions and use electronic repeat dispensing for all patients from April 2019.

All practices will ensure at least 25% of appointments are available for online booking by July 2019.

From April 2019 it will no longer be legal for any NHS GP provider to advertise or host private paid-for GP services that fall within the scope of NHS funded primary care services.

"No further seniority changes have been announced so it is assumed that as previously agreed, seniority payments will cease on 31 March 2020."

For 2019-20 NHS 111 will have direct access to book into practice appointments based on one appointment per day per 3,000 patients, two per 6,000 patients and so on in increments of 3,000 patients.

Funding distribution

For 2019-20 the rurality index element of the Carr-Hill formula will be amended to apply to patients living within the practice catchment area only. The London adjustment will be amended to apply to patients resident there rather than registered with a London-based practice.

No other changes will be made to the Carr-Hill formula. The new global sum per weighted patient is set to rise by 92p from the 2018-19 figure of £88.96 to the current year's figure of £89.88.

The out-of-hours deduction has changed from 4.87% to 4.82%.

Vaccinations and immunisations

The Item Of Service fee (IOS) for the following programmes is uplifted to £10.06 per dose:

- Childhood seasonal influenza
- Pertussis
- Seasonal influenza and pneumococcal polysaccharide.

Care home and social care staff will be added to the categories of those entitled to a flu vaccine at an IOS fee of £10.06.

HPV vaccination for women from age 18-25 will be at the IOS fee of £10.06 and the HPV programme for boys will start in schools from September 2019

An IOS fee of £5 will be paid for the extra cost of an MMR catch-up campaign based on each case recorded of an unvaccinated child.

Seniority

No further seniority changes have been announced so it is assumed that as previously agreed, seniority payments will cease on 31 March 2020.

Those GPs being paid or eligible for seniority payments on 31 March 2014 will continue to receive payments and progress as set out in the Statement of Fees and Entitlements (SFE) during the phasing out process.

Money from the seniority pot is recycled into the global sum.

There is still a time lag in finalising the amount of seniority a GP may be entitled to due to the link with final average superannuation.

In theory the final factors are known to 2014-15 but PCSE may not yet have updated its systems to that date.

Interim seniority factors based on average NHS superannuable earnings

• 2014-15	£96,097
• 2015-16	£95,001
• 2016-17	£94,982
• 2017-18	£93,540
• 2018-19	£95,419

FINAL SENIORITY FACTORS

- 2014-15 £89,573

"Collaboration across networks will be a key change and early advice should be taken about how best to make the network arrangements work for your practice."

Other 2019-20 changes

NHS pension tiered rate contribution levels have been extended for another year to 31 March 2020 and remain:

GP (and non-GP provider) tiered contribution rate table from 1 April 2019 to 31 March 2020

	Total Pensionable Income	Contribution Rate
1	Up to £15,431.99	5%
2	£15,432.00 to £21,477.99	5.6%
3	£21,478.00 to £26,823.99	7.1%
4	£26,824.00 to £47,845.99	9.3%
5	£47,846.00 to £70,630.99	12.5%
6	£70,631.00 to £111,376.99	13.5%
7	£111,377.00 and over	14.5%

The employer rate is increased to 20.68% from 14.38% but the additional 6.3% will be paid directly by NHSE and will not be collected from employers in 2019-20.

Contraception services will no longer be an additional service and will become part of essential services.

For all future prescriptions where the medicine is for a sexually transmitted infection the prescriber must write SH as an endorsement on the FP10 form.

MPIG will continue to be reduced by a further 1/7th and is recycled back into the global sum.

GPs with total NHS earnings in 2019-20 of over £150,000 will be listed by name and earnings in a national publication. This is unlikely to be available before April 2021.

GP practices will be required to support six national NHS marketing campaigns a year.

From October 2019 there will be contractual requirements for practices relating to MHRA central alerting and use of the NHS logo.

Locum costs to cover the new shared parental leave entitlements will be reimbursed in the same way as maternity leave.

Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS)

Any changes announced to the core GMS contract are expected to be mirrored via PMS and APMS.

