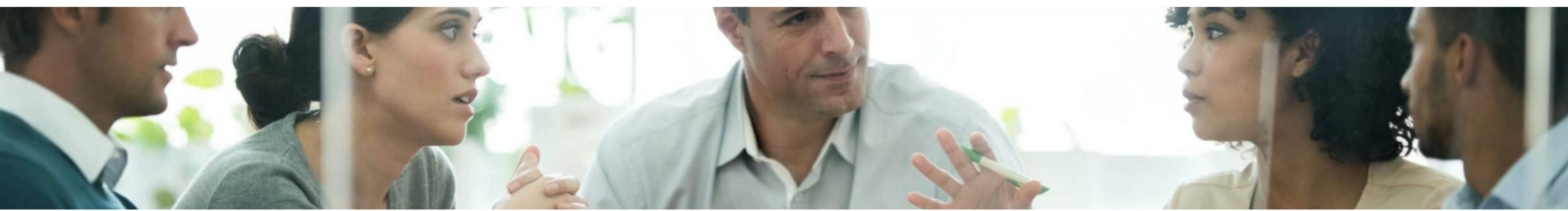
Insight

April 2023



Primary care in focus

Primary care is at the heart of this edition of PCC insight. We look at the changes to the GP contract in 2023/24, consider what causes conflict in GP practices, consider primary care network incorporation and why it is being considered by many primary care networks at the current time. PCC's personal and team development trainer Barrie Sample offers his top tips for dealing with difficult situations and Nicola O'Connor considers how primary care should be included in provider collaboratives.

Author
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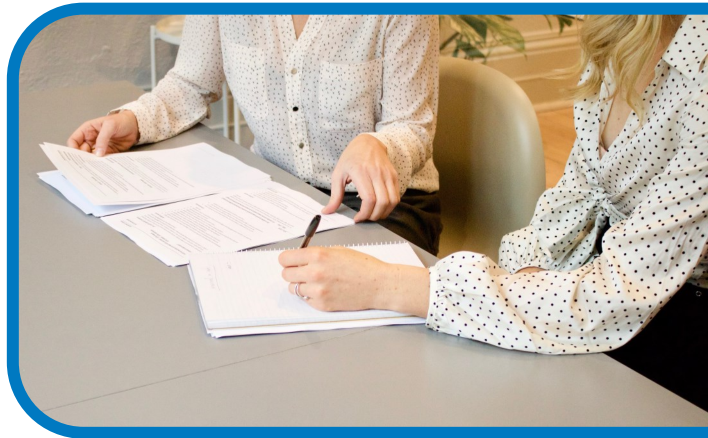
Chief Executive, PCC

Changes to the GP contract in 2023/24

On 6 March NHS England published a [letter to all GP practices and primary care network (PCN) clinical directors] in England setting out the changes that will take place to the GP Contract in 2023/24, setting out the requirements of general practice and PCNs with the goal of improving patient experience and satisfaction. The changes highlighted in the letter include:



Access

- Ensuring patients should be offered an assessment of need or signposted to an appropriate service at first contact with the practice
- Make it easier for patients to access their healthcare information online
- Require all practices once their current telephony contracts expire to procure their telephony solutions from a recommended supplier framework

Investment and impact fund (IIF) and quality and outcomes framework (QOF)

- Reduction in the number of IIF indicators from 36 to five
- Remaining IIF funding to be focussed on improving patient experience of contacting their practice and receiving a response with an assessment and/or being seen within an appropriate period
- Development of access improvement plans
- 25% reduction in the number of QOF indicators
- QOF quality improvement (QI) modules to focus on workforce wellbeing and optimising demand and capacity in general practice

Additional roles reimbursement scheme (ARRS)

- Addition of advanced clinical practitioner nurses to the roles eligible for reimbursement as advanced practitioners
- Addition of apprentice physician associates
- Increasing the cap on advanced practitioners to three per PCN

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- Removal of caps on mental health practitioners

Immunisations and vaccinations

- Removal of the vaccination and immunisations repayment mechanism for practice performance below 80%
- Changes to childhood vaccination and immunisation thresholds
- No additional requirements to PCN service specification in 2023/24

Other highlights:

- Further details are expected shortly on the delivery plan for recovering access to primary care (to include further support for practice and PCNs on improving patient experience and satisfaction)
- The profession and patient representative groups are to be consulted on the QOF and its future form

Further details on the changes including a revised Network directed enhanced service (DES) specification will be published shortly.

