Report from the BMA Clinical Directors conference on 5 June 2019

Somerset was well represented at the BMA Clinical Director's conference at BMA House, with Kelsey Boddington (West Somerset), Sam Rainsbury (West Mendip PCN) and me (Central Mendip) in attendance, between the three of us covering road, rail and air to get there.

This was an event organised by the BMA in collaboration with GPDF and NHS England, aimed at the emerging Clinical Directors (CDs) of the nascent Primary Care Networks (PCNs) across England. The presence of big names representing these organisations and the fact the event was organised and delivered free perhaps demonstrated their commitment to the success of PCNs. This was a chance for the BMA, GPDF and NHS England to provide more substance and a human touch to the nitty gritty detail of network contract and an opportunity to answer questions. After a welcome from BMA GPC UK chair Dr Richard Vautrey, Dr Douglas Mederle-Lumb outlined the role of GPDF in supporting GPs, reassuring us that the keenly awaited guidance notes and template schedules were soon to be released. NHS England's acting director of primary care Dr Nikki Kanani and director of primary care delivery Dominic Hardy, outlined how PCNs fit in to the wider aims of the NHS Long Term Plan.

The over-arching message was that NHS England's new Network Contract aims to sure up Primary Care for the future, give General Practice a collective voice and put Primary Care back at the heart of the NHS. They encouraged us to be confident about our place within in the wider health and social care system. PCNs have the potential for real impact, working together to deliver tailored services addressing the needs of their local populations. The very fact, said BMA GPC Chair Dr Richard Vautrey, that GPs had risen to the challenge of forming these new networks in the relatively short time-scale since the announcement of the contract, demonstrates to the wider system what Primary Care is capable of. We should be proud of that.

Breakout sessions followed.

Strategic and clinical leadership
Led by Dr Mark Sanford-Wood, BMA GPC exectutive team member and Dr Andrew Seymour, BMA committee of medical managers deputy chair, who after giving a brief introduction to different leadership styles, encouraged the attending CDs to come up with their own ideas on which attributes might be important to their new role. Emerging themes such as integrity, honesty, decisiveness and drive reminded me of the traits of successful CEOs (dubbed 'Level 5 Leaders' in Jim Collins *Good to Great*): a powerful combination of personal humility and indomitable will. We are the future leaders of the NHS, said Sandford-Wood, and they're not looking for big-named hero's to fly-in externally but instead develop team-playing, honest and driven leaders from within.

Workforce development
Dr Krishna Kasaraneni, BMA GPC executive team member, ran this session with a good touch of humour. Given the falling numbers of Full Time Equivalent (FTE) doctors and nurses in Primary Care, the Additional Roles Reimbursement Scheme (ARRS) was developed to provide extra support for the existing primary care workforce while not destabilising it (hence the focus on additional staff rather than existing doctor/nurse workforce). Primary care lags behind secondary care in making use of other health care professionals for direct patient care, so the contract aims to encourage a change in working.

A useful reminder that there is flexibility in terms of the roles which PCNs can employ, in discussion with local CCGs, to enable networks to recruit those roles most needed. Additionality rules are only based on the baseline survey of existing roles on 31 March 2019, so a PCN could for example decide

to employ a paramedic now and fund this themselves and then get funding through the ARRS when it becomes available for the role in 2yrs.

From 2020/21 each network will be allotted a single combined maximum reimbursement sum, covering all staff roles. Each networks share will be based on weighted capitation.

It's important that PCNs develop a suitable structure or model for employment before rushing into recruitment. The BMA PCN handbook is updated regularly so check online for the most recent edition. The PCN model can change at any time, it's up to the network to decide. A note of caution that the federation model using a Limited liability vehicle is not a simple solution and will require time, investment (through appropriate legal and accountancy advice) to set up. It's not something that can be drawn up on a kitchen table on the weekend, said Kasaraneni. BMA have been seeking advice from HRMC about VAT implications, but can only provide advice about the principles, not advice for specific situations.

The schedules of the Network Agreement can be as simple as networks need initially. They set out how the PCN member practices plan to work together. It's important to note that Schedules 2-7 do not need to be submitted to CCGs or NHS England. The only requirement of PCNs is to provide confirmation that we have completed these by the June deadline.

