Contract Special Update 4 March 2024

From: Dr Brian McGregor, Medical Secretary, YORLMC Ltd

This update will purely focus on the contract, the implications, the timelines and next steps. I have been accused a few times in the last few weeks of being a cynic and a harbinger of doom, this may also make a depressing (but vitally important) read. [The BMA has responded to the declaration of the contract imposition]

There is still time to sign up to our roadshows if you want a personal presentation or to ask questions. We will also issue further communications after the roadshows.

The letter to practices came last week. There are multiple concerns with regards to the lack of respect for the profession, not least being that this was not sent to all GPs. The letter is 12 pages long, I would strongly recommend EVERY GP – be they a GP Registrar, Locum, Salaried or Contractor - needs to read and comprehend this document and the impact it will have on our profession. Ultimately, all funding for GP pay comes from the contract and payments made to practices, and hence everyone's career and income depends on this contract being sufficient to sustain, stabilise and support the delivery of General Practice.

Firstly, the update of 1.9% was decided in the spending review of 2021, i.e. our 5 year deal was fixed as a 6 year deal, and NHSE and DHSC have decided that the changes in the economy since that time were not sufficient to consider asking for additional funding or offering a better deal. The 2% overall uplift come from ARRS being uplifted (note not all of the PCN DES funding is being uplifted, just ARRS). The 1.68% deflator inflationary measure is a measure of price increases, similar to CPI/RPI and is being used to suggest 1.9% is generous. It is NOT an additional 1.68%. Overall, the contract will be increased nationally by 2.23% (£259M) the additional is to compensate for a rising population and per capita payments.

The promise of "jam tomorrow" via a possible DDRB award is disingenuous – this is not in the gift of NHSE/DHSC, and will be purely down to the Treasury, which currently is looking to fund election promises and attempts to seduce the unwary into voting for the government when the election comes around. GPCE wrote to the Treasury looking for further support and it has been declined, the Chancellor, Jeremy Hunt, cannot claim to be unaware of the crisis following his paper from the Health select committee in October 2022, the conclusions are particularly damning.

There is little more to comment on in the contract – some of the language used will identify how NHSE and DHSC are now approaching the profession of General Practice, what we have always seen as negotiations they now refer to as a consultation, and the imposition for a third successive year they now refer to as an implementation.

My bleak cynical outlook would suggest the vaccine changes are about data cleansing in preparation for removing them from practices, and the ARRS changes are about GPs training up the workforce that will ultimately replace us as clinicians, all the while whittling away global sum and core practice payments, until we see practices falling over financially (something I expect to see in the next year for our regions). The question every Contractor/Partner needs to ask themselves is what impact this contract has on the financial viability of their business? Salaried and locum colleagues need to ask how safe they are when ARRS staff are reimbursed and for practices, redundancy or failing to replace those leaving is rapidly being seen as a cost saving exercise. GP Registrars need to ask whether there will be employment for them in the future at all.

Briefly, the removed QOF indicators will have minimal impact on workload. Not keeping a register is irrelevant when achievement is measured against the register. IIF has been decimated to only be

worth £13million nationally. Access is once again the drive, via the increasing capacity and access funding, despite the increasing evidence that continuity is what saves money, adds life to years and years to life. The actual evidence can be accessed via X (Twitter). The ARRS flexibility is smoke and mirrors – allowing you to employ direct care staff "if agreed" and also allowing you to take 100% of cost and risk for PCMHWs (if you can find them) but not allowing you to employ them at any point, enhanced nurses are poorly defined and remain capped. The PCN changes fail to protect the terms and conditions of clinical directors and opens the door for managers to step into CD roles. A decision has also been made to permanently allow non-performers list doctors work in General Practice, potentially paving the way for SAS Doctors to move into GP roles. The promise of not using cloud based telephony to put pressure on practices has evaporated, with extensive practice level data mining to be introduced from October.

GPC England rejected this contract unanimously on 1st February – our podcast covered most of the details. The next step is the referendum as highlighted above – starting 7th March.

The referendum will be a simple, single question, wording not yet finalised but along the lines of do you accept the contract as imposed? Yes/No.

You MUST be a BMA member to vote – the reason is the vote is run by an independent organisation to have validity and the dataset used for voting is supplied by the BMA, as a Trade Union the BMA can only communicate directly with members. It is possible to join on a direct debit system, that can be cancelled at any time and it is tax deductible, we genuinely need every GP to join to enhance the voice and viewpoint of GPs in this action.

March will have the YORLMC roadshows, webinars from GPCE, then an extraordinary GPCE meeting 28th March to discuss the outcome. The Executive of GPCE will then commence roadshows nationally in May/June, and the potential for further collective and industrial action will be determined by the referendum and feedback. The process for this is set in trade union legislation and includes a 3 month "data cleansing" exercise to ensure the BMA liaises with the appropriate members but would essentially mean action in late autumn. There are already a range of options for action that would not impact on patient care or involve contract breaches, details of which will be shared nearer the time. In summary, the offer is not thought to be acceptable, but come and listen, ask questions, get involved and if you want to have a voice join the BMA.

Locally, we will be setting up "Broadcast" WhatsApp groups that any GP/GPR will be able to join to disseminate information rapidly from GPCE and the LMC over the coming year. I would encourage every GP to look to sign up, and we will also have additional groups for Practice Managers to be part of, there are again specific trade union reasons for not having everyone on a single group, that will protect the LMC going forwards, it is not about exclusion. For each of our neighbourhoods we will be asking the newly elected committee members to set up a local WhatsApp group with GPs they know to allow information to flow in both directions and feed the debate, this will allow peer-to-peer conversations and better engagement going forwards.

Finally, I consider these updates to be public once published, please share them widely, with friends, family, colleagues, not just locally but as wide as possible, we need to really engage the profession and public in a way never seen before. The time has come for each and every one of us to stand up for the profession, there is a genuine possibility we will see a stark choice of following dentistry into private practice or simply not have GPs available at all unless we all start looking at the direction of travel, and we are talking 3-7 years' time, not in the longer term. This introduction of a two-tier system may well be the ultimate ambition of those driving this from the national perspective in NHSE/DHSC.

Regards,

Brian McGregor
Medical Secretary, YORLMC Ltd