Author
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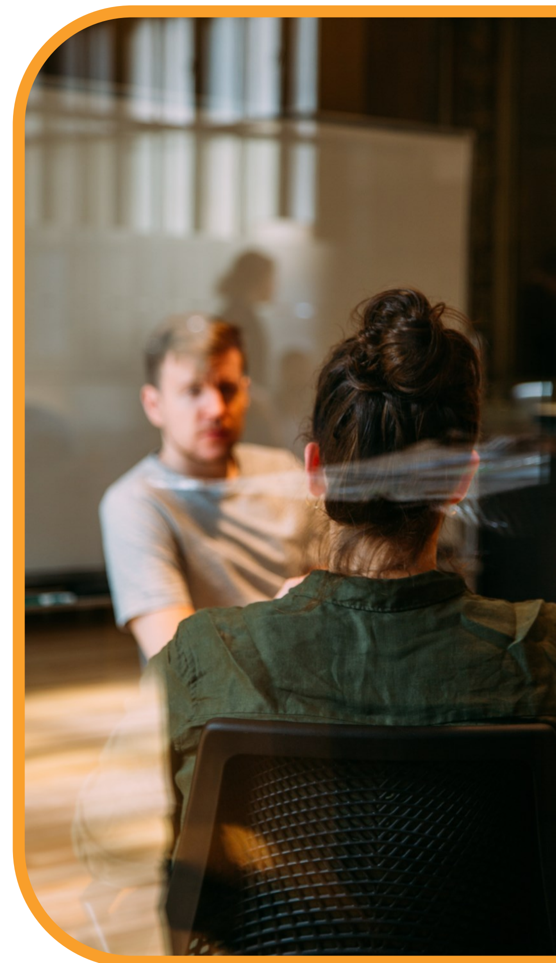
Adviser, PCC

Conflict in general practice: Why is it on the rise?

Conflict is all around us; it's a normal part of our interaction with other human beings, and many would argue that without constructive handling of conflict, individuals, teams and organisations cannot improve, innovate nor fulfil their true potential.

However, as a mediator of disputes in primary care, I'm coming across more and more destructive conflicts in practices and primary care networks (PCNs). Why might that be?

Well, in GP partnerships, the 'common' causes of disputes remain and will be here to stay as long as general practice is: sharing of clinical and non-clinical workload, retirement (whether that be forced or voluntary), personality / ethos clashes, premises issues, General Medical Council/NHS England level investigations, and Care Quality Commission (CQC) problems to name but a few.



And as long as GPs are human, there will also be fair numbers of conflicts about money, sex (sometimes with colleagues; occasionally with patients…), fraud and other crimes. It certainly makes for varied work.

But Covid has had a permanent impact now too. Some GPs have succumbed to long Covid which has resulted in them being removed from their partnership. Others were working at home for large parts of the pandemic because of their risk assessment which of course caused tensions in the workplace and difficulties with communicating. We're now in the 'new normal', but often find ourselves disagreeing on what that new normal should look like… how much remote consulting should we offer? Should all patients still be triaged first?

We all had time to ponder life a bit more during those days of home-schooling and zoom quizzes. Many have decided to change their work-life balance, take sabbaticals or even switch careers.

PCN conflicts are also on the rise; it's been four years now since the PCN directed enhanced service (DES) was introduced. Incentivising practices to work together - practices that deliberately hadn't already merged because of differences in the way

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they work - was always going to be difficult. Some will be hot on governance, some will make all decisions by consensus over tea and biscuits, some will let their practice manager (PM) make almost every decision, others will have a PM who is told what to do. Some will be watching the money, others will be interested in having the best relationship with patients and reputation that they possibly can. All will use the same additional roles recruitment scheme (ARRS) staff in a different way.

