

**Cheshire Local Medical Committee Ltd**

**A Practice Guide to the GP Contract Agreement 2019/20**

 **Investment and evolution:**

**A five-year framework for GP contract reform to implement *The NHS Long Term Plan***

A resource for 2019/20

Version 2: April 2019

This is a Practice Guide to the GP Contract Agreement 2019/20 developed and issued by Cheshire LMC. No part of the document supersedes the actual guidance or notes issued by NHS England. It is our intention to update the guide on our web site as the detailed instruction on various sections is released.

**Contents**

Introduction Page 3

Contract Agreement Headlines Page 4

General Practice Indemnity Page 5

QOF Indicator Changes Page 7

QOF Quality Improvement Page 9

Network Contract DES Page 10

Additional Changes and Services Page 14

Network Investment and Impact Fund Page 14

NHS111 Direct Booking Page 14

Access Page 14

Vaccination & Immunisation Page 15

Online Consultation Systems/ Digital Offer Page 15

NHS Marketing Campaigns Page 16

Temporary Resident Payments Page 16

Subject Access Fund Page 16

Some figures Page 16

FAQs Page 17

LMC Support Page 23

Example of PCN Funding Page 25

Timeline for PCN Submission/ Start Page 25

Reference List Page 26

**Introduction**

GPC England has negotiated a deal spanning the next five years. ‘New’ parts of the agreement will be introduced throughout the five year period. 2019 will focus on building the foundations for creating Primary Care Networks and starting to expand the workforce.

Resources for primary medical and community services will increase by over £4.5 billion by 2023/24, and rise as a share of the overall NHS budget.

The most substantial changes start in April 2019. The changes should provide much needed support and resources for general practice, expanding the workforce, reducing workload, increases to funding, retaining GP and partnership autonomy and ensuring GPs have a leadership role at the centre of primary care.

The LMC welcomes any funding or support for General Practice but recognises that it is incredibly difficult to keep track of what is available and how the different pots of money relate to one another. This year £109m will be invested into the ‘core practice’ contract. Details of how this increase will be put into the global sum are now emerging and are reflected in this ‘first update’ to our Guide. This year’s comparatively low increase reflects money put into the state backed indemnity scheme.

This Guide (issue 2 April 2019) is intended to be a reference tool for practices. We would encourage you to make the time to read it through from beginning to end. Having identified any options might be right for your practice you can then begin to plan your application within your practice or Primary Care Network cluster.

**Set out in sections, this guide aims to summarise:**

• The different contract changes and funding streams currently (or soon to be) available

• What the opportunities can mean for your practice

• Relevant criteria to be met

• Where to find more information

This LMC document will be updated to reflect new information released by NHS England or the BMA and add any new resources to help you prepare your practice for changes. We hope that this guide will save you time and effort! If you have any feedback or suggestions for improvement, please email them to Cheshire LMC at WGreenwood@cheshirelmc@org.uk

The LMC is committed to ensuring that as much of the available funding and support flows into your practices in Cheshire. To help us champion our practices we will be developing events to help practices prepare for the new agreements for the GP contract in 2019/20. You can read more about these planned changes by looking out for items in our e-newsletter and on the LMC website.

As the detailed guidance is received the LMC will provide updates via our e-newsletter ‘Heartbeat’ and when appropriate we will be hosting sessions on key elements.

**Contract Agreement Headlines**

For those in a hurry here are the basic headlines of the five year agreement –

2019/20 cumulative increase £109m annual increase % 1.4

2020/21 £296m 2.3

2021/22 £525m 2.8

2022/23 £741m 2.5

2023/24 £978 2.7

* A one-off adjustment to the global sum to secure state backed indemnity scheme.
* 1% uplift deferred from 2018/19 payable within Network Participation Payment alongside global sum as part of Network DES reimbursement.
* Extended Hours DES/111 practice appointments global sum uplift consequent on transfer to Primary Care Networks of the responsibility for the DES (£30m.
* Subject Access Requests related global sum uplift (£20m).

The global sum for 2019/20 will rise to £89.88 from the current £88.96 with the OOHs deduction falling to 4.82% from the current 4.87%.

Practices will be paid £1.76 per weighted patient annually as the Network Participation Payment, in instalments via the SFE, once a practice has signed up to the Network Contract DES.

There will be a further indemnity inflation adjustment payable to reflect the average inflationary increase in indemnity costs in 2018/19 which has been lower than the previous 2 years; this will be the final such payment to be made following introduction of the state-backed scheme in April 2019.

The contract also equalises immunisation payments at £10.06 and the MMR catchup programme. Finally the Government is committed to reimbursing the 6.3% increase in the NHS Employers’ Superannuation costs – further guidance and details on this will follow later.

This Guide is intended to be a reference tool for practices. We would encourage you to make the time to read it through from beginning to end. Having identified any options which might be right for your practice you can then begin to plan your application within your practice or Primary Care Network cluster.

William Greenwood

Chief Executive

**General Practice Indemnity**

**Description:**

From April 2019, all clinical negligence costs relating to NHS general practice activity will be covered by the Clinical Negligence Scheme for general practice (CNSGP) which will be operated through NHS Resolutions.

There is no subscription cost for the scheme; membership will be free. There will be a one-off permanent adjustment to the global sum which takes into account previous money allocated to indemnity in general practice.

