AIS500 PCN Specification Consultation

AISMA response to the PCN Specification consultation dated December 2019

The Association of Independent Specialist Medical Accountants (AISMA) is a national network of over 75 firms providing expert advice to GP partners in medical practices, sessional GPs, salaried GPs, locums, hospital doctors, specialists and consultants.

Our members advise on accounting, taxation, practice management and pension issues affecting the medical profession.

AIS500 PCN Specification Consultation Questions

1 Is there anything else that we should consider for inclusion as a requirement in this service? For example, are there approaches that have delivered benefits in your area that you think we should consider for inclusion?

2 Are there any aspects of the service requirements that are confusing or could be better clarified?

3 What other practical implementation support could CCGs and Integrated Care Systems provide to help support delivery of the service requirements?

4 To what extent do you think that the proposed approach to phasing the service requirements is manageable in your area?

5 Do you have any examples of good practice that you can share with other sites to assist with delivering the suggested service requirements?

☐ Yes, I have examples of good practice that I would like to share
Please email your examples to england.contractengagement@nhs.net

6 Referring to the 'proposed metrics' section of each of the services described in this document, which measures do you feel are most important in monitoring the delivery of the specification?

The above questions largely relate to the delivery aspects of the specification and do not relate to the financial aspects

Extracts relating to finance from the consultation document

1.11 The Network Contract DES provides funding entitlements worth £552m in 2020/21, rising to £1.799bn by 2023/24. This comes on top of increases to the core practice contract worth £296m in 2020/21, rising to £978m in 2023/24. **Funding is not allocated directly for delivery of the service specifications;** rather, the largest portion of network funding (£257m in 2020/21, rising to £891m in 2023/24) provides reimbursement for additional workforce roles that PCNs can engage to support the delivery of the specifications and alleviate wider workforce pressures. This funding enables the deployment of over 6,000 additional staff by 2020/21, rising to over 20,000 by 2023/24. For a PCN covering a population of 50,000 people, that could equate to around five additional staff in 2020/21 and around 16 additional staff by 2023/24. **This represents a major uplift in the workforce capacity within primary care.**

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1.14 In addition to the funding for additional workforce roles, a typical practice within a PCN will receive funding of £14,000 for participating in a PCN through their PCN participation payment. Each PCN is guaranteed a cash payment of £1.50 per registered patient and 0.25 FTE funding to support its Clinical Director. **Taken together, this provides over £109,000 for a PCN covering 50,000 people.**

1.15 Other funding is available to PCNs through the contract agreement, for example through their share of the *Investment and Impact Fund (IIF)* where they make strong progress in delivering the service specifications. The IIF is worth £75m in 2020/21, rising to £300m in 2023/24**. An average PCN could secure funding of c.£60,000 in 2020/21, rising to an additional c.£240,000 by 2023/24**.

The AISMA response that follows is largely in relation to the financial aspects of the DES and the impact on the client practices that our AISMA members act for.

We have provided the following points for consideration as part of the consultation exercise

1 The PCN is a DES funded at £1.50 per patient directly for the operation and development of the PCN together with an initial £1.76 per patient paid to practices in 2019/20 to engage with PCNs.

2 The information at section 1.14 of the document suggests that the £1.76 will continue to be funded into 2020/21, but this will not be confirmed until the 2020/21 contract negotiations have been completed.

3 There has not been any additional financial funding outlined in the consultation document that is to be paid to the PCN or the practices specifically for the delivery of the additional service specification requirements.

4 The information at section 1.15 refers to the IIF funding. Clarification is needed on how this will be made available to the PCNs and when so that assessment of the funding feasibility for the specifications can be made.

5 The PCN will receive funding to reimburse 70% of the employment costs of the additional roles available to be recruited, so the practices will need to agree between them how the ongoing funding of the remaining 30% will be met.

6 Practices will also need to evaluate, in collaboration across the PCN, what the new specifications will mean in terms of existing GP or other practice staff commitments. Can the specs be fully delivered just through those additional roles, if able to be recruited, and if not, how can capacity be created elsewhere?

7 The shared workforce arrangements across the PCN will inevitably lead to issues with respect to VAT arising on supply of staff between the PCN member organisations.

8 Where joint contracts of employment are entered into across the PCN membership there are NHS Pension scheme membership issues to consider.

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9 GPs and practice staff continue to struggle to meet their existing workload demands and the PCN DES arrangements should be set up to ensure additional capacity is created at GP level to meet the demand of existing general practice patient workload before expecting practices to undertake additional new workload activity .

10 The consultation document emphasises co-delivery of services with other community service providers via NHS standard contracts. Will these be commissioned directly by CCGs or will these be sub-contracted delivery of the PCN DES by the practices? There are some fundamental issues relating to sub-contractors and employment which will need to be considered arising from the off-payroll workers IR35 regulations.

11 NHS Pension scheme rules apply differently depending on which entity holds which type of contract, i.e. GMS/PMS/APMS core contracts for the DES, NHS standard contracts/sub-contracts for the collaborative delivery of the services. These will also need to be well understood and correctly implemented on a timely basis via NHS Pensions and PCSE.