There's more and more funding coming into PCNs these days, so there's more to argue about - or more to be greedy about depending on how you view things. Covid brought much more money in to PCNs – the clinical director (CD) uplift, vaccination payments etc. Over the past eight years that I've been supporting GPs in conflict, I see disputes about money being much more commonplace in the highest earning practices and PCNs. More money, more problems…

Voting or decision making is another cause of conflict in PCNs. A lot of PCNs have, or had, quite a casual system for making decisions that wasn't necessarily in keeping with what their network agreement says. Some PCNs leave it all down to the CD to make decisions… until it's a decision they disagree with. There are often few people willing to take on the CD role, and it's the same people that may already be involved in the integrated care board, the local medical committee or the local federation, which then gives rise to conflicts of interest; another source of conflict.

What is the impact of all of these conflicts? Well, in the early stages people will start to avoid each other or the situation. Meetings will feel 'strange'; some people might not turn up, others may not contribute. There'll be sickness, closed doors and awkward coffee breaks. If this doesn't get dealt with, it starts to affect staff performance, patient care, profits, CQC rating, and sometimes the practice contract gets handed back or the PCN dissolves.

There are some simple steps that GP providers can take, however, to either prevent or de-escalate conflict. Beyond that there is the option of mediation, which gives people a confidential, legally safe space to attempt to resolve their issues on the same day with the outcome being a legally-binding agreement that ends the matter entirely. In the next blog, I will talk about this in more detail, but do get in contact if you'd like further information or to discuss a case.

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Clare Sieber

Clare is a practising GP in West Sussex. She is a fully insured CEDR -accredited mediator and gained a distinction-level qualifying law degree whilst working as a GP. She has worked as a medical director for local medical committee. A lot of this work involved providing pragmatic support to individual GPs, practice employees, partnerships, and PCNs that found themselves in a dispute.

She mediates:

- commercial disputes in general practice (mainly partnership, property and PCN disputes)
- workplace disputes in primary and secondary care settings (i.e., disputes between employees)
- disputes between a patient (or their family) and the clinical team

Clare is a PCC associate. To discuss how Clare can support you please email: enquiries@pcc-cic.org.uk

PCN incorporation – what, why, how and who

Many primary care networks (PCNs) around the country have either formed corporate vehicles or are in the process of doing so. In this article, Hill Dickinson's specialist primary care partner **Alison Oliver** and legal director **Ruth Griffiths** explore what PCN incorporation involves, why PCNs might want to consider this model, how to go about putting a corporate structure in place and who the key players are in the process.

What is PCN incorporation?

The first point to note is that the term "PCN incorporation" is used loosely and rarely means that the PCN itself becomes incorporated.

Incorporating a business of any kind generally involves forming a corporate vehicle and transferring the assets, staff and contracts of that business into the corporate vehicle. In the case of a PCN, the network contract directed enhanced service (DES contract) is held by individual practices as an "add on" to their core GMS/PMS/APMS contracts. The PCN does not exist as an entity or hold the DES contract in its own right and so is not in

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a position to incorporate the whole business of the PCN into a corporate vehicle unless all the core network practices in a PCN merge into a single practice.

What PCN incorporation therefore tends to mean in practical terms is that the PCN practices form a corporate vehicle which sits alongside the network. The practices in the network continue to hold the DES contract and retain ultimate responsibility for its delivery, but delegate certain functions to the corporate vehicle.

The functions taken on by PCN corporate vehicles vary between PCNs. At one end of the spectrum, a PCN corporate vehicle might just provide “back office” functions, such as administrative support for the PCN activities. At the other end of the spectrum, the practice could sub-contract responsibility for all the clinical services delivered under the DES contract to the corporate vehicle. In between there are various hybrid scenarios where the corporate vehicle performs a combination of functions on behalf of the network.

Why incorporate?