Please note: all the above information relates to contracts in England only.

Northern Ireland/Scotland/Wales

Information can be obtained from your local AISMA accountant.

What now?

As ever practices must be fully aware of these many changes and their impact on practice funding and workload.

They need to take a careful look at future strategy, and work on finding the best and most profitable way of using time and resources.

Collaboration across networks will be a key change and early advice should be taken about how best to make the network arrangements work for your practice.

The 2019-20 contract is just the start of a five-year programme with many financial matters now clarified for the whole of that period.

This should encourage practices to be able to plan with more certainty over a meaningful period.

Reference material

Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan. Published jointly by NHSE and the BMA 31 January 2019.

https://resolution.nhs.uk/services/claims-management/clinical-claims/clinical-negligence-scheme-for-general-practice/

A warning over some rash treatment

OPINION **Bob Senior**, chairman, AISMA

The last few months have seen publication of a flurry of documents that will affect the lives of GPs over the next five to ten years.

First up, at the end of December, was Dr Nigel Watson's GP partnership model review (see page 11), with a string of recommendations.

Next, at the end of January, NHS England published its document *Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan* (see page 9).

Perhaps unsurprisingly, this document addressed some recommendations made in the partnership review. These were around the introduction of Primary Care Networks (PCNs) and working at scale.

But unfortunately the document did not address several issues which are vitally important to improve GP retention.

One simple recommendation was that GPs should not simply have a binary choice of either pensioning all their income within the NHS scheme or pensioning none of it. The review suggested the scheme should allow a third option of GPs, pensioning 50% of their income.

Other public sector schemes already allow their members to do that. It is hard to conceive why that change was not simply rubber stamped and a commitment made to allow it to be introduced as soon as possible. Possibly the delay is due to the Treasury not liking the look of the impact on its cash collection.

The PCN-related changes are being introduced with an incredibly tight timetable. In essence, everything needs to be sorted out and ready to roll by the beginning of July.

Now there is nothing wrong with setting an ambitious timetable for implementing change but it is rash to do so before the associated legal matters have been fully resolved.

The intention was that clear guidance on what legal forms the PCN might take would be published by the end of March. However, before then practices were being asked to work together, typically to sort out a practice to lead the PCN, receive funds on its behalf, and potentially employ staff the PCN requires.

Practices are effectively being asked to work together in what is, without an adequate legal form being established, simply a large unlimited partnership.

It seems strange that at a time when practices are becoming increasingly risk-averse they appear to be happy to sign up for such an arrangement.

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*** Jim Duggan is a partner at Albert Goodman

The NHS Long Term Plan – how to quickly benefit

There has been a flurry of activity since January's release of the NHS Long Term Plan. Its contents were interpreted through the new GP contract. James Gransby assesses how GP practices can benefit from the proposals**

Key themes addressed in the plan include:

- Increasing funding for primary and community care by at least £4.5bn
- Bringing together different professionals to better co-ordinate care via Primary Care Networks (PCNs), and
- Improved use of data and digital technology.

An extract from the plan explains:

'Doing things differently: we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

'Backing our workforce: we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships.

'We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

'Making better use of data and digital technology: we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

'Getting the most out of taxpayers' investment in the NHS: we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.'

Drilling down on the PCN aspect

The aim of introducing PCNs is to achieve fully integrated community-based healthcare. Typically they will have a 30,000 - 50,000 patient list size but there is flexibility if the natural fit for an area is slightly outside this range.

A PCN could be as few as just two practices coming together, if they each already have a large list size, or perhaps up to eight or nine small to medium-sized practices in an area.

Choosing which PCN to join

Fundamentally they are designed with a local population's needs in mind and so this is by far the greatest determining factor as to which surgeries work together.

Some neighbouring practices may have historically worked within different groupings - federations - but now they will be drawn together

to cover a much more defined locality, rather than an overall 'patch'.

The important aspect is that there are no gaps left for patients to fall in between neighbouring networks.