Extended hours should be based on the population need (for example a predominantly young/student population might prefer evening telephone or online consultations), so Kasaraneni encouraged PCNs to have the conversation, consult the patients and determine what is best for your patients before deciding on the type and timing of extended hours consultations. Again a word on flexibility: in certain circumstances, for example where there is lack of capacity or workforce, there may be the option to deliver less than the full extended hours requirement (with less reimbursement as a result) through negotiation with CCG local CCGs.

QOF

Led by Dr Andrew Green, BMA GPC clinical and prescribing policy lead and Rachel Foskett-Tharnby, NHS England assistant Head of primary care incentives.

Nationally there have been calls for QOF to be dropped and the money fed into the global sum. But it's not possible to abolish QOF, not something that could be negotiated with the government. If we moved money from QOF into the global sum, this could transfer reimbursement for well performing practices to lower performing practices and remove the incentive to perform well.

We were reassured that the alternative was QOF reform, and that this was possible. What you see in the latest contract is reform. Underpinning any change is the clinical vision that change should increase the likelihood of improved patient outcomes, decrease the likelihood of harm from over treatment and improve the personalisation of care. It shouldn't represent an additional burden on practices. There was a need to move to better collaboration between practices and represent this through QOF.

The main changes: Modification of indicators to improve efficacy where there is good evidence; updating and rebranding of exception reporting; and inclusion of the Quality Improvement (QI) domain.

Quality Improvement in QOF

The new Quality Improvement domain of QOF for 2019/20 involves a total of 74 points (34 each):

1. Prescribing safety

2. End of life care

Both QI areas of QOF run from April 2019 - March 2020. Each year will see the introduction of new topics to replace, not run in addition to, the past topics. Topics are selected as areas of care which are: important; not readily amenable to traditional QOF indicators; and build on existing work at practice and CCG level. There are currently eight topics in development aligned to investment and evolution of the NHS long term plan. The hope is that each project will result in longer lasting change in practise. There will be an independent and national evaluation on its effectiveness at the end of the year, but for individual practices the focus is on the learning not the outcome.

What do practices need to do? Evaluate the quality of current care for example through audit, identify areas for improvement and set improvement goals relevant to each topic. Implement and re-evaluate at the end, reflecting on lessons learnt and best practise going forward.

On a PCN level, each practice must participate in a minimum of two network peer review meetings (each practice needs to demonstrate that they have attended at least two to be eligible for the QOF point). It was suggested that first meeting is held at the beginning of the year to discuss and plan improvement activity, then at the end to share the learning from the projects. This is about sharing learning and ideas, but each PCN member can do their own individual project. Each practice should nominate a lead clinician to attend for each of the clinical areas, but all team members can take part in the process. Other organisations (such as community palliative care teams or pharmacists) can be involved in this process if the PCNs wish Up to each PCN. Staff employed through the ARRS could also be used to assist in implementing the QI activity.

At the end of the process, each practice needs to then complete the QI reporting templates - they stressed this only need to be a brief 1-2 page report at most – and self-declare completion of the activity on CQRS. The QOF points are awarded based on the participation in the process not on the results of a specific QI activity. It is about participating together, learning through peer based meetings and positive changes to practise.

The task may appear daunting at first but we were encouraged to read the example case studies available from NHS England to see it is easily achievable. Practices can follow these case studies if they wish. Additional support will be available from other organisations and policy teams within NHS England are developing supportive materials (RCGP QI webpages which have open access, for example). A reminder that completion of any training or toolkits won't be compulsorily for QOF.

BMA Law update
An interesting but cautionary talk by Robert Day, Principal Associate at Mills & Reeve, outlining the areas of risk associated with PCNs that should be addressed.

Risk 1: choosing a structure/model that fits the objectives of the PCN, not just limited to the DES, and takes into account existing structures and operating models. Consider, both now and on an ongoing basis, the core issues facing PCNs: Liability, data handling, VAT and NHS pensions.

