**Transformation Part 2: New Contract, Networks and Neighbourhoods Study Day  
Tuesday 9th April 2019**

After a rather laboured commentary on the whole new contract Michael Bainbridge outlined the substantial investment in primary care and out of hospital care generally which he welcomed. He said that local contract negotiations were concluding soon and this would also deliver more money. Although practices had a contract entitlement to join a network the CCG had the responsibility to ensure that all patients benefited fully. He looked for an organised general practice approach and promised to work with practices to make this happen: practices need not be daunted by the scope of the DES. As far as definitions were concerned the PCN would consist of practices and he hoped that the new contract would enable practices struggling to “keep the show on the road” whilst looking to work with closer (pharmacy, secondary care) and wider partners in neighbourhoods (voluntary organisations, schools, local government). A briefing on PCN organisation was being prepared by the CCG. The CCG was offering Devon Doctor cover for meetings to make decisions. He said that NAPC could help with decisions such as the size of the PCN and suborganisations that could solve “over population” problems. He stressed the lack of directiveness in the PCN DES regarding mergers and acquisitions pointing out empirical evidence that some smaller practices offered the very best care. Since the last study day the number of GPs working in Somerset was higher and he thanked the LMC, Training Hub and SPH for the Careers Plus scheme all of which had helped achieve this. Much good work was being done and he named the Rural Practice Network from South Somerset. He hoped that the nationally clinical priorities would unleash the entrepreneurialism of GPs to solve local problems. He reminded us that 30,000-50,000 had been chosen to maximise the balance between personalised care and economies of organisational scale. He looked beyond the Additional Roles Reimbursement Scheme for extending social prescribing beyond practices and into neighbourhoods. All in all he trusted that the new contract would enable GPs to ensure better health across the communities they served.

Harry Yoxall and Ian Creek from the Somerset GP Board discussed the role of the Clinical Directors which HY called the most important role in new general practice as it would bring GP skills directly into play with new managerial set up. As the contract was largely silent on the details he proposed to outline how local priorities would be considered. IC said that in a world without every detail the new CD role would help to develop itself. It was a great opportunity for primary care to drive integration in general practice and also the wider integrated care systems as they came along. Developing internal governance on decision making would be key to strengthen relationships ensuring the needs of patients were always considered. Other providers would inevitably look to primary care and strategic plans would have to ensure cohesion. Colleagues were bound to turn to CDs to resolve problems and conflicts in their own practices. A quality improvement collaborative would only start with the new QOF domains. Workforce development was bound to be more extensive than implied by the ARRS. Clinical Directors would meet to ensure improvement schemes were in line with local and national priorities. CDs were also expected to represent PCNs at CCG and STP meetings contributing to ICSs but it was hoped that representation would be streamlined. This would have to be an iterative and progressive process and there would be support available. It was hoped that the WTE proportionate reimbursement could be supplemented with support, training through the Training Hub (formerly SCEPN/SGPET) and secretarial help. CDs were expected to be GPs and could only be in charge of one PCN. The SGPB had a process to help selection and HY outlined some useful attributes including a “thick skin”! Anyone interested was invited to speak to HY and IC later in the day.

Jane Jordan, a Director of Lentells Chartered Accountants, spoke next. Global sum was to rise by only 92p this year to take into account indemnity costs. Two percent pay increases were expected for practice staff including salaried GPs. How locum costs were dealt with would be interesting. JJ had been surprised how much information on the PCN DES has been published on time at the end of March. The DES would come into effect on 1st July. To join a network would entitle a payment of £1.761 per weighted patient but extended hours funding of £1.90 would be reduced to £1.45 and that paid to the PCN. Practices carrying on with extended hours would then lose 50p a patient. Networks will receive a £1.50 administration per "raw" patient from July (back dated to April). Additional staff reimbursement was for new staff only but pharmacists in place by 31st March could transfer to the new scheme in July. Social prescribers would be 100% reimbursed. Those and CD reimbursement would be paid monthly in arrears on receipt of invoice. Advantages for smaller PCNs in the first year would be only temporary and JJ encouraged a longer view.

Potential problems included VAT on staff recharges when staff were shared as the normal medical exemption would not apply. For staff to enjoy NHS pensions they had to work for an organisation holding an NHS contract. Who would bear employment liabilities in the event of a harassment or discrimination claim?

JJ went on to discuss the various models of organisation shown in the BMA PCN handbook starting with the “flat model” which circumvented the three big issues in the last paragraph.

The “lead practice” model could also work but the VAT problem could apply.

An LLP, federation or provider entity would protect practices from employer liabilities but this might be something for the future. It would however have implications for CQC registration.

The “flat practice model” would require a separate bank account and accounting system running to a March year end irrespective of practice accounting.

Next Nick Bray opened an account of what was happening in Somerset pointing out the advantages of having a single CCG with good relationships, an established group of federations, two foundation trusts which were very engaged and work towards an ICS had been going on. The SGPB and the CCG had made progress on transformation. He was also candid about reform fatigue and trust overspend. He outlined the composition and role of the SGPB. He went on to bring us up to date with Fit for My Future and how he had subdued expectations at the Community Settings of Care Workstream who thought PCNs would be up and running in July.

