Cambs LMC
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2020/21 GP CONTRACT & 2020/21 PCN DES FAQs

2020/21 Contract

What is this year's contract in a nutshell?

This year the package of changes includes funding to make it less financially onerous to take up a new partnership and also new funding to expand the practice team and help alleviate the workload. Does it go far enough? No. Is it the best we could get? Well, had you asked in February, the opinion may have been divided - but we are now in a time of emergency legislation and the economy has shrunk by 2% in the past 8 weeks, so there might be relief that HM Treasury signed it off when they did.

We've certainly moved a long way from the early Christmas present of those initial draft PCN service specs that should never have seen the light of day in the first place. But the united feedback from the profession at that time (1. trust us to be the professionals we are 2. give us autonomy to get the job done and 3. simplify the bureaucracy) have largely been realised by the advent of Covid-19. QOF is frozen; appraisal and realisation are frozen; CQC is on hold. It makes a cynic wonder how we can justify the expense of the bureaucracy...

Virtual Open Evening Slides

The advent of Covid-19 has changed everything - and so it's important that we clarify what impact the Coronavirus Act 2020 has had on timelines and finances for this year and beyond, that may differ to the information produced in these slides below for the GPC Spring roadshows that were originally planned for March, and which Katie spoke to last Thursday (which are not paywalled for non-BMA members):

https://archive.bma.org.uk/-/media/files/pdfs/collective%20voice/committees/gpc/gpc%20england/gp-contract-england-briefing-feb-2020.pdf?la=en

What are the headlines of the 'core' GMS contract changes?

- The new value of the Global Sum from 1st April 2020 will be £93.46
- The new value of a QOF point will be £194.83
- Extra investment to fund new GP training recruitment and retention measures with £20,000 pro rata loan plus training support for every new partner
- Monies for fellowships for newly-qualified GPs and practice nurses
- Payment arrangements for vaccinations and immunisations to be reformed
- QOF to be updated including QI modules

What guidance is there around pay for practice staff?

GPC has confirmed that predicted inflation rates have been included in the uplifts, and because the reimbursement of PCN staff will rise to 100% of national pay-scales reimbursement, there *may* be funding available for a discretionary pay rise. A cynical LMC member wryly observed, that because you don't have the 30% expenses you never wanted, and never got, you can now use that money you never had, to give to your staff an uplift you will never get. We couldn't possibly comment.

The DDRB process is very late, again, and will make a recommendation on salaried GP and GP trainee pay, and if there is any uplift it will be backdated to April. It could be that a practice might want to use that as a guide for other practice staff - *but that is for a practice to decide*, bearing in mind the CPI for February was 1.7%.

How will the new contract help GP recruitment and retention?

NHS England and NHS Improvement tell us that their revenue budget has increased for the specific purpose of supporting additional recruitment and retention schemes aimed at GPs, with the government's pledge to see an extra 6,000 doctors in general practice. This includes increases in the number of places on the Targeted Enhanced Recruitment Schemes (TERS), a two-year Fellowship Programme for all newly qualified GPs and nurses, a 'New to Partnership Payment' of £20,000 plus training support, a locum support scheme, changes to the existing Induction and Refresher Scheme to cover some childcare costs and a new national supporting mentors' scheme.

In Cambridgeshire, it is worth remembering that funding for the GP Retainer scheme comes out of the delegated commissioning budget, and we are pushing nationally for those monies to be funded centrally. This is not a problem at present, but we remain vigilant as we appreciate it is another cost pressure on a financially stretched system that we strongly feel needs national protection.

GPC England are chasing the final paperwork around the 'New to Partnership Payment' from NHSE. It will apply to all new* clinical partners from 01 April, and the payments can be claimed back retrospectively – we will share them immediately once they become available. *NB: the definition of new means that individuals who have historically held partnerships in the past are excluded. Whilst we do not yet have details, we do not expect a minimum time for a partner to be in practice prior to becoming eligible.

Enhanced parental leave – this will increase eligibility criteria under the statutory reimbursements in the SFE for parental leave, which should be reflected/honoured in salaried GP contracts and deeds of partnership when the details are released.