Who will run the PCN

There are different options, broadly split from one of these:

1. Flat contracting model - one practice receives the DES money but the workforce will be jointly employed and work across all practices.
2. Lead practice model - one practice receives the money and will employ the PCN workforce sharing them among all other practices to deliver the contract.
3. Corporate vehicle model - the PCN either creates a new corporate vehicle, a limited company, or uses an existing federation. The PCN then passes the funding up to that entity which then employs the workforce who are deployed back into the PCN practices.
4. Outsourced model - the PCN enters an agreement with a Trust, CCG or some other body who are paid to provide the staff and/or potentially the wider DES service.

Depending on the area, the CCG or NHS England will need to approve and sign off the grouping of practices included in each PCN. This needs doing by 15 May 2019. 100% geographical coverage by PCNs needs to be by 30 June 2019 at the latest to meet the Network Contract DES criteria.

How will the PCN receive money?

Under the contract, £1.50 per patient a year will be paid to the PCN – typically giving some £45,000 to £75,000 for running costs. Many CCGs will also provide additional funding as well as support from their staff.

Will practices get money for joining a PCN?

Practices will be paid based on their 'network engagement' via the global sum. This is expected to amount to £14,000 a year for a typical practice. Further details were awaited at the time of writing.

How will they be governed?

They will be led by a clinical director, most likely a local GP. The clinical director role will be funded at 0.25 of a whole time equivalent (WTE) salary per 50,000 patients on a sliding scale based on network size.

The WTE cost of a clinical director is initially set at £137,516 meaning that the 0.25 reimbursement would give funding of £34,379 for this role based on a PCN covering 50,000 patients. Model governing documents will be supplied.

Is it mandatory for my practice to join a PCN?

No, but there is a strong expectation that there will be extremely few practices choosing not to join one, not least due to the financial reasons for doing so.

Every patient must be covered by a network and so if a practice decides not to join then coverage must still be provided by the PCN for its patients.

As of October 2018, 88% of practices were already part of some form of network and so in many cases this will give the natural grouping needed to qualify as a PCN.

What resources will be available within the PCN?

Each PCN will receive £1.50 per patient as a Network Financial Entitlement.

Sharing staff within a locality is a strong underlying theme. The new contract says:

'The scheme will meet a recurrent 70% of the costs of additional clinical pharmacists, physician associates, first contact physiotherapists, and first contact community paramedics; and 100% of the costs of additional social prescribing link workers.'

NHS England expects a typical network to have five clinical pharmacists, three social prescribers, three first contact physiotherapists, two physician associates and one community paramedic by 2024.

As the funding does not increase with list size, but only once the network jumps from 30,000 to 100,000 patients, there is a financial incentive to keep the PCN network size close to, but not below, 30,000 patients. For example, a PCN with 90,000 patients will receive the same Additional Role Reimbursement as one with 40,000 patients.

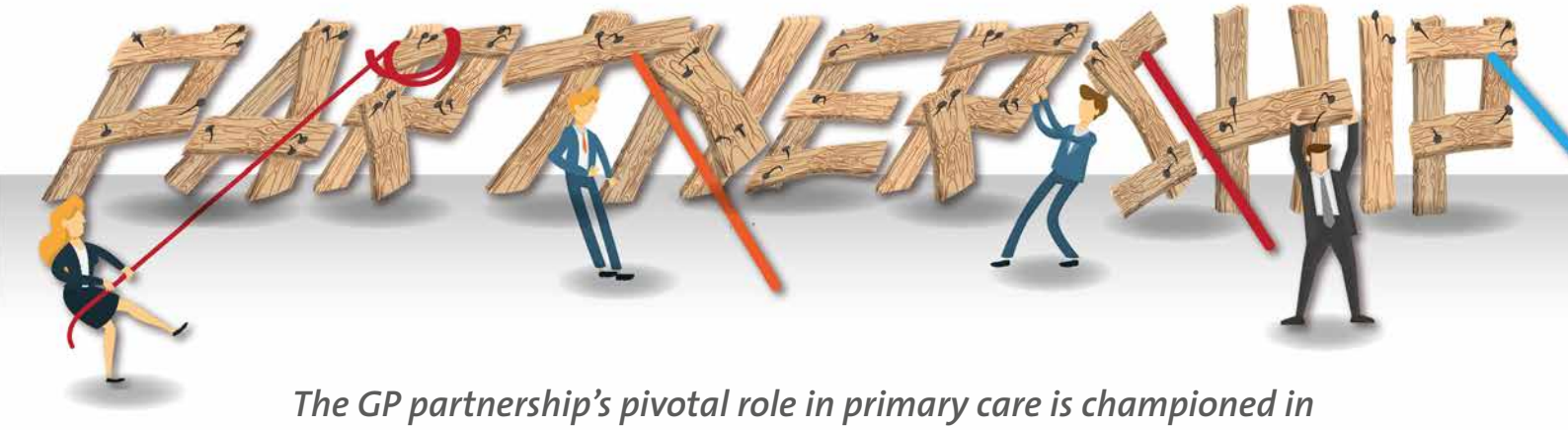
What should I be doing right now?