As PCNs are not legal entities, they cannot hold contracts, employ staff or own property. This means that where there is no corporate model, it is the practices themselves that have to enter these arrangements on behalf of the network. This usually involves either a single lead practice employing staff and hosting funds on behalf of the other practices or these responsibilities being shared between different practices.

As PCN workforce and liabilities grow, many practices are concerned this model is unsustainable, posing too great a risk to their individual practices.

As a corporate vehicle has its own legal personality separate from its members, it can enter contracts in its own right, own property and – crucially – it bears its own liabilities. By delegating certain responsibilities to a corporate vehicle – in particular the responsibility for employment of network staff – the network practices are able to pass on at least part of their liability.

If set up properly, a corporate vehicle can be a useful tool in managing PCN activity, funding and VAT on supplies between network members.

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How do we go about it?

The first step is to consider what functions you want the corporate vehicle to perform. We are aware of some PCNs that have formed companies which have then remained dormant because they did not have a clear vision as to why they needed a company or what it would be used for. The form should always follow the function. We would recommend speaking to your accountants about how you envisage using the corporate structure so that they can advise on the tax and accounting implications and benefits of different models.

Once you have identified a need for a corporate structure, you will need to settle on the particular type of corporate vehicle to adopt. There are a number of different types of corporate structure, but the most commonly adopted model for PCNs is the company limited by shares. This is registered at Companies House with a unique name and registration number.

The constitution of the company (the articles of association) will need to be drafted to align with your network governance structure, and you may need to make revisions to your network agreement schedules to reflect the corporate model and how this relates to the wider network. It would be usual for the company to become an associate member of the network and a party to the network agreement.

Depending on the particular functions that you want the company to perform, various other practical matters will need to be addressed, including:

- Staff transfers: if the company will employ staff currently employed by network practices (e.g. ARRS roles), you will need to manage the transfer of staff in accordance with the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE).
- Employment business requirements: if the company employs PCN staff and then supplies them to the practices, you need to consider whether the company is acting as an employment business. This might apply where the company doesn't exercise predominant control over what the staff do on a day-to-day basis. If that is the case, the company must provide the staff member with certain key information and have an agreement with the staff member about certain matters such as their notice period. These requirements are not particularly onerous, but should be considered nonetheless.
- CQC registration: if the company is performing any activities which are regulated by the Care Quality Commission (for example if it is performing clinical services

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as a sub-contractor of the network practices) then it will need its own registration.

- Pensions access: as the company is unlikely to have automatic status as an NHS pensions employing authority (because it would have to hold a qualifying NHS contract to obtain this status), it will need to apply to the NHS Business Services Authority for special access. This is currently time limited but the government has indicated that it is considering arrangements to confer permanent NHS pension access for staff employed by companies supporting DES contract delivery.
- Sub-contracting requirements: there are provisions in the DES contract and the practices' core contracts which apply if the practices are sub-contracting delivery of services. Essentially, this means that the commissioner must be notified and the commissioner has the right to object or withhold consent in certain circumstances. The terms and conditions of sub-contracting or delegation of functions from the practices to the company should be documented to put the arrangement on formal terms – this might be through a sub-contract, service level agreement or via the network agreement, depending on the type of functions being delegated or sub-contracted.

Options for limited company support

Existing Primary Care Network	Limited company provides back office/employment support	Practices subcontract some DES services to the limited company	Full-service limited company
• Core Network Practices hold core contracts. • Staff employed by one or more Core Network Practice(s). • Each Core Network Practice delivers its share of services under the DES.	• Core Network Practices hold core contracts. • Limited company employs staff and supplies to Core Network Practices. • "employment business" (section 13 EEA 1973).	• Core Network Practices subcontract some DES obligations to the limited company. • DES and core contract subcontracting requirements apply. • CQC registration required if any regulated activities contracted.	• Core Network Practices subcontract all DES obligations to the limited company. • DES and core contract subcontracting requirements apply. • CQC registration required.
Key documentation: Network Agreement and Schedules	+ Service level agreement + Articles of association	+ Subcontract	+Subcontract

Who needs to be involved?