What's changed with QOF?

Further changes have been agreed to the Quality and Outcomes Framework in 2020/21, in line with the findings of the 2018 QOF Review. Indicator amendments have been agreed to bring the asthma, COPD and heart failure domains up to date with best clinical guidance. QOF currently comprises 559 points. NHSE/I has agreed to recycle 97 points into 11 more clinically appropriate indicators. There will also be additional funding of £10m to contribute to a new indicator to support annual blood tests for patient with non-diabetic hyperglycaemia. QOF total points will therefore increase to 567 from 2020/21. *Due to Covid however, QOF is currently frozen until September and practices will be paid on equivalent adjusted 2019 rates for Q1 and Q2. The situation is being kept under review.*

QI module points remain at 74, but with different criteria this year (retiring high risk medicines and EOL, and replacing with early cancer diagnoses and learning disabilities). *At present there will be no expectation that practices are to undertake these, save for the wider NHS ensuring two week wait pathways are in place and that screening arrangements are back up and running.*

Back in March, NHSE committed for 20/21 to "protect QOF income as necessary to respond to Covid-19". They were advised by GPC England to prepare this to be for the full financial year – as whilst practices needed headspace to deal with the pandemic, as we are now realising, we need time to manage the deferred demand and plan for a new normal. There is no suggestion of suddenly being asked to the whole of QOF in a few months. The impact of a potential second or third surge is still also a significant risk at the present time.

What's changed with vaccs and imms?

Vaccinations and immunisations will become an essential service rather than an additional service. All practices will be expected to offer all routine, pre and post-exposure vaccinations and NHS travel vaccinations currently covered by the previous additional service to their registered eligible population. The element of global sum related to the additional service for immunisations and vaccinations that practices receive, will be retained in full. This is worth £164.5m in 2020/21. It will continue to cover NHS travel vaccinations and pre/post prophylaxis vaccinations.

A new item of service fee of £10.06 will be introduced for the delivery of each dose of all routine and annual vaccines, starting with MMR in 2020/21 and to include all childhood vaccinations from 2021/22. Practices will need to achieve 80% coverage in order to receive the full item of service value.

- <50% achievement will only result in a global sum value
- 50-80% achievement will result in an additional payment over the global sum for those vaccinations delivered above 50%
- 80%+ will result in global sum payments plus an additional £10.06 for every MMR given

From 2021 the current 70% and 90% immunisation targets will be removed. This is good news in removing the cliff edge impact that caused problems for many practices. Those practices with demographics that may prove a barrier to uptake will be able to discuss with their commissioner their exceptional circumstances. We would encourage practices in this position to liaise with us also to support you. Childhood imms may also potentially replace influenza in QOF next year, as NHSE is keen to move 'flu into the IIF scheme.

NHS travel vaccs will remain funded as part of the global sum. However, it is likely that pharmacies may be able to do these in the future as an NHS service, so there would be an opportunity for a practice to direct such patients to the pharmacy if they wanted to reduce their workload in this area.

Last year the LMC said the DES 'might' be worth signing this year, is that still the case?

Our position has not changed.

A year ago, the LMC view was that 19/20 was worth signing up to - admittedly there was the extended hours for £1.50 which filled no one with joy, but there was £1.76 (not weighted) for engaging with it in a 'dress rehearsal' of collaborative working; funds towards a clinical pharmacist; a 'free' social prescribing link worker in return for assembling into PCNs; oh, and indemnity under the Clinical Negligence Service for General Practice.

We said that this year, 20/21, *might* be worth signing up to - depending on what was going to be on offer, and being aware that 20/21 monies would be weighted. *What we didn't know, and what the LMC could not have foretold, was that we would be working under emergency legislation amidst a global pandemic - and that does change things.*

We are still reserving judgement and expressing caution about 21/22 onwards, primarily as there remains the intention to link the Improved Access APMS contracts into the PCN DES - yes, these could still be subcontracted to, for example, a federation, or another PCN, but the liability will be on core network practices to deliver - and we think we need to give PCNs more time to mature and to understand their role.