**Timeframe**

1 April 2019.

**Who is covered?**

All NHS activity that consists of, or is in connection with, the provision of primary medical services under a GMS, PMS or APMS contract will be covered, plus out-of-hours provision. It will automatically cover contractor and salaried GPs, GP locums, prison GPs, Trainees, nurses, Allied Health Professionals and all other professional groups working in delivery of primary medical services, as defined in forthcoming regulations.

**Plain English: What is included?**

The scheme covers:

•Liabilities incurred on or after 1 April 2019; and

•Liabilities arising from an act (or an omission to act) on the part of a GP or any other person working in a general practice setting where that act (or omission):

- is connected to the diagnosis, care or treatment of a patient; and

- results in personal injury or loss to the patient.

There is no formal membership or other registration requirements for either individuals or practices/organisations. The indemnity provided under the scheme continues to apply where a GP or other person is no longer practising or working in general practice at the time a claim is made (which can be many months, sometimes years, after the clinically negligent act or omission occurred).

**Plain English: What is not included?**

CNSGP **does not cover** all general practice activities. Practices and staff will still need to take out separate medical defence organisation (MDO) cover for professional practice, additional advisory services, and private work. The cost of such indemnity will not be covered by the Government and GPs are advised to retain or continue with membership of an MDO to cover all eventualities. Regarding practice coverage of fees for such cover, what constitutes a fair solution for practice staff will vary and be a matter for individual practices to decide.

Activities and services **not covered** by the scheme include:

• Legal advice, • GMC representation, • Indemnity for private non-NHS work, • Inquests,

• Regulatory and disciplinary proceedings, • Employment and contractual disputes, • Non-clinical liabilities such as those relating to defamation, • Complaints (unless there is a formal claim for compensation for clinical negligence as well), and • Primary care NHS dentistry, optometry and community pharmacy.

**Continuing MDO Membership**

While it is unlikely to be a condition of inclusion on the Medical Performers' List (MPL) or GMC register that a doctor maintains membership of an MDO after the 1st of April, we would strongly recommend that doctors continue to maintain membership with an MDO or other indemnity provider in respect of activities and services not covered by CNSGP.

**Cover for historic practice**

If you have indemnity arrangements that are not an occurrence-based product – for example, claims paid products – the Department of Health and Social Care has confirmed you will require run-off cover for historic claims unless the terms of your cover specify any defined circumstances where this would not be required. This will particularly apply to MDU members on the Transitional Benefits Scheme (TBS). If you are unsure of your current indemnity arrangements, then you should contact your existing indemnity provider.

**QOF Indicator Changes**

**Description:**

QOF has been reformed to remove ‘unnecessary’ indicators under the new GP contract. The framework is being reformed further to bring in ‘clinically-proven’ improvements for the management of prevalent conditions such as diabetes and blood pressure control; and improvements to the management of heart failure, asthma, COPD and mental health.

QOF currently comprises 559 points. 28 indicators worth 175 points in total are retired from 1 April 2019.Of these 175 points, 101 points have been recycled into 15 ‘clinically appropriate’ indicators. In 2019/20, the remaining 74 points arising from indicator retirement will be used to create two Quality Improvement modules within a new quality improvement domain.

**Timeframe:**

1 April 2019.

**How much?**

There is a 4.7% increase in the value f QOF points from £179.26 to £187.74 to reflect the increase in the average practice list size (CPI: Contractor Population Index).

**Indicator Changes**

Annex A to the new GP contract agreement lists all the indicator changes.

**New Indicators**

Section 3.10 of the agreement details the new indicators:

* Reducing iatrogenic harm and improving outcomes in diabetic care (43 points)
* Aligning blood pressure control targets with NICE guidance (41 points)
* Supporting age appropriate cervical screening (11 points) which brings QOF into line with National Screening Committee recommendations. The GMS Cervical Screening Additional Service is unchanged.
* Improving weight management as part of physical care for patients with complex enduring mental illness (4 points)

See the NHSE guidance for the full list of retired indicators.

**Exclusions**

Exclusions are replaced by a ‘**Personalised Care Adjustment**’. Patients will now be differentiated as being removed from the indictor denominator because of:

* Unsuitability (i.e. medicine intolerances)
* Patient choice
* Failure to respond to recorded offers of care (normally 2 invitations)
* The specific services are not available locally
* Newly diagnosed or registered patients

**INLIQ Mandatory Extraction**

There are minor changes to these with 4 being added and 6 removed leaving 23 INLIQ indicator extractions. The continuing and retiring indicators are also listed in the Contract Agreement.

**Further Developments**

Over the next 2 years a review of heart failure, asthma, COPD (2020) and mental health (2021) indicators is planned, together with further Quality Improvement Modules. The full QOF implementation guidance, indicating changes in the SFE is due for issue at the time of this revision to our Guide.

**The LMC comment**

QOF provides vital core income to cover practice staff pay and expenses. These changes are intended to address inefficiencies in the current QOF scheme and are also clearly designed to help secure early progress on clinical priorities identified in The NHS Long Term Plan.

**QOF Quality Improvement**

**Description:**

As mentioned in the last section the remaining 74 (retired) points of the current/ previous QOF Scheme will be used to create two Quality Improvement modules within a new quality improvement domain (each worth 37 points).