The core network practices in the PCN will need to agree to form a company. Typically, each practice would own one or more shares in the company, either directly (in the case of a sole practitioner or company-operated practice) or via a nominee partner (in the case of a partnership – because a partnership is not a legal entity capable of owning shares).

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In a company, the ownership and management are separate. While the shareholders own the company, there is a separate board of directors which is responsible for the day-to-day management of the company. In most PCNs, each practice would also nominate a director to the board of the company. Usually, it would be the existing PCN board members who are appointed to the board of the company in order to ensure continuity and oversight of the company and network. Where all practices are represented on the board of directors, the board would usually have relative freedom to exercise its management powers.

In larger PCNs, rather than have every practice represented on the board of directors (which could be unwieldy) you might instead agree a process for selecting and appointing a smaller board, but reserve certain more significant decision to be taken by the shareholders.

The governance and management structure of the PCN and the company can be aligned to avoid unnecessary duplication of meetings and maximise clinical leadership time.

Key take-aways:

- A company structure can be a useful means of managing PCN activity, liabilities and finances.
- The core network practices should agree the functions and purpose of the company – form should follow function.
- You should seek your accountant's advice on the different models as there are tax and accounting implications.
- The constitution of the company should be aligned with the network agreement.
- Depending on the functions of the company, it might need to apply for NHS pensions access, consider regulations applicable to employment business and / or obtain CQC registration.

Hill Dickinson's primary care team has assisted PCNs across the company form corporate structures to support their work. Please get in touch if you would like to discuss how we can help enquiries@pcc-cic.org.uk.

Dealing with difficult situations

Have you ever found yourself worrying before a meeting or conversation? We've probably all been in that situation, you know the one where you would rather be doing anything else.

So where do these emotions and feelings originate?

They could be the result of a previous bad experience or, a perception that has been imposed on us by others.

If you are about to face a challenging situation, there are tools and techniques you can use to help lessen your feelings of worry and anxiety.

Here are my top five tips for managing difficult situations.

Tip 1: Obtain the facts.

Gathering relevant information is the first step to a successful conversation. Be aware of how other people with powerful characteristics might influence you with their opinions. Work through specific examples of what happened and when and how the situation came about, ask the other person for examples and their views where possible

Tip 2: Actively listen.

Carefully consider any opposing viewpoints, before speaking up. You are much more effective at listening if you can focus your attention to both what is being said and the body language used. Active listening results in more co-operation and collaborative working

Tip 3: Planning and preparation.

Your ability to adapt 'in the moment' while handling the situation will be aided by careful planning and preparation. If you're planning for a difficult meeting, try to find out who will be attending, what their role is, and where you might be able to contribute. Being clear about others involved and where you can add value will help reduce stress levels and help create a positive outcome.

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Tip 4: Talk to your colleagues or likeminded individuals.

When you're faced with a potentially difficult situation, it can be immensely beneficial to sit down and discuss with colleagues or like-minded individuals on the potential course of action to take.

Tip 5: Self-care.

We are all responsible for our own self-care and for taking time to look after ourselves. A good night's sleep the night before a potentially challenging situation can help your body and mind to feel rested, so you're more likely to be at your best when entering the situation. Think about what relaxes you and try not to focus on the anxiety.

Keep in mind that the more you encounter and manage those situations, the more practised you are and the more resilient you become.

Dealing with difficult situations – courageous conversations is one of the workshops PCC offers. See our event calendar for more details.

Author
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Personal and team development trainer, PCC

Enhance your communication skills

Following requests from our clients, we have added some new course topics to our e-learning portal.

The new courses will enhance your communication skills.

Communication is one of the most important aspects of our life, be it in the workplace or your personal life. It's important to tailor your communication style to your audience so that you communicate effectively with others and build good relationships. Communicating is an essential skill for everyone as there may be times when you have difficult conversations.

This new playlist which we have added to our e-learning portal includes courses on managing difficult conversations, communicating under pressure and active listening skills.