As for this year, your practice will need to factor in its own circumstances; the maturity and stability of its PCN; your experiences of how that has worked; your recruitment and retention; your viability as a practice - and those practices around you. No practice is an island. Next door's crisis today, can mean yours tomorrow.

The role of your LMC is to support and advise you, to help you make *an informed choice* in guiding you to the right decision for your practice, for now.

Is it right that we should be expected to make such a decision in the middle of Covid?

General Practice is a complex at the best of times, both from a contractual and a delivery point of view. Add into this, the crisis in workforce and workload; rapid changes in ways that we work; uncertainty about the future; and the current COVID-19 pandemic, and it is understandable that decision making about signing up for this particular DES is going to make you think a bit more than it did last year.

You might wonder why you are even being put in this position now - and we would have sympathy with that - the decision to proceed was made as much by those in GPC as in NHSE: some wanted to ring-fence monies signed off by HM Treasury before the economy was hit by Covid, against those who see PCNs as a potential Trojan Horse for NHSE response to emergency provisions in the midst of Covid - both scenarios are correct in their own way, but we are where we are. Whilst NHSE has paused QOF, appraisal, revalidation and CQC inspections, the agenda within the NHS Five Year Plan of PCNs has not been paused.

What evidence is there that PCNs will help my practice anyway?

The concept of PCNs allows practices to keep their independence while working with local colleagues to deliver services that they wouldn't be able to do alone. This in turn will allow practices an independent voice in the local ICSs as they develop - and even despite Covid, ICSs are still a thing that NHSE is committed to.

If fully engaged, and appropriately funded, PCNs will deliver high quality, patient centred services far more efficiently than other providers. However, it is equally fair to say that PCNs were around before the DES, and regardless of whether practices decide to sign up to the DES or not, you are still free to work in networks.

What happens if we do nothing? Aren't we signed-up automatically?

Your practice has until 31 May 2020 to decide if you want to sign up to the PCN DES. There is no automatic sign-up to the DES this year; *you will have to actively sign up or opt out via a form submitted by your Clinical Director.* Auto-enrolment starts next year, from April 2021. So we will be coming to you in the new year, to start meaningful conversations around PCN futures and what the service specification negotiations have delivered, in good time for you to decide if you wish to continue or opt-out, ahead of 01 April 2021.

What happens if we decide not to sign-up?

If you decide you do not wish to sign up, and this decision is made on or before 31 May, you will not receive any of the additional funding.

What if we want to switch PCNs?

As we advised last month, it's really important that if you are thinking as a practice that you may leave your PCN, you need to be having those conversations right now - with your partners, with your other core network practices, with your clinical director, with us, with the commissioner, so that we can identify potential areas where alternative commissioning arrangements may need to be made. This will have an effect on other PCNs too, so it needs thinking through, and as we have the bird's eye view, we can potentially give advice, or mediate.

Couldn't we have had this information a bit earlier?

We have deferred coming to you with guidance, in part due to our original open meeting having to be cancelled with Covid rapidly escalating, but also because some elements of the implementation of the DES were unclear, and some assurances called for at the Special Conference on 11 March needed time to be negotiated. Also, we feel our practices should take as much time as is needed to reach the decision that is right for them in such a changing environment. A deadline is a deadline.

If the PCN DES doesn't work out this year, can't we just serve notice and leave?

Unlike previous DESs which usually have a three month notice period (so a practice could choose to stop providing it mid-year), *signing up to the PCN DES this year will tie your practice in for 10 months (1 June to 31 March) meaning that the earliest a practice could choose to withdraw from the DES, is 1 April 2021.*

If a practice wanted to stop providing the DES before April 2021, they would have to have permission from the CCG. We would probably also become involved too. Sometimes significant events happen, we expect this would be an exceptional set of circumstances.

Another exception is where the DES specification is changed mid-year – if that happens, practices now have a month in which to withdraw from the DES if they do not like or agree with the changes. In the current climate, this is actually very helpful in providing some control to practices.

Is it true that if we don't deliver the PCN DES, we could lose our GMS contract?