12 It is possible that for some practices, services outlined in the consultation documents are already being provided and paid for through local CCG commissioned schemes. It will be essential to ensure that the funding available through those schemes is not subsequently withdrawn by the CCGs but is paid into either the practice or PCN delivering the service under the new system. The funding must be ring-fenced for primary care and not passed over into budgets for other community service providers.

13 Financial benefits that arise from implementation of any of the proposed specifications and any efficiencies created must be seen to benefit primary care as it is primary care through the contractual DES requirements that bears full responsibility, accountability and risk. If this is an aspect of the IIF mechanism it must be transparent, and the funds distributed fairly and in a way that can easily be followed.

14 Ongoing development of service delivery will require significant project management time input. Most PCNs do not have project management capacity from within their practice membership. If this must be outsourced to third parties that will entail substantial consultancy fees. There could be many PCNs reinventing the wheel and cost duplication. Where is the funding for this?

15 Given the DES went live in June and the first funding was not sent to practices until July 19 then we are only 6 months in. PCNs have struggled with organisational structure partly because the DES doesn't really fit well with VAT and PAYE tax rules which have been much debated in the accountancy world.

16 A DES, being a practice specific contract, is not suited to providing services across multiple businesses. AISMA have been lobbying hard to get NHSE, the BMA and HMRC to sit down and discuss the issues as it probably needs a pragmatic solution to avoid creating tax and NHS pension issues which are not in the public interest.

17 PCN maturity is delayed due to putting into place a further tier of "organisation" at local level. Many areas already had similar things to PCNs but on a wider basis involving other community services. The PCN is different in that it is a GP contract DES – so confusion remains around how other community services fit into what is fundamentally a GP contract issue. It's taken time for new groups to form and work out where they sit with the old groups.

18 Recruitment is an issue. Pharmacists in general practice are not a new concept. Many practices already had them funded via local CCGs. Simply recruiting another wave didn't really match up demand with supply. The concept of a social prescriber still causes concern for many.

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19 The problem is that the new funding that General Practice gets comes with conditions. And this document goes beyond what they were initially intended to do.

20 The new staff funding in the main is 70% funded by new money with 30% to be funded by the practice. The logic of giving funding to a PCN rather than a practice was sensible in that smaller practices would not have received a significant amount of funding to go and employ new people – this way pharmacists, physios, paramedics etc can be employed across practices so each can benefit. Again, the logic of NHSE was that new staff were being brought in to plug the hole in GP recruitment – so the 30% could be funded by practices by natural savings in the cost of employing GPs – simply because they are not employable. There is a wealth of evidence out there to show that these days allied healthcare professionals can do a lot of the work that general practice does – it doesn't need to be a GP. So, whilst not perfect that practices were being asked to pay 30%, there was some understandable method in the proposal. But this then leads to two issues;

20.1 There are practices out there who do cope and who don't need to expand staff. They also don't have a shortfall in GPs – so quickly finding 30% means either cutting existing staff or cutting existing profits or not employing PCN staff. The obvious route is the latter.

20.2 Practices will only accept paying the 30% element if it is having a positive impact on the workload involved in doing the core work and if they can fund it, for example by reducing locum costs. This specification doesn't do this at all. It increases workload by bringing in work not currently done. And practices must fund 30% of the cost. If you take that to the extreme by year 5 the staff funding element is something like £891m (per section 1.11) so, the 30% required to be funded is close to £400m, coming out of existing GP funding streams to fund these new roles. For a PCN covering a population of 50,000 people that is equivalent to almost £305,000.

21 There also remains the risk of what happens after year 5 – if the funding stops then the redundancy costs and risk remain with the practices.

22 Clinical Director/Clinical Lead roles: The specification increases the number of leads for different areas of the specification. There is no mention of funding. Nor any mention of how this will be resourced. If the average PCN is 50,000 and England's population is 60m then there must be around 1200 PCNs. So that's a lot more GP time needed – who is going to do this?

23 Should this really be a DES? The consultation gives a flavour of NHSE's ambition and direction. For PCNs to make a real difference to community health they will have to bring in services outside the NHS, for example working with the charitable sector. Should that really be a bolt-on to the GP contract or does this not lead better to a community-based contract done at Federation/CCG level which is then able to employ all these staff locally and service the wider provider interests in this? Models already exist of this happening. You could keep the PCN involvement element of the DES to encourage practices to be involved – but commissioning should be done differently.

24 A DES is limited by being a national contract so with national terms, and what is apparent from this document, national measurement and control. The problems of rural practices are completely different from the problems of inner-city practices. So, putting national terms and conditions and removing local knowledge and choice is a backward step in terms of healthcare delivery.

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25 And finally – in 2021 the full extended access work moves to PCNs. If it remains a DES GP practices will become responsible not just for delivering the core contract but also a significant proportion of work outside in non-core hours. That could be a bridge too far for many.

Prepared on behalf of AISMA
Deborah Wood Vice Chairman and Andrew Pow Executive Member
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https://www.aisma.org.uk/