Jeremy Martin, the programme director for neighbourhoods spoke about the inaugural meeting of the Neighbourhood Board which includes district councils, the Police, adult and children's social care amongst others.

Rob Bowen from NAPC was on next and said how work across the country was proceeding on neighbourhoods and how pleased the organisation was to be working in Somerset. Reasons to be cheerful included a system level range of organisations that were all keen to see PCNs and neighbourhoods go forward and working to this end. He thought Somerset contained examples of good collaborative work already including Symphony and in West Somerset. He detected little self-interest in discussions compared with those in other less happy places. He urged the meeting to not become fixated on the DES, losing existing momentum, but to see it as a foundation for future collaboration. Networks would look outside themselves and should not be constrained by boundaries. He said that looking for a “coalition of the willing” was absolutely fundamental. Staff empowerment was also crucial - ask them what would make things better. Finally it was important not to fall back into existing patterns of working if things got tough.

After question time we attended workshops, your correspondent being at the workforce session run by Martyn Hughes and Carol Hobbs from the Somerset Training Hub. It was vital that PCNs were not set up to fail under the weight of unrealistic expectations. MH outlined the TC's core functions. There was a discussion on the workforce implications of the new clinical contract and there were some negative feelings about the CDs coming out of clinical sessions, the risk of destabilisation of other sectors, the training of the new specialists, the potentiality value of social prescribers and village agents over scarcer clinical pharmacists and the problems that practices already registered for VAT could encounter. Questions about sick leave and maternity pay were raised. Opportunities for training students both medical, nursing and even business could be improved by placements and administration across networks including organising more room space.

Kelsey Boddington from Dulverton spoke about the Living Better project to support independence and well-being. This involves the West Somerset federation with Living Better (complex care) nurses and village agents and KB is the clinical lead. The LB steering group consists of practice managers, the nurses and village agents, voluntary sector, the QI nurse from T&S, SomPar representatives, an administrator and the NAPC. Visionary workshops are intended to lay the foundations of trust and understanding, improve relationships and promote ownership, development and to recruit all those working in the area (and so the younger generation of GPs from outside). Complex care meetings had lost momentum but are being held regularly monthly again with a wide range of attendees including GPs and an outreach nurse and consultant from T&S. The consultant spends a day a month at a satellite clinic including domiciliary visits. A similar multidisciplinary arrangement was being set up for women and children's health to incorporate the community maternity matron who has to enact the “better births” strategy. It was refreshing not to concentrate only on the frail elderly. Another prospect was to include mental health. Voluntary agencies are represented at open access “talking cafes.” Village Agents have a network of volunteers available through the “good neighbour” scheme including allowing regularly caring neighbours take time off. A directory of services and website is being devised. KB pointed out that West Somerset's vanguard primary next had started four years ago and so new PCNs would have a steep learning curve and would be well advised to concentrate on developing local relationships first. Maturity was bound to develop at different rates.

Finally I attended the seminar on community pharmacies and the LPC’s Michael Lennox opened by making an offer to practices along the lines of the Beacon Group in Plymouth which had seen both overall flu vaccine uptake and practice income rise without “mini flu wars” breaking out. Anne Cole talked about the advanced services offered by pharmacists including Medicines Use Reviews but these were not medication reviews but advice on how medicines were taken. New Medication Reviews are for new asthma and COPD drugs and antiplatelet medication. Disappointingly antidepressants were not included. Pharmacists work with Smoke Stop services. In Sedgemoor a project to deepen MURs into proper medication reviews on AF and stroke. A third of pharmacies run the NHS urgent supply access service with patients directed via NHS111. Similarly minor illness consultations can be directed to community pharmacists under the digital minor illness referral service. Proper GP triage could direct patients to the DMIRS which was already happening in Devon. Of Somerset's 104 pharmacies 102 are accredited as Healthy Living Pharmacies with a HL champion who is usually a dispenser rather than a pharmacist and these could be “ideally placed” to work with Village Agents. Transfer of Care Around Medication (TCAM) enables pharmacists to be made aware directly of changes to drug regimens of discharge from hospital. This could be a great benefit to practices except that EMIS would have to be updated still. By a strange coincidence 12 pharmaceutical neighbourhood champions have been appointed with CCG money to work in PCNs. The pharmacists are jealous of the new GP contract and current negotiations had been stalled the last 18/12. New areas for discussion included how community pharmacists might work with the clinical pharmacists in the PCNs. Perhaps they could be joint roles as the former were in short supply. These roles could help alignment of the new clinical priorities over time like CVD case finding. Pharmacists were hoping to be paid for improving care rather than chasing dispensing prescriptions.

The final session was about “what next?" and our esteemed chairman called for reflections on the day with any lacunae that might have appeared. He said the LMC was to organise “confederation” meetings in future. Michael Bainbridge had been asked if a weekly bulletin could be available. He could provide information on Devon Doctors providing cover for meetings. He committed to answer contract queries particularly on extended access. Jeremy Martin asked for a straw poll - most were feeling positive with a few abstainers. It was pointed out that those present were the interested - never mind those who didn't come but what about those who had left early?