That is not true. If you do not sign up, your GMS contract remains. If you do sign up, then Section 3 of the PCN DES contract is absolutely key and core network practices signing the DES must understand this detail:

If you don't fulfil your PCN requirements or obligations as a practice, all the core network practices could, in theory as an extreme, face action from a commissioner, as it becomes a core contract requirement (see 3.1.2 and 3.1.3 below) . But well before we reach the end of that road, we would be working with the CCG to mediate, arbitrate and help understand the root problem.

For those signing up, our advice this year, however, is that signing up means signing up. Engage and get on with it. Find out if this is going to work for you before next April. Spend your funds so the commissioner isn't left with the invidious position of a significant underspend in the ARRS against a significant deficit in the delegated primary care budget.

Here is the all important section 3 in full:

3.1.1 Where this Network Contract DES Specification sets out a requirement or obligation of a PCN, each Core Network Practice of a PCN is responsible for ensuring the requirement or obligation is carried out on behalf of that PCN.

3.1.2. A practice participating in the Network Contract DES must enter into a variation of its primary medical services contract to incorporate the provisions of this Network Contract DES Specification. (True for all DESs since 2016)

3.1.3. The provisions of this Network Contract DES Specification therefore become *part of the practice's primary medical services contract.*

3.1.4. Where a practice chooses not to participate in the Network Contract DES, this will not impact on the continuation of primary medical services under its primary medical services contract.

Do we even want the PCN DES?

Originally, HM Treasury had the option of commissioning PCNs from community trusts. GPC helped argue the case to commission them from practices as a means of attracting funding into general practice and a way to alleviate the workforce crisis. Cambs has a monopoly community trust provider, commissioned to provide services across the whole CCG/STP footprint unlike many other STPs. It may be that Cambs practices might choose to keep this funding in their PCNs rather than declining it, or subcontracting it, lest a community provider take that place. CCGs *must* offer DESs to general practices - they cannot choose to commission from another provider, *unless practices choose not to provide the DES*.

At present, practices have the power to walk away, and theoretically disable PCNs through a lack of commitment and funds. Moving this into the core contract removes that lever for negotiation, so the LMC believes it is vital that this is kept as a DES.

HM Treasury argues that when increased monies are invested into the global sum, partner profits rise - but the workload doesn't get any better, and the workforce doesn't look any better. Their argument for this funding mechanism is that their pounds and pennies are better spent on paying for additional roles, to help alleviate the burden of our workload that we cite as the most significant factor in our workforce crisis. This is why the balancing mechanism is there – to mitigate against profit and focus on workforce and sustainability.

What about the service specifications and Covid?

Structured Medication Review Specification

The implementation date for the Structured Medication Review service requirements has now been postponed until 1 October. This date will be kept under review.

Early Cancer Diagnosis Specification

This is for 1st October too. In fact, the pressure will possibly be more relevant in light of how we know patients are keeping urgent and acute non-Covid presentations away from us and ED. It is likely that PCNs will be expected to make every possible effort to begin work on the Early Cancer Diagnosis specification as planned - unless work to support the COVID-19 response intervenes, such as a second surge.

Enhanced Heath in Care Homes Specification

This spec has caused the most uncertainty and anxiety as the goalposts keep shifting depending on ~~how much pressure Number Ten feels~~ the reported status of our most vulnerable patients. GPC did not agree to the DES being brought forward, and successfully pushed back against any regulatory change, but as you may be aware - care homes are still front-page news, and rightly so.

Simon Stevens' letter was clear - where local arrangements go beyond the service model set out, and are working well for care homes, these should not be disrupted. Where this service does not exist, it needs to be established as part of the COVID-19 response by CCGs, working with practices, CPFT, care homes, and the LMC. Also, "additional costs for practices which can't be met from a CCG's existing resources – may be eligible for reimbursement".

It is worth remembering that the DES service specification is predicated on an expanded workforce being available. That wasn't the case in 19/20, and that workforce has not yet been recruited in the majority of areas.