We will also be adding some new courses to our health and wellbeing playlist. Look out for these coming soon.

E-learning can be purchased through our website, and we are happy to discuss discounts for multiple orders. One payment allows access to all our courses for a year.

To see our full list of courses at https://www.pcc-cic.org.uk/e-learning/ or contact enquiries@pcc-cic.org.uk for more information.

Provider collaboratives – should primary care be involved?

Much has been said and written about the importance provider collaboration as part of the new integrated care system (ICS) arrangements in the NHS. Far less has been said about the role of primary care within what could be viewed, as a structure designed exclusively for the larger providers within the NHS.

What has changed with the introduction of ICSs?

The 2022 Health and Care Act, made ICSs legal entities with statutory powers and responsibilities, creating integrated care boards (ICB) to plan and fund NHS services within its boundaries, and absorb the previous responsibilities from clinical commissioning groups.

The legislation has also changed procurement and competition requirements, taking away the requirement for competitive retendering. The division between commissioning and provision of services is becoming increasingly blurred with the expectation that the ICB and providers within its footprint will work increasingly more collaboratively.

The national direction of travel is that commissioners and providers should increasingly be working hand in hand to plan care for their populations. NHS providers are expected to look beyond their organisational priorities to focus on system-wide objectives, improving outcomes and reducing inequalities for the communities they serve. Increasingly the vehicle chosen to deliver system objectives is via the provider collaborative route, building upon learning and greater collaboration during the COVID-19 pandemic.

What are provider collaboratives?

Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements.

In many systems, provider collaboratives – alongside place-based partnerships –

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will play a key role in leading service and pathway improvements, recovering backlogs of care, and delivering NHS long-term plan objectives and system-wide clinical strategies.

My experience as a senior executive involved at the start of one of the largest integrated care systems in the country and then latterly setting up one of the smallest has shown there is a great deal of scope for provider collaboration to improve services for patients which is being fully exploited in some systems, and barely at the starting point in others.

Formalised provider collaborative arrangements tend to fall into three broad categories:

- Lead provider arrangements – usually focussed on improving specific services with one provider in a system taking contractual responsibility for delivery in partnership with others. Mental health services often utilise lead provider models.
- Provider boards – a formal board within a system where chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards, so that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative. Lancashire and South Cumbria have a well-regarded provider board which is beginning to tackle some long standing challenges in that area.
- Shared leadership model: the same person or people lead each of the providers involved, with at least a joint chief executive and/or chair. This model can be achieved by NHS trust or foundation trust boards appointing the same person or people to leadership posts. This is often seen as a quick route to achieving common aims, without the complexity of a merger, and has become a very popular model in the Midlands and in London.

What should be the role of primary care?

There is an obvious and defined role for primary care within place based partnerships in a system as distinct from provider collaboratives. Place based partnerships co-ordinate the planning and delivery of integrated services within localities, while provider collaboratives are partnership arrangements spanning several places, with the aim of effective decision making focusing on scale and mutual aid across multiple places or systems.

Provider collaboratives do however need to consider how to work best with primary care. Collaboratives also offer an opportunity for trusts to consider how they can better support primary care, including working with primary care networks, to support priorities relating to prevention, access to urgent and emergency care and whole pathway developments.

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In my experience, the more mature ICSs already do this, and often have well established mechanisms for primary care to have a real voice in how the system is run. In Greater Manchester there is a strong primary care board, ensuring the views of colleagues feed into the decisions of the ICB. In Staffordshire and Stoke on Trent, GPs are involved in collaborations improving mental health pathways, long term conditions and end of life care.

Provider collaboratives should not just be about NHS trusts and foundation trusts. There is a real opportunity for primary care to be involved, to help some of those bigger institutions think out of the box and to support real improvements in patient care.

Understanding the purpose and role of provider collaboratives can be confusing and then appreciating how primary care can be key in the decision-making processes may need some debate, negotiation and support. I can offer support to primary care colleagues by demystifying some of this through short workshops and engaging with acute sector colleagues to find the right roles for primary care partners.