* Prescribing safety (Q1001, Q1002)
* End of life care (Q1003.Q1004)

Details of both Quality Improvement Modules are available in the main Contract Agreement document. There are no threshold achievements within this domain; both modules include 10 points to incentivise shared learning within the practice’s Primary Care Network.

Quality Improvement Modules will be supported within QOF for one year and future modules are in development.

**Timeframe:**

1 April 2019.

**How much?**

As reported in the last section there is a 4.7% increase in the value of QOF points from £179.26 to £187.74 to reflect the increase in the average practice list size.

**The LMC comment**

Initially when QOF was introduced, practices did receive a major increase in income, and government did get unexpectedly high-quality care in return. However, over time both the profession and the government have had reason to feel aggrieved with QOF. For GPs, the initial increase in income has been clawed back even as practice workload has risen. For payers, early suspicions that QOF was too easy to deliver or that GPs gamed the system for profit undermined confidence, with more concrete concerns that QOF wasn’t effective at driving continuous improvement in outcomes.

Indeed, many failed indicators in QOF resulted from well-meaning attempts to widen the scope beyond such processes. QOF has therefore proved a blunt tool, and is particularly ill-suited to drive better care for the rapidly growing numbers of people with complex multi-morbidity and frailty.

There are no magic bullets in improvement, but it does seem sensible to try blended approaches where incentives primarily promote engagement and participation, while education, informatics, support for implementation, and collaborative approaches to share learning potentially deliver sustainable change. Major initiatives like QOF reform inevitably require imaginative leaps of faith, and there is much that could go right or go wrong with QOF reform in England.

**General Practice Network Contract DES**

**Description:**

The new DES is ‘voluntary’ but NHSE and the BMA expect 100% uptake. To quality for funding from July 2019, practices will need to join a network and appoint a Clinical Lead. Following that your network will have to work towards seven ‘service specifications’ based on the aims of the NHS Long Term Plan.

**How much?**

As a DES all practices are eligible to participate and so receive an annual weighted Network Participation Payment of £1.76 for doing so (see below). This is paid alongside the global sum from 1 July 2019.

The DES has several additional funding elements:

Network Financial Entitlements of:

* The Additional Roles Reimbursement Scheme
* Recurrent funding for the role of Clinical Director (sliding scale)
* £1.50 per head recurrent funding from CCG allocation
* £1.76 Network Participation Payment (see previous paragraph - this is paid directly to the practice and not the Network)

**Timeframe:**

Complete registration form and submit by 15 May 2019. Practices must sign up by July 2019.

**Establishing a PCN/ How to Apply**

It’s an entitlement for all practices and the biggest way to increase practice income.

The target is 100% coverage of the DES by 1 July. To be eligible for the Network Contract DES, a Primary Care Network needs to submit a completed registration form to its CCG by no later than 15 May 2019, and have all member practices signed-up to the DES. The form is attached at Annex C to the Contract Agreement.

It asks for six factual pieces of information:

(i) the names and the ODS codes of the member practices;

(ii) the Network list size, i.e. the sum of its member practices’ registered lists as of 1 January 2019;

(iii) a map clearly marking the agreed Network area;

(iv) the initial Network Agreement signed by all member practices;

(v) the single practice or provider that will receive funding on behalf of the PCN; and

(vi) the named accountable Clinical Director.

**In Plain English…**

You are being asked to lead change at local levels and work in Primary Care Networks to provide services to registered populations of 30-50,000. Working collaboratively, possibly sharing (some) community staff across the network you will start to lead integration of out of hospital services.

The aim is that you will look at things from new perspectives and develop the skills and confidence to be a leader of change. In time your network will engage a wider range of professionals – some health and some other sectors to meet the needs of your registered population. It is very likely the new Integrated Care Partnerships will look to support PCNs in terms of service delivery.

In subsequent years, seven 'service specifications' will be gradually implemented as part of the DES based on the clinical strategies set out in the NHS long-term plan, including increased screening and earlier detection of cancer.

**The LMC comment -**

Practices are going to have to find a way to come together to attract the additional income in the Network Contract. Those practices which are already developing models such as the Primary Care Home, Localities, Neighbourhoods, will be well placed to apply for the DES. It is therefore now essential if you have not started this work to take the time to explore your future model and how locally you want to work “at scale”. It is also essential that CCGs ensure the funding intended to support Primary Care Network development, arrives with the Networks.

Where PCNs have approached the LMC already we have suggested four quick points to try and help. These are things to consider and have clarity over at the start of the journey:

i Outside of the NHS Long Term Plan is there a local catalyst for the scaling up of

 practices?

 Is there established good working relationships/affinity/trust between the

 constituents?

ii What is the geographic fit? How are other health and care services aligned with the

 population to be served?

iii What is the size of the combined registered population to be served and what is the

 evidence that this size is the right size to scale and the right size to care?

 iv) How will the new scaled-up registered population’s care need be assessed and then

 Multi Disciplinary Team workforce is developed to meet that need?

Answering these is the basic start point for development. Also speak to your accountants and other professional advisors if the Primary Care Network starts to employ ‘other’ staff or provide ‘new’ services. You may need reassurance that you have good legal structures and that you will not incur hidden tax or VAT bills.