If you have not entered dialogue with neighbouring practices then now is the time to do it.

Much has been lauded about the need for practices at local level to be talking to each other, perhaps socialising together and certainly sitting down and thinking strategically about how their PCN can work.

NHS England is keen to avoid mandating this upon GPs - nobody likes being told what to do - and they have kept the guidance flexible so that it can be interpreted in the way the GPs see fit.

Shoring up the



The GP partnership's pivotal role in primary care is championed in Dr Nigel Watson's January review. Jim Duggan*** *believes while some recommendations are welcome, others need careful consideration as there could be unintended consequences*

General practice's invaluable contribution to the NHS, providing cradle-to-grave care for generations, is recognised in this hefty report born from the doctor recruitment crisis.

It recognises that the partnership model GPs have invested in financially and emotionally has underpinned general practice.

While the partnership model is still pivotal to the NHS the report concludes there is little denying that elements need adapting to fit a 70-years-old organisation.

Partnerships have become less popular in recent years and the report points the finger in the direction of an increased workload, to the point of making a GP's working day unmanageable, and a distinct lack of morale among doctors deriving from a feeling of being undervalued.

It also identifies the significant role the perceived levels of risk contribute to the decrease in popularity of partnership applications.

I would go further and say additional significant factors in this decline include the funding model's failure to adapt to society's changing attitudes to healthcare, and years of attack from sections of the national press publishing 'fake news'.

More recently the detrimental effect resulting from NHS Pension Scheme changes and the rules around annual allowance tapering have seen an exodus of experienced GPs.

The report highlights partnership strengths:

- relative autonomy in patient care decisions
- freedom to innovate
- ability to act as a powerful advocate for patients, and
- providing value for money.

But it warns these may be completely lost – and that would doubtless be a disaster.

Clearly action is needed if primary care is to be prepared for the 6.3% increase in over 65s forecast by 2041, especially in a challenging climate of reduced recruitment and retention that saw GP numbers decline by 3.4% between September 2016 and 2018.

The report proceeds to consider the challenges and recommends:

1 Action to reduce the personal risk currently associated with GP partnerships.

Premises

These include introducing a more comprehensive regime for the assignment of leases, particularly when they are for over 20 years, although it does recognise there is a form of protection within the standard BMA lease template, which stipulates that the lease obligations cease when the NHS contract does.

While calling on NHS England to provide

"The current GP exodus in the latter years means their experience and wisdom is lost. The report recommends funded time enabling these GPs to do a variety of roles supporting primary care."

more support and guidance for partnerships on separating property ownership from the partnership model, it is very light on any specifics about what this would entail.

Separating property ownership from the partnership model could have major implications and I would strongly advise delaying any decision around this until you have discussed it with your AISMA accountant.

Legal structure

The report records some GPs' concern that the risks associated with partnership now significantly outweigh the benefits.

It calls on the Government to allow GP partnerships to hold a GMS/PMS contract in structures which limit potential risks - such as a Limited Liability Partnership, Social Enterprise Companies or companies limited by shares or guarantee.

But care is needed as introducing these structures could lead to the privatisation of the NHS.