The additional funding to deliver this is a payment of £60/bed from 1 August to 31 March for *any CQC registered care home. (*Aug/Sept intended to be a preparatory phase). Many CCGs and LMCs, like Cambs, already have in place care home LESs that pay more than this, hence the reference in the letter to established schemes being replicated. CCGs should continue to fund similar schemes at historic LES levels, because if they don't, the service that practices can provide will be very limited. It is important to again underline this isn't just about practices - the reference to community service providers, care home staff and wider partners in the letter was quite deliberate.

This will lead to a cost pressure for the CCG as the number of CQC registered beds is greater than what the LES has historically funded. But the shortfall should be met by the savings from the new DES investment into beds, and any difference should be covered by an application to the Covid fund.

We are working closely with the CCG around this and making the LES that already exists, match up with the central demands from NHSE but giving practices the flexibility of how they choose to deliver this. Again, we are working under emergency legislation so this is an unusual time where government can very easily impose what it wishes, which adds a different angle to negotiations. *NHSE and GPC have repeatedly confirmed that this does not mean that the DES requirements for care homes have been brought forward.*

We believe that the ability and the willingness of NHS England to make decisions and changes like these without consultation - which they can because of the emergency legislation - makes it incredibly difficult for practices to make an informed decision as to what they will be committing themselves to as part of the delivery of the DES. *That's why the addition of exceptions to notice periods with new amendments is key in gaining some element of control.*

Would you recommend a Limited Liability Vehicle for our PCN?

Clinical Directors may want to seek professional advice on this. We are not qualified to instruct you, but we can recommend some legal organisations that we trust. This model and others beside is referred to in the excellent living document produced by the GPC secretariat, the BMA PCN Handbook which is not paywalled to non-BMA members:
https://www.bma.org.uk/media/2144/bma-pcn-handbook-march-2020.pdf

Do you have any worked-up scenarios?

See this non-paywalled link on the BMA website for examples:

https://archive.bma.org.uk/-/media/files/pdfs/collective%20voice/committees/gpc/gpc%20england/bma-pcn-scenario-a-march-2020.pdf?la=en

See also the NHSE ready reckoner:
https://www.england.nhs.uk/publication/general-medical-services-gms-ready-reckoner-2020-21/

So, are you recommending that PCNs make the most of the additional roles?

In short, yes. Expand the primary care workforce to support the growing and changing needs of patients, and supplement the gaps in GP and nursing supply with recruiting to the roles on offer that you can make use of. More roles have been added to the Additional Roles Reimbursement Scheme, and whilst there is little detail behind the definition of some of the new roles, this can at least support a more flexible approach to role selection and appointments. A care-co-ordination might be ideal with managing Care Home MDTs or the interface between referrals at a primary/secondary care level as but one example.

All roles are to be reimbursed at 100% of recommended pay-scale, including on-costs, which helps to mitigate the risks attached to affordability. There is also greater clarity about transferring staff to another PCN or successor provider, should circumstances in the PCN change or future opt-outs occur. PCNs could also subcontract certain areas to their own limited liability vehicle or a local federation.

Are the Additional Roles deadlines likely to be extended?

The submission of the workforce plans has been postponed until the end of August giving PCNs more time to work through what is needed and how new roles will fit into local working arrangements and pathways.

The initial deadlines were much tighter. The rationale for dates for PCNs to declare their workforce plans are predicated on the sooner a PCN declares this, the quicker the CCG can estimate the potential ARRS underspend – which in turn allows the CCG, PCNs and the LMC more time to discuss how the potential underspend is going to be used locally.

GPC continues to push for greater flexibility around the ARRS monies, and to pushback on deadlines as they arise if this is necessary whilst monitoring the Covid situation closely.

There may be an exception, where there is a change in organisational governance around a PCN, and potentially a need to TUPE staff to a new contract holder.

Can we hire doctors and nurses out of PCN Additional Roles monies? - that's what we really need.

The scheme has been designed in recognition that the doctor and nursing supply, so greatly needed in general practice, is just not there. Reimbursement will be attached to the list of roles set out in the DES, and whilst there is flexibility in how these are selected, *salaries for those staff not included in the scheme will not be covered* but there is the New to Partnership Fund and fellowship monies for newly qualified GPs and Practice Nurses.