**A Positive Choice**

Membership of a particular PCN can’t be forced on a practice by a CCG. It must be a positive choice by the practice. Practices should not feel pressurised into such arrangements. The contract does state that PCN coverage must be 100% of patients even if practices have not signed up to the DES. In those cases the PCN would have to make provision through member practices or other means. In some cases a practice with a list size of 30k may register as a PCN.

**PCN Boundaries**

PCN boundaries should make sense in terms of the geography of local practices, how other community services configure their teams and other practical issues. Practice boundaries can overlap across more than one PCN but it would be expected that they wold join only one Network.

The aim is for PCNs to cover 30-50k populations. The list sizes are indicative and not a strict requirement, however PCNs much larger than 50k defeat the purpose of locally focussed services delivered by close working teams who know each other. PCNs can work collaboratively for wider service delivery or with their GP federations.

**Appointment of Clinical Director**

The LMC has been approached by several PCs on this subject. Our advice is not to rush into this important leadership role. If necessary create time by appointing someone for a fixed period say 6-12 months whilst you finalise your internal ‘Board’ processes. Individuals can be appointed or elected. The PCN membership should determine the process to be used. The LMC recommends that there should be an open and transparent process agreed by all the practices in the PCN.

Only a PCN can appoint their Clinical Director. A Clinical Director does not have to be a GP (but must have a clinical background) but in most cases will be a local GP. You should avoid conflicts of interest – for example the Clinical Director being a current CCG Governing Body/ Board Member. Current leadership roles cannot be assumed to map across to the PCN Clinical Director role.

The individual will have two key roles namely accountable for the successful delivery of PCN services and working relationships amongst PCN member practices (and other providers in the longer term); and supporting the PCN in the wider integration of the healthcare system, given that PCNs are integral to the delivery of community services to the local population.

Each Network will receive additional funding to the equivalent of 0.25 wte funding per 50k population (so 40k would get 0.2 wte funding). This will be based on an averaged remuneration figure. A more detailed outline of the role and responsibilities is set out in the Contract Agreement. NHSE is establishing a significant development programme for both PCNs and PCN Clinical Directors.

**Workforce**

The DES provides for workforce reimbursement for the Network on a 70/30 split **(**including on-costs), covering a number of specified health professions and designed to allow the Network to build up an expanded primary care team. For practical purposes, and to enable Networks to be fully up and running before the scheme fully develops, for the first year of the DES (2019/20) every network of at least 30,000 population will be able to claim **70% funding as above for one additional whole time** **equivalent (WTE) clinical pharmacist** and **100% funding for one additional** **WTE social prescribing link worker**. Beyond 100,000 network size, the 2019/20 reimbursement scheme doubles to two WTE pharmacists and two social prescribers; with a further WTE of each, for every additional 50,000 network population size.

The scope of the extra workforce extends each year –

2019 Clinical Pharmacists and Social Prescribing Link Workers

2020 Physician Associates and First Contact Physiotherapists

2021 First Contact Community Paramedics

**Additional Changes**

(this section will be expanded as we get to know more detail but the main changes are noted here. You should read the full NHSE/BMA document for further details)

**Network Investment and Impact Fund**

**Description:**

Available in 2020, a new *Network Dashboard* will set out progress on network metrics, covering population health, urgent and anticipatory care, prescribing and hospital use. Metrics for the seven new services will be included. A national Network Investment and Impact fund will be established.

This is intended to help networks make faster progress against the dashboard and *NHS Long Term Plan* goals. Part of the Investment and Impact Fund will be dedicated to NHS utilisation, which could cover:

i) A&E attendances;

ii) emergency admissions;

iii) hospital discharge;

iv) outpatients; and

v) prescribing.

The Fund will be linked to performance and its design will be agreed with GPC England and Government. We envisage that access to the Fund becomes a national network entitlement, with national rules as well as locally agreed elements. Networks will agree with their Integrated Care System how they spend any monies earned from the Fund.

**How much?**

The national Network *Investment and Impact Fund* will start in 2020, rising to an expected £300 million in 2023/24.

**Timeframe:**

Five years from 2020.

**NHS 111**

Practices will make available 1 appointment for 3,000 patients per day for NHS 111 to book directly into practice appointments.

Commissioners will be expected to work with LMCs to ensure that the arrangements are effective.

**How much?**

£30m funding to practices via global sum.

**Access**

There will be Extended Hours Access DES requirements introduced covering all practices in every network until March 2021. A wider review of access arrangements in general practice will be carried out nationally. The DES will require 100% coverage for all patients. Some areas already have 100% coverage through a hub model and they are likely to want to continue the same offer. Other areas have individual practices offering the DES but not all—so they will have to deliver the DES within a network somehow from 1 July 2019. Using your PCN (and potentially your GP federation) you can access this funding for your patients.

**Vaccination and Immunisation**

**Description:**

A Review of Vaccination and Immunisation arrangements and outcomes under the GP contract will take place in 2019 and also cover screening.

HPV vaccination catch-up for girls will be extended to those aged 25 and HPV vaccination will commence for boys in Sept 2019 (via the school scheme). Catch-up arrangements for boys will mirror those for girls.

There will be a V&I MMR catch up for 10-11 year olds.

**How much?**

The item of service fee for childhood seasonal flu, pertussis, and seasonal flu and pneumococcal polysaccharide will be uplifted to £10.06 from April 2019.