Indemnity scheme

In the run-up to 1 April, the report urged the Government and all relevant stakeholders to continue supporting negotiations on the new state backed indemnity scheme.

But as it only covers future NHS clinical work it seems to me this now complicates the whole indemnity area and I wonder if it was ever intended to be a realistic alternative to the medical defence organisation's offering.

In business it is difficult to avoid risk totally and perhaps GPs need to be educated to understand the true nature of these risks and what steps they can take to minimise the likelihood of them happening.

2 A funded increase in the number of GPs who work in practices and roles that support direct patient care.

A major desire of GPs at all career stages is to reduce patient numbers seen in the day and have more time for those with complex problems.

The report looks at three periods in a GP's career.

Early career

The era of a newly-qualified GP joining one of the first practices to offer a partnership and stay there for their whole career has passed so ways to attract and accommodate potential new partners are needed.

The report recommends creating a Primary Care Fellowship to support the development of primary care and community health staff in areas appropriate to patients' future needs.

It is hoped this will also help newly qualified GPs gain valuable experience as part of a supported team.

Mid-career

Another significant wish is for GPs to develop a portfolio career above the current opportunities in education and commissioning.

The report recommends a structured programme to improve career opportunities and training for future leaders. New posts should be supported with appropriate funding.

Late career

The current GP exodus in the latter years means their experience and wisdom is lost. The report recommends funded time enabling these GPs to do a variety of roles supporting primary care.

It also recommends the streamlining and simplification of the process for GPs who qualify abroad or return after over two years overseas.

A review of GPs' complex pension arrangements is suggested due to the negative impact on partnerships.

3 Increase the capacity and range of healthcare professionals through services embedded in partnership with general practice.

The report cites examples including advanced nurse practitioners, pharmacists and musculoskeletal therapists.

It says the practice manager role needs

"The report recommends general practice be regarded as a specialty in its own right - and not before time."

developing, although given their current workload it is unclear where the time will be found to do so.

The need to develop the practice nurses' role is recognised and funding is advocated through a form of training grant. But the report fails to recognise the possibility of a low uptake and the dis-incentivising effect this would have on practices who saw little benefit training someone only to see them leave shortly after.

4 Refocusing medical training to increase time spent in general practice.

The report suggests this would develop a better understanding of the strengths and opportunities of primary care partnership. There would be a clear funded opportunity for clinical professionals to support primary care.

It also advocates simplification of the process of becoming a GP trainer and making it more consistent.

5 Primary Care Networks (PCNs) should be established to make practices more sustainable and help partners address workload and safe working capacity without compromising services.

The review suggests PCNs should address the balance between urgent and routine care and see how to extend services to areas having difficulty attracting GPs.

It also reiterates its support for the work aimed at reducing unnecessary bureaucracy, specifically identifying the unnecessary level of reporting required by locally commissioned contracts, unresolved Capita issues, the heavy administration processes associated with the Care Quality Commission and the issues surrounding leases to practices occupying NHS-owned premises.

The report recommends NHS England should work with the RCGP, GPC and the DHSC to develop a strategy for the effective use of workload data to help practices manage these challenges.

6 General practice must have a strong consistent and fully representative voice at system level.

For far too long GPs have been viewed as generalists whereas hospital doctors have been considered as specialists. This attitude displays a complete lack of understanding as to what being a GP means. The report recommends general practice be regarded as a specialty in its own right - and not before time.

It also calls for the implementation of the Wass report's recommendations to prevent negativity from undermining GP recruitment.

And it recognises the need to plan for a future health system that operates more in primary care with general practice at its core. It calls on Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems (ICSs) to put together a primary care plan to achieve this.

7 Opportunities should be taken to enable practices to use essential IT equipment and innovative digital services to operate more efficiently.

The report says more can be done to save time by reducing paperwork. Some projects are already underway, such as the Electronic Prescription Service and GP2GP, but the report wants more to be done.

It suggests practices would benefit from a streamlined digital platform to share common documents and information, and to facilitate the extraction of information from GPs by other national bodies.

Health departments have wanted this for years and GPs have resisted it. I believe caution is needed because the more organisations that have access to data the greater the potential for breaches.