Contact enquiries@pcc-cic.org.uk to discuss how Nicky can support your provider collaborative to develop.

Author
Nicky O'Connor

Associate, PCC and Director,
Nicky OConnor Developments Ltd

The Strategic programme for primary care in Wales

We recently caught up with Alan Lawrie who is the national programme advisor (primary care) for the strategic programme for primary care. Alan updated us on the purpose of strategic programme, its key aims and functions and how the accelerated cluster development (ACD) work has been rapidly evolving in 2022/23 and the plans for 2023/24.

Strategic programme for primary care (SPPC)

The SPPC is an all-Wales health board-led programme that works in collaboration with Welsh Government and responds to A Healthier Wales. The programme commenced in November 2018 and is in its fifth year of operation.

The programme aims to bring together and develop all previous primary care strategies and reviews at an accelerated pace and scale, whilst addressing emerging priorities highlighted within A Healthier Wales.

To achieve success, the programme looks to all health, social and wellbeing providers, health boards and other stakeholders to work collaboratively in sharing local initiatives, products and solutions that could add value to the delivery of primary care services on a 'once for Wales basis'.

There are six strategic programme work streams:

Key to the success of the programme is support, engagement and collaborative working across all independent contractors, clusters, health boards and wider stakeholders.

Access the full article https://www.pcc-cic.org.uk/the-strategic-programme-for-primary-care-in-wales/

We also produce PCC Insight (Wales edition) the full article is available in this version.

You can sign up for the Wales edition of PCC Insight here.

Helpdesk FAQ April 2023

Examples of questions received by our helpdesk for commissioners. For details on how to access the helpdesk see www.pcc-cic.org.uk/annual-contracts/

Dental query

Can a company change to another company and still hold their GDS dental contract?

A company-to-company change isn't covered in regulations but can be managed by way of a contract novation. Commissioners can use the process (outlined in the policy book) for managing an incorporation request, to look at their decision-making process and what would be looked at to decide whether to allow a novation request or not. Because it is a change outside of the regulations it does carry a risk that someone may raise a procurement challenge. Commissioners can again use the principles of managing an incorporation request when looking at the procurement risk. The risk of challenge doesn't mean the request should not be allowed, but that the commissioner should put themselves in the best place to defend the decision.

Eyecare

Suppliers of optical appliances

Do suppliers of optical appliances (glasses and contact lenses) need to hold a contract with the NHS?

No. Suppliers of optical appliances who choose to only dispense and submit GOS 3 forms (NHS optical voucher and patient statement) and GOS 4 forms (NHS optical repair and replacement application form) do not need to hold a GOS contract with NHS England as the GOS claim forms contain the required wording to support reimbursement.

Suppliers who dispense to patients who are under 16 years of age or who are registered sight impaired or severely sight impaired (previously partially sighted or blind) must be carried out by, or under the supervision of, a **registered optometrist, Ophthalmic Medical Practitioner (OMP) or dispensing optician. The registered practitioner should be identified on the dispensing record.

**Registered with the General Optical Council (GOC)

Upcoming PCC Events

Using SHAPE in relation to commissioning pharmaceutical services

Wednesday 19 April 2023 (14.00 - 16.00)

Online training session

https://www.pccevents.co.uk/2977

Primary care estates - ask the expert

Thursday 9 February, Tuesday 25 April, Tuesday 4 July, Tuesday 10 October 2023

Online training session

https://www.pccevents.co.uk/2879

Dealing with difficult situations - courageous conversations

Wednesday 26 April 2023 (09.30-12.30)

Online training session

https://www.pccevents.co.uk/2901

The leader as a coach - building stronger teams

Thursday 27 April 2023 (10.00-12.00) and Tuesday 2 May 2023 (10.00-12.00)

Online training session

https://www.pccevents.co.uk/2892

Full events calendar https://www.pccevents.co.uk/calendar

PCC welcomes your news for future editions of PCC Insight—if you have something to share or would like to contribute an article please let us know enquiries@pcc-cic.org.uk

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