Also from April 2019 an item of service fee of £5 per patient has been agreed for the extra cost of the catch-up campaign for MMR vaccine for 10 and 11 year olds in the light of the current measles outbreak.

**Digital Services**

All practices will be required to enable patients to have full record access as a default position from April 2020 with new patients having full online access to data from April 2019.

Practices will need to offer and promote electronic ordering of repeat prescriptions for which it is clinically appropriate as a default from April 2019.

25% (minimum) of appointments must be available for online booking by July 2019.

There will be a review of out of area registration and choice of ‘digital first’ registration

By April 2021 all patients will have the right to online and video consultations.

**How will NHS 111 book into appointments available to book online?**

This is currently being developed and implementation will be subject to system capabilities. Our current understanding is 1 appointment per 3000 patients, spread throughout the day and the practice decides how to manage patients booked into these slots. NHS clinicians not lay call handlers can book patients into the appointments.

**Marketing Campaigns**

From 2019 GP practices will be required to support 6 national NHS marketing campaigns on an annual basis. NHSE will produce the campaign materials and will distribute to practices for them to display.

**Temporary Residents**

Guidance will be issued to CCGs and practices in 2019 to facilitate local solutions around TRs. This guidance when available will set out flexibilities to support practices that have faced a significant increase (or decrease) in the numbers of unregistered patients requesting treatment and how to apply appropriate temporary patient adjustment funding.

**Subject Access Requests**

A £20m annual funding pot will be made available for practices to deal with subject access requests following the removal of the ability to cover costs under GDPR legislation. Practices will also have access to a data protection officer through their CCG to provide support on GDPR issues.

**Contraceptive and Maternity Services**

The contraceptive additional service will cease and its requirements will be rolled into essential services.

There will be a review of whether to include perinatal checks for mothers within the Maternity Medical Service additional service.

**Some Contract Funding Figures at a Glance**

**Item 2019/20 £**

**Global Sum (per weighted pt.) 89.88**

**QOF (value per point) 187.74**

**Weighted SFE payment for network 1.76 per patient**

**Total increase in practice funding 2.68 per patient plus new network funding**

These figures include the recycling of MPIG and seniority into the global sum and therefore represent greater than 1.4% contract uplift noted in the contract agreement. The new values of global sum, QOF, out-of-hours adjustment and the new practice participation payment have now been published, and can be accessed on the GP contract webpage **<**[**https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-england/gp-contract-agreement-england**](https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-england/gp-contract-agreement-england)**>** (in the ‘practice funding and pay’ tab).

The 1.4% additional investment to the practice contract includes a 1% uplift to global sum and a SFE payment, linked to practice participation in primary care networks, of £1.76 per weighted patient. This therefore delivers an extra £2.68 per weighted patient in to practice budgets for 2019/20. In addition specific vaccination item of service fees have increased, including seasonal influenza. Together with the removal of indemnity expenses this means practices will be able to deliver a 2% uplift to practice staff pay.

**Frequently Asked Questions**

**Does the money provided to cover staff uplift incorporate the 6% increase in employer’s pension contributions?**

No. The funding announced in the contract is separate from any employer pension contributions reimbursement. It has been agreed that if employer contributions increase in 2019 funding will be provided in addition to the contract deal that has been announced

**GPC England and NHSE have asked DDRB not to make recommendations for salaried GPs in 2019. What does this mean?**

GPCE and NHSE have asked for no recommendation in 2019 because the effects of the indemnity scheme will be so different for different circumstances, depending on whether a salaried GP previously paid their own indemnity or not. The agreement is clear that the investment to practice funding is designed to deliver 2% pay uplift for staff (including salaried GPs).

**PCNs**

**Does the Network have to be a set size?**

It is expected the most Networks will be between 30k and 50k patients. However, there will be exceptions to this, depending on local geography and what fits best with GP practices. For example, in rural areas a Network of less than 30,000 patients may exceptionally be necessary. In contrast, some areas may wish to have, or may have already developed, Networks of greater than 50k patients - In these cases, practices should discuss with the commissioner, what they think the best size for the Network should be, and the reasoning behind it prior to submitting their application documentation.

**We are a practice with a patient list of over 30k can we be a network on our own?**

There will be some practices with patients’ lists in excess of the suggested 30k – 50k and which already operate across multiple sites within a geographic area. In such cases it is possible for the practice to operate as a Network itself, with an informal split of its constituent sites into ‘neighbourhoods’ of approximately 30k-50k patients. More detail on how this will operate will be available in later guidance.

**Can practices in different areas form a Network?**

Networks should form a single coherent area, without any gaps in coverage within the Networks outer boundaries.

**Can CCGs dictate Network configurations?**

No. The decision about how Networks will be configured rests almost entirely with the practices who can define their own structure subject to the rules around size and geographical contiguity. The exception to this rule is that CCGs have a responsibility to ensure that all practices can be a part of a Network and may need to intervene to ensure this. It is expected that CCGs will work with LMCs in these discussions, but outside of this caveat the power to define structure rests completely with the practices themselves.

**Who employs the extended workforce funded under the DES?**

The network workforce could be employed in a number of ways, depending upon the structure of the Network, and how its member practices wish it to operate. For example, the Network may wish for the practice which has been nominated to hold the funding to use that funding to directly employ the staff that can then be utilised across the Network. Alternatively, employment of staff could be spread across the member practices, with funding redistributed from the fundholding practice as required.