A more palatable recommendation is the wider use of digital solutions to support GPs and others working in primary care, but this depends on a high-speed broadband or 4G + infrastructure.

Now work out your financial survival plan

Spring is a great time of year for the management team to have a real impact in any practice of any size. Now is the time to think ahead about financial opportunities and threats, and plan for them. Fiona Dalziel *looks at what this might include*

The basics

Refresh your income and expenditure monitoring system to ensure any problems and changes are included in next year's monitoring. Detailed monitoring is essential and may help you spot anomalies. The sudden reclaim of an unobserved overpayment would be a nasty surprise.

Set budgets for your largest income and cost centres, for example:

- List size changes and the annual uplift
- Changes to enhanced services and QOF income
- Other income – such as new or ceasing sources of private income
- Staff costs including locums
- Premises costs.

Ensure planned changes have a business case including the purpose of the change, costed options and cost benefit analysis. Keep this simple and have more complex data to hand to back up the choices. Review the change's financial impact after an agreed period.

The crystal ball

1 Scan the financial horizon

Look ahead through the year for anticipated costs such as a cost of living pay award, changes to premises costs, changes in loans or mortgages or a retirement, and include estimates for them in the relevant months.

2 Minimise surprises

Get the accounts finalised as soon as possible after the year end so that you can ask your accountants for a tax estimate and an estimate of superannuation balancing payments. Make use of their skills and knowledge!

3 Review and renegotiate

Keep an eye on suppliers' contract charges and renewal dates for services such as telephones

"... a timetable showing anticipated major roles over the next five years may help avoid surprises and unexpected costs."

and photocopiers. Could you renegotiate or get a better deal somewhere else?

4 The impact of big changes

Last year's Lloyds Bank Healthcare Confidence Index showed that around half of practices in England will merge or somehow restructure in the next few years. Might this affect you? What would the financial implications be?

5 The impact of contract changes

The new contract framework in England may present savings opportunities or potential costs. Plan for the impact of changes in indemnity costs and the introduction of the network contract DES amongst others.

The biggest area of all

Your people are your most important resource and biggest cost centre. In most practices the planning process is ongoing.

What manpower changes are looming?

- Retirement/resignation and paying out to that partner?
- New replacement partner, salaried doctor or different professional?
- What value for money do they all offer?
- What roles may need to be picked up by others and what is the potential cost of that?
- What are the opportunities for delegation and what training costs might there be?
- Will there be temporary locum costs?
- What will be the full cost of an employee versus, for instance, a partner? Remember to include NI and employer's superannuation contributions.

What about succession planning?

Although some changes are unexpected, most retirements or resignations do give a short time to plan. But succession planning is wider-ranging than trying to recruit during a notice period.

It should include looking ahead at anticipated gaps and planning for how they will be filled. Consider looking ahead a few years. Duties such as clinical lead, trainer and business partner may all need to shift around and, for instance, a new trainer will need time to be able to take on the role and may need to drop other responsibilities.

How will you manage that? As with all plans, this may not work out exactly, but a timetable showing anticipated major roles over the next five years may help avoid surprises and unexpected costs.

What about value for money?

A pharmacist, paramedic, nurse practitioner or physician associate are obviously not straight replacements for a GP. Their roles can vary widely and the introduction of such a post will have costs which should be compared with the potential saving of not having a GP.

Watch for the hidden costs of not having a GP, especially a partner. An employee has a different psychological contract with the practice to that of a partner and the impact can be felt in an increase to the workload of remaining partners. This should be factored in when considering value for money, assuming, of course, that you can actually recruit a partner.

Why not just replace like for like?

A straight replacement for any team member should not be the automatic default position. It may be that some tasks could be redistributed with a consequent reduction in hours and costs.

Why might a system change cost us money?

Transitioning a receptionist into a care navigator should eventually be an efficiency. You may also retain a valued and skilled member of staff by giving a development opportunity.

But part of managing the transition will involve time for training coupled with a change in job description and possibly a change of grade.

Reference material

https://resources.lloydsbank.com/insight/healthcare-confidence-index/

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