Risk 2: working with the 'enemy'. The need for 100% coverage and competing arguments over the network area may well result in practices working with others they don't necessarily trust. Seek clarity on purpose, function and decision making to reduce the chance of issues arising. Consider a process of escalation in the event of disputes, one that might involve LMCs. Seek commissioner prior approval to processes to remove practices from the PCn. Note: commissioners must approve a change in the constitution of the PCN (such consent not to be unreasonably withheld or delayed).

Risk 3: trade-off between efficiency vs member involvement. A suitable decision making process is needed and should be reflected in the Network Agreement. PCNs will (to the extent not already done) need to discuss and agree any additional or supplemental decision making provisions. There is no right or wrong answer. Types of questions PCNs should be asking: How often will regular meetings take place? What are the agenda requirements (adding agenda items)? What is the necessary quorum? Can proxies be appointed? How will decisions be taken? Will there be a 'board like' structure and delegation?

Risk 4: data handling. For data analytical and clinical purposes there will be new flows of data between PCN members. This creates potential GDPR risks and issues. The potential implications for getting this wrong are high practically, financially and reputationally. Watch out for the national Data Sharing & Data Processing Agreements (and the guidance to help complete). The operational and practical elements still need to be covered, including: What information needs to be shared; what organisations will be involved in the data sharing; what you will tell patients about the data sharing (i.e. how, why and with whom data will be shared) and how you will communicate that information (updated privacy policies etc.); what measures will be in place to ensure adequate security is in place to protect the data; what arrangements will be in place to deal with subject access requests; what will be the common retention periods for the data.

See the ICOs Data Protection Information Assessment which provides useful assessment tools for new flows of data: https://ico.org.uk/media/2553993/dpiatemplate.docx

Risk 5: other issues. Subcontracting: permitted under reasonable circumstances, but there is prohibition on further subcontracting by a subcontractor. Always best to ask for rubber stamping by your CCG if you plan to have this kind of arrangement. Terms and conditions of employment don't need to mirror those of existing practice staff, provided there are justifiable reason for any difference, this is ok.

Don't lose sight of the fact PCNs are there to supplement existing collaborations, neighbourhood projects etc. PCNs don't have to do everything, consider your local needs and population. There is wiggle room around the national contract to enable you to deliver something that will make a difference. Don't let the specification crowd out aspirations you have to do other things within the PCN.

Final Q&A
Some final nuggets of information that came from the top in response to some questions from the floor:

Money flow: Eventually NHS England want to allow funds to be able to flow to a specific PCN account, but in this 'transitional year' it was easier and more secure to have a lead/nominated practice. Likely this will change from April 2020.

Was the Network Contract a sneaky way to force large-scale working and merging of small practices? Ian Dodge, NHS England's national director of strategy and innovation said categorically no. The contract aims to build on the existing contract and supports the independent contractor status. NHS England wants to maintain and support existing practices, not force them to merge or work together.

Will CQC inspect PCNs? Currently CQC does not envisage widening their inspection to cover PCNs and their staff.

Extended Hours: PCNs can make use of a range of clinical staff to deliver extended hours (if appropriately supervised) and this could include targeting, for example, working-age mums for smears, LD reviews, etc. NHS England have deliberately not specified what type of appointment has to be offered and are willing to be reasonable in allowing flexibility where necessary, in order to not put unnecessary pressure on practices. Have sensible discussions with commissioners.

Conclusions

The conference demonstrated the BMA and NHS England's commitment to supporting primary care and helping us make PCNs a success. There were many opportunities to meet fellow CDs from around the country in the coffee and lunch breaks, and it struck me what huge variety there is and how important there is flexibility in the details of the contract. From a Hackney GP who is grappling with how to communicate with the several different secondary care providers on his doorstep to the single-hander GP from Cumbria who's asking her retired partners to cover for her CD time, GPs are demonstrating their ability to take on new challenges and keep their patients at the heart. It will be vital that local CCGs work closely with the CDs to ensure that there is flexibility in the detail for PCNs, to enable them to flourish rather than take on any unnecessary extra burdens.

I feel very fortunate to be from a county that, with the support of an excellent LMC, there is already a sense of comradery and mutual support among the emerging CDs, with an active WhatsApp group and Slack platform, as well as a social event at the end of the month and monthly training organised by the CCG.

Exciting times ahead.

Robert Weaver