**What are the associated VAT and employment liabilities for the employing practices in a PCN?**

GPC will be issuing joint guidance with NHS England in the coming weeks.

**What happens if my practice does not want to join a Network?**

The 2019/20 contract agreement includes additional funding for engagement and participation within a Network. Should a practice not wish to engage in the Network DES, the respective practice will no longer qualify for this and the network will take responsibility (and the network level funding) for the provision of Network level service to that practice’s patients, following discussions between the LMC, CCG and PCN.

**How will the Clinical Lead of the Network be appointed?**

The appointment process for the role of the Network’s Clinical Lead is down to the respective Network to decide and will need to be outlined within the Network Agreement. Whilst this can be discussed with the commissioner and LMC, the decision ultimately lies with the PCN.

**Will we be able to claim reimbursement for existing staff under the DES?**

The scheme is designed to grow additional capacity through new roles, not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a CCG or a local NHS provider. Reimbursement through this route will only be for demonstrably additional people (or, in future years, replacement of those additional people as a result of staff turnover). The only exception to the ‘additionality’ rule is existing clinical pharmacists reimbursed under either (i) the national Clinical Pharmacists in General Practice scheme, or (ii) the national Pharmacists in Care Homes scheme. Both schemes have tapered funding. Both will be subsumed into the new more generous arrangement.

**What will the Network Services within the DES contain?**

The service requirements within the DES will be phased in gradually over the next 5 years, covering the 7 areas as below:

1. Medication review and optimisation

2. Enhanced health in care home service

3. Anticipatory care (with community services)

4. Personalised care

5. Supporting early cancer diagnosis

6. Cardiovascular disease prevention and diagnosis, through case finding

7. Action to tackle inequalities

These will be discussed and agreed with GPC England prior to each implementation, and full guidance will be issued as each service specification is introduced to the DES. Further information on what is broadly expected that each of these 7 services will cover will be available within the full DES guidance.

**Will the geographical mapping be a problem for University practices, with branch surgeries?**

We have agreed that PCNs can overlap one another. The essential requirement is that all patients within a CCG area are covered but if there are no geographical gaps then there should be some flexibility. For example, currently if a branch surgery sits within a different CCG to the main practice they fall under the respective CCG patch, a similar arrangement could work for PCNs. Therefore, LMCs should be working with CCGs to try and work with PCNs within an area to agree sensible working arrangements.

**What will happen to the local funding we already receive to support collaboration?**

If there are current arrangements that have been funded for collaborative structures locally, then local discussions between the LMC, CCG and the PCNs should take place to decide if and how that needs to change to fit in to the structures of PCNs. This may involve previous funding being reinvested in new primary care activities.

**What happens to the unspent money if a PCN has difficulty recruiting in to their network?**

A PCN will only be reimbursed for the workforce they have employed. However, if recruitment proves difficult for certain groups or specific areas of the country, there is a shared wish between GPCE and NHSE to use unspent workforce expansion funding. If this proves to be the case GPCE and NHSE will discuss how to ensure the funding is retained within general practice.

**To whom are the PCN clinical directors accountable?**

They will be accountable to the member practices. This will be set out in the Network agreement and therefore, exactly how this is done will be decided by the practices within Network.

**Will practices own the PCN?**

As a PCN is based on a DES, which is part of the GMS/PMS contract, it is for practices to lead and shape them.

**How will the funding work in the network contract?**

Practices will receive recurrent payment of £1.50 per patient as an entitlement for networks, from CCG central allocations, to assist in the general administration costs of the Network. Precisely how this funding is utilised will be for the Network collectively to decide. The first payment will be received on 1 July 2019, paying 4 months in arrears and monthly thereafter.

From 2019/20 the requirements and funding of the Extended Hours DES will be transferred to Networks. This will provide approximately £1.45 per patient and following an Access Review in 2019, a more coherent set of access arrangements will start being implemented in 2020, including transferring the £6 per patient funding under the GPFV Improving Access scheme to Networks. There will be additional funding for workforce paid on a reimbursement basis.

**We have a LES which many practices rely on, how will this be impacted by PCNs?**

It is possible that the CCG may want to avoid double payment for areas now covered by the national deal but the funding they currently spend locally should be retained in general practice. CCGs and LMCs should discuss how this funding is reinvested in general practice.

**If the CCG wishes to commission additional service from the PCN, on top of those contained within the DES, will these require competitive procurement?**

As with current Locally Enhanced Services, there will be a reduced emphasis on competitive procurement as PCNs will be built through the GMS contract and PCNs will have entitlements to funding for specific service provision, and contracts can be awarded without competitive tendering if they are based on the Network list.

**How should PCNs appoint Clinical Directors?**

GPC are currently preparing guidance on various aspects of PCNs, and aiming to give practical advice on various things. The contract agreement is simply that the networks themselves will decide who the Clinical Director is, and therefore one of the guidance documents currently being drafted is about the Clinical Director, who should it be and how to decide – providing options for PCNs and LMCs, to decide how to proceed.

**How is the funding for extra staff (pharmacists, social prescribers, etc.) worked out, i.e. is it based on a population of a care community or by PCN?**

For the first year only each PCN will get funding for one pharmacist and one social prescriber, so for two networks would get this each. From the second year onwards the funding allocation is based on the population size of the PCN.