So no, sadly you can't use the underspend from 19/20 to employ e.g. an ANP or Paramedic to support your home visits across the PCN, but you could employ more than one role of what you need (e.g. clinical pharmacist or physiotherapist) and part time/flexible roles are all permitted within the confines of the allocated funding too.

Whilst 20/21 plans are to be submitted by the end of August, PCNs do not have to submit indicative plans for next year until the end of October - and we wouldn't be surprised if this deadline gets deferred again come the autumn.

How will the Investment and Impact Fund work this year?

The IIF (investment and impact fund) is suspended for the first six months and instead, the equivalent fund of 27p per weighted patient for this period will be paid to PCNs directly. This is now referred to as the PCN (SP) support payment.

Arrangements for its introduction for the remaining six months of the year are under review.

Extended hours not required at present as no demand, how do we stand on this?

Capacity to provide extended hours access is going to fluctuate over the coming months. The focus needs to remain on staff and patient welfare, and must not be compromised by efforts to deliver the specified hours in the DES. It is not realistic or appropriate to work long days – this is a marathon not a sprint. The payment of £1.45 per patient will be made to the PCN to be passed on to practices.

Will we now be able to have a PCN bank account through which funds can flow?

We need to be careful here. If funding has to go through an Open Exeter account, then that makes it harder to commission non-GMS providers for the services of the DES. Also not being a legal entity, and keeping governance aligned to the core network practices, helps push back arguments around the need for e.g. CQC registration. So perversely, some of these problems we should not be in a mad rush to solve. Saying that, GPC and NHSE are aligned over putting pressure on HMRC around tax liabilities on unspent funds.

What if the CCG force us to take a practice into our PCN and we don't want to?

Locally, we only had half a dozen practices *across the entire East of England* that weren't part of a PCN in 19/20. For 20/21 a commissioner now does have powers to allocate a practice into a PCN. We have always maintained the same position: practices are far better off leaving destiny to choice rather than chance, and working (with mediation if necessary) to break down barriers and negotiate a compromise. Find individuals you can work with, negotiate terms both parties can work with, and be pragmatic - and we and the CCG will do what we can to support you.

What about the balancing mechanism?

The DES offers opportunities for additional investment for practices in exchange for agreeing to participate. There may be the opportunity to earn additional income as a member of a PCN (although the amounts available are low) as well as any additional funding that may be available from the CCG for additional work, but this DES is not about profit. It's about funding to help you and your local practices recruit additional staff, to help deliver your services in a more sustainable way. The balancing mechanism is designed to keep profit in check. The primary purpose of the PCN was always to stabilise its core network practices first and foremost in terms of workforce, not profit.

The service specs are designed to be delivered in part, by your increased workforce - but you can and should define their capacity. We would foresee additional roles needing 70-80% of their time for core network practice needs, and perhaps 20-30% available for PCN additional work. Focus on this, and the balancing mechanism's effects will be mitigated.

Where does a community provider fit in?

Community services are also going to have contractual changes which will force them to align more to PCN footprints. Given that General Practice remains in control of the PCN, this should give GPs greater control of community workforce with increased community service input into aligned care homes. If we stay in control and make PCNs work for general practice, this could allow for the rebuilding of community teams around practices that has been missed for many years. The directions also reference that core network practices cannot be held responsible for the actions of e.g. community trusts in the delivery of the DES.

What other risks do we need to consider?

It's a disappointment that the DES is very rigid in terms of what priorities the PCN has to address, so it may feel like you are at the whim of NHSE's priorities rather than your practice's or patients' priorities – but that's arguably pretty much how it's been since 2004. We also feel that the service specs need greater flexibility in them, and regret the absence of choice. We don't think that £1.50 for running costs is realistic, we know the vast majority of you have subsidised the PCN via unfunded time of clinical and admin staff. We know the tax and employment liabilities remain unsolved. We are just as worried as you that PCNs are the vehicle for investment rather than the core contract. We don't want to see practices becoming dependent on their PCN funding. We are very alive to these concerns and have been a consistent constructive critical voice at a national level.