**Is there clarity on how the money can be used? For example using the Pharmacist funding proposal - is it a requirement that a new member of staff is employed for the network (i.e. someone who doesn’t current work within that setting) or could the funding be used to pay for existing pharmacists within the practices who are part of the PCN?**

The funding is for new employees, with the exception of pharmacists on the current national scheme that can be transferred across to the new 70% recurrent reimbursement scheme. This doesn't apply to pharmacists already employed directly by the practice who are not part of the national scheme.

**Who funds the other 30% of PCN employed staff?**

The remaining 30% comes from the PCN practices. It's for the PCN to decide who employs the new staff and further guidance about the different options will be issued shortly. The governance arrangements and network agreement will also cover this.

**Digital**

**How will NHS 111 book into appointments available to book online?**

This is currently being developed and implementation will be subject to system capabilities.

**If 25% of appointments are to be available online, how is an appointment defined?**

It is for the practice to determine which appointments they make available online. These appointments could be focused on appointments for clearly defined purposes, such as cervical smear check, NHS Health checks, long term condition annual reviews, phlebotomy or may be released as part of the book on the day allocation to reduce the pressure on telephone lines and reduce work for receptionists.

**Indemnity**

**Will the one-off adjustment to global sum to pay for the indemnity scheme result in a decrease to global sum?**

No. The global sum will rise this year. The launch of the new state-backed indemnity scheme includes a one-off agreement that places all future cost risk with the government. There will be no future global adjustments in relation to indemnity

**Does the indemnity cover LA Public Health and CCG specifications/services?**

Yes, these services, delivered by GMS, PMS or APMS practices will be covered.

**If a locum chooses to be employed through their own limited company will the new indemnity scheme provide the same cover as a practice employing a locum/salaried/partner directly for NHS GP services?**

Yes, as the cover is for the provider in which the locum is working.

**Does this mean that the provider must process the claim?**

NHS Resolution will share the details of how this works in the coming weeks.

**Does this mean I can stop being a member of an MDO after 1st April?**

You are strongly advised to remain a member of an MDO after 1st April. You will continue to need all the support that you currently receive that is not related specifically to clinical indemnity, which includes GMC help, PAG matters, cover for private work related to general practice responsibilities

(HGV medicals, firearms certificates, private medical reports etc.) and criminal and coroners’ cases. Without this cover you may be exposed.

**If a GP were to get a complaint on 2 April and needs advice, who will they call? Their MDO or NHS resolutions?**

If you receive a complaint letter and want help answering you will need to go to your MDO. If you receive a letter from a solicitor in anticipation of a claim being made you should contact NHS Resolution.

**If a GP were to be referred to PAG, who will attend and support me after 1 April?**

A GP seeking support in a PAG should contact their MDO in just the same way as for GMC or coroners court.

**What will be the cost of MDO cover after April?**

The post-April 2019 market will continue to be a competitive one and that to an extent the MDOs are in competition for the business. Each will determine its new pricing structure and will notify GPs shortly.

**What are the expected costs to trainees under the new scheme?**

All trainees will be covered for clinical negligence under the CNSGP scheme. We also have an assurance from DHSC that no doctor will be out of pocket as a result of the introduction of the scheme. There is a patchwork of arrangements in operation by different deaneries with some buying block products for their trainees and others reimbursing cost. We are discussing with HEE how the future arrangements will work.

**QOF**

**As QOF indicators have been removed, what has replaced them?**

A new Quality Improvement domain. Two quality improvement models will be introduced for 2019.

**Access**

**Do all practices have to ensure that their patients are covered by the Extended Hours DES?**

Yes. The DES will require 100% coverage for all patients. Practices and their Networks can agree how coverage is achieved. This could be through a hub model organised via the local GP Federation or some other locally agreed approach. It must be delivered within a network area from 1 July 2019.

**LMC Support**

**Pastoral Care Scheme**

We relaunched our pastoral care scheme in April 2018. It is available to any GP working in a Cheshire practice. We relaunched our pastoral care scheme in April 2018. It is available to any GP working in a Cheshire practice.

As the pressures within practices ever increase, there is a growing need for this.

Our Pastoral Network has been in existence for a number of years. It is made up of a number of experienced advisors, who are current or recently retired GPs, available and trained to provide personal and confidential support to any local GP undergoing any kind of personal difficulty or crisis.

The personal difficulties which could give rise to a request for our advisors’ services include:

* Domestic or family matters, such as a marriage break-up or bereavement
* Professional matters, like being subject to a patient complaint, performance review investigation or referral to the GMC
* A breakdown in relationships at work, with professional partners, employers or staff
* Health problems ranging from coping with a disability or depression, to serious mental health problems, or an addiction to drugs or alcohol

**Nature of help provided**

 Ourpastoral advisors may offer telephone advice, but will also be happy to meet with the doctor needing help, and where appropriate, others concerned about their welfare. Their objective is to help the doctor in question get through the crisis. They will provide confidential advice, interceding where appropriate, with other agencies on the doctor’s behalf, or signposting them to other sources of help and advice.

Check out our web site or contact the LMC Medical Director who will put you in touch with our service.

We welcome all practical measures to support GPs. Please also remember that the LMC is always available to provide GPs with a listening ear, to provide pastoral support and to support GPs in relation to performance matters.

**GP Retirement Planning**

The LMC is presently reviewing opportunities to runs some retirement planning sessions for those GPs thinking of leaving general practice within the next 2 years. Check out our Heartbeat newsletter in the coming months.

**Business Support**

The LMC supports practices with the sometimes lengthy and challenging process of obtaining funding or securing contracts. In 2017/18 we funded and delivered a practice development programme including bid writing, negotiation skills and contracting. Whilst we do not profess to be expert bid-writers, we can be:

• A critical friend – someone to test your ideas on who will give you honest feedback

• Impartial – the LMC has no conflicts of interest as a provider or funder

• A useful source of information and expertise on both clinical and management/leadership

 aspects of your plans

We are also currently provide the following within our resources –

**Think Tank Session**

A session with an experienced LMC member or officer focused on developing your ideas. This session can be used early in your thinking process to develop your PCN or if you are considering a practice merger. It’s about open discussion, generating ideas, obtaining a different perspective and starting to pull out key themes to be developed. It’s also an opportunity to spot weaknesses and areas for further development. Contact the LMC Chief Executive about PCN work or check out our merger briefing document on the LMC web site.

**Sounding Board Session**

Once you have something down in writing we can be your sounding board. Send it to us in confidence and we’ll review it, sending you back any ideas, comments and questions. We’ll look at it from the funder, commissioner or regulator perspective and try to be as ruthless as they will be.

**Pitch It Session**

If you are developing a service bid some commissioners require a presentation. Even when this is not the case, being able to ‘pitch’ your bid (Dragon’s Den style) requires you to know your material inside out and more importantly, being able to communicate the key elements to others.

The LMC can provide an hour-long ‘Pitch It’ session inviting you to present your (almost) finished proposal to a panel of LMC members/officers. As well as valuable rehearsal time, we will seek to give you constructive feedback to help you make those all-important final enhancements to your ideas.

To take advantage of any of our bidding support sessions email us or call the LMC Chief Executive to book your session.

Availability of sessions will be limited in number and will be allocated on a first come first served basis.

**An Example of Funding for a Primary Care Network**

Based on a Network of 40k population made up of 5 practices. (note most examples in the contract are for 50k population calculations)

 £

60,000 from £1.50 per patient entitlement

43,500 from £1.45 per patient Extended Hours funding (Qtrs. 2, 3, 4 only)

27,503 from 0.2 wte Clinical Director (note 0.25 per 50,000 population) pass on costs

37,810 (max) from 1 clinical pharmacist (including on costs at 70%) pass on costs

34,113 (max) from 1 social prescriber (includes on costs) pass on costs

203,000 Total for 2019. Of this sum £103,500 is for Network decisions

Expenditure in 2019 will include 30% (including on costs) for Clinical Pharmacist (approx. £16,000) and additional resource to cover 100% of population for extended hours (varied depending on arrangements in each Network).

**Time Line for Primary Care Network Submission/ Start**

|  |  |
| --- | --- |
| **Date** | **Network DES Action** |
| **Jan-Apr 2019** | **PCNs prepare to meet the Network Contract registration requirements** |
| **By 29 Mar 2019** | **NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract** |
| **By 15 May 2019** | **All Primary Care Networks submit registration information to their CCG** |
| **By 31 May 2019** | **CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts** |
| **Early Jun** | **NHS England and GPC England jointly work with CCGs and LMCs to resolve any issues** |
| **1 Jul 2019** | **Network Contract goes live across 100% of the country** |
| **Jul 2019-Mar 2020** | **National entitlements under the 2019/20 Network Contract start:****•year 1 of the workforce funding****•ongoing support funding for the Clinical Director** **•ongoing £1.50/head from CCG allocations**  |
| **Apr 2020 onwards** | **National Network Services start under the 2020/21 Network Contract** |

**Reference List**

**BMA contract guidance**

[**http://www.bma.org.uk/gpcontractengland**](http://www.bma.org.uk/gpcontractengland)

**Practice blogs from GPC executive, sessional GPs sub committee and others**

[**https://wwwbma.org.uk/connecting-doctors/the\_practice/b/weblog/**](https://wwwbma.org.uk/connecting-doctors/the_practice/b/weblog/)

**NHS England (2019) The NHS Long Term Plan. Available from:** [**https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf**](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf)

**Department of Health and Social Care (2019) GP partnership review: final report. Available from:** [**https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/770916/gp-partnership-review-final-report.pdf**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf)

**NHS England (2016) General Practice Forward View. Available from:** [**https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf**](https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf)

**NHS England (2018) Report of the Review of the Quality and Outcomes Framework in England. Available from:** [**https://www.england.nhs.uk/wp-content/uploads/2018/07/05-a-i-pb-04-07-2018-qof-report.pdf**](https://www.england.nhs.uk/wp-content/uploads/2018/07/05-a-i-pb-04-07-2018-qof-report.pdf)

**NHS Digital (2019) GP Systems of Choice. Available from:** [**https://digital.nhs.uk/services/gp-systems-of-choice**](https://digital.nhs.uk/services/gp-systems-of-choice)

Cheshire LMC is a member based organisation, independently funded by its member practices. It is the only representative voice in the local NHS that is recognised by statute. We exist to represent and support you.

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