While it's being commissioned as an annual DES, the growing number of staff employed by the PCN each year may make it harder to withdraw from the PCN DES in future years - this is the quid pro quo of the subsidised workforce - and we think this will reach a critical point around Summer 2021. We also recognise that whilst the additional roles reimbursement funding has been increased to 100% of national pay-scales, for many practices this money does not cover the true cost of employing the staff in a challenging recruitment climate. It's also possible given the climate we are in, that NHSE may come up with new changes and expect you to decide if you're in or out again within a month (to be honest, that might not be a bad thing).

What happens if some or all of our PCN practices decide to opt out of the DES for 20/21?

If all the core network practices in a PCN hand back the DES, the CCG will have to transfer staff under TUPE to another provider, e.g. another PCN or an NHS community provider. NB: This only applies if all the practices in a PCN stop providing the DES. If some of the core network practices decide to opt out, then those practices lose funding for 20/21 and that funding is allocated to the PCN that remains, comprised of the core network practices still opted-in. Practices that have opted-out will still need to engage with their PCN in terms of offering the DES to their patients – so it might make more sense for you all to make a collective decision within your PCN.

In summary:

As with all DESs, the PCN DES represents additional work over and above the GMS contract. When practices signed up for the DES last year, they had a reasonable understanding of the workload demands of the following year. We are now in a very different world, with the full impact of the COVID-19 pandemic on general practice still unclear. It is likely that for some practices, the PCN may present the best opportunity for managing workload and workforce in new and innovative ways with income guaranteed by a pre-Covid Treasury. But the LMC would urge any practice signing up to fully understand how their practice and PCN was going to make it work for them, and to prioritise the needs of the core network practices in defining capacity of the additional roles to take on PCN work.

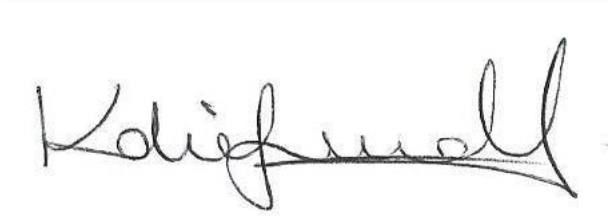
You might want to ask yourself, how well do you function as a group of practices within the existing PCN? What's going to need to change if it's not working now? What proportion of PCN time is focused on issues related to patients vs internal business? If there are issues within the PCN, do you think these can be easily overcome or are they likely to be a continued distraction? Do you need us or the CCG to help you with some mediation or arbitration? How much of the work in the current DES specification do you already do? If the specs do not reflect additional work, that will

have an impact on your decision. How much capacity do you have to do additional work (bearing in mind the impact of COVID-19)? So please consider our advice around recruiting to your Additional Roles sooner rather than later if you decide to proceed. The DES is a national specification so cannot be altered by the CCG, though it may be interpreted in different ways that could be advantageous or disadvantageous to practices. Ironically the financial pressures in our local system give us greater confidence that a commissioner would be more receptive to a gentler approach.

General Practice remains in control of how a PCN functions. But it will be only as strong as its members driving it. Don't be asleep behind the wheel. The government's message has been stay alert - protect the NHS - save lives. Ours might be more akin to stay alert - if you deliver the DES - make it work for you. We have tried to be completely honest with you. You may feel, that given all we have covered, that the potential benefits outweigh the risks - this year - but that might not be the case for everyone and we recognise that too. Your LMC has a duty to represent, support and advise every practice and every GP on our patch. We know that each practice will need to make a decision based on the best interests of their practice and the patients they serve.

This information has been written in good faith and accurate as of when it was written. Things are changing all the time, and we will continue to update you.

Now use the bank holiday weekend to read and reflect on this. Discuss among your practice team, discuss among your PCN. Your clinical director will then be able to collate responses, and return by the 31 May deadline.



Dr Katie Bramall-Stainer

Chief Executive, Cambs LMC

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Cambs LMC

Representing • Supporting • Advising