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 1: February 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

GPC England has negotiated a deal spanning the next five years. Elements 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. 2020 onwards will see the workforce increase further, additional funding and services reconfigured (as decided by the networks).

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 commence from 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. It's not yet clear how much will go directly into the global sum, but it is an increase, with more to be put into core contract each year. This year's comparatively low increase reflects money put into the state backed indemnity scheme.

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 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 –

- Overall funding in excess of £2.8bn over a five-year period, through practices and networks
- Indemnity state backed scheme introduced
- Pay & expenses uplift each year through global sum, in line with predicted inflation
- Creation of a new Primary Care Network, built up over the five years
- Additional workforce & linked funding through a new Primary Care Network
- Amendments to QOF
- Resources for IT and digital, including greater digital access for patients
- Delivery of the NHS Long Term Plan ambitions through the additional funding and workforce
- In terms of funding for 2019, the GP contract will increase by 1.4% (in addition to the funding through networks). This includes:
    - 2% uplift for GP and staff pay and expenses.
    - Uplift for practices to establish and develop networks (via an additional service within global sum).
    - Uplift due to population increase.
    - Adjustment for indemnity state-backed scheme.
    - Increase to value of some vaccinations and immunisations, including influenza, to bring them all up to the same level of £10.06
    - £20m recurrent for costs associated with SARs.
    - £30m for practices to make appointments available to NHS 111.

This means that every practice will be able to uplift their staff pay by 2%. Details of the pay uplift for GPs, and its interaction with the indemnity expenses reduction, are available separately on the BMA web site.

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:

The NHS is to fund all staff indemnity on top of the global sum. There had been hints that the global sum would be decreased to fund the indemnity scheme but under the agreed scheme, the NHS will cover indemnity costs for all GPs and practice staff. This is on top of the global sum increases every year for the next five years.

How much?

The purpose of the new state-backed scheme is to solve the indemnity problem, not to deliver at the same time either a reduction in GP pay or a windfall increase. Following extensive discussion, NHS England and GPC England have agreed a one-off permanent adjustment to the global sum figure that takes account of the existing contributions from general practice for indemnity. Given other investment made under the contract agreement (including the Network Participation Practice Payment and funding to meet the costs of subject access requests), investment in the practice contract overall will still rise by 1.4% in 2019/20, even after accounting for the indemnity change.

Timeframe:

Commences 1 April 2019.

Coverage

The new Clinical Negligence Scheme for General Practice will start from 1 April 2019, operated by NHS Resolution. It will be established through government regulations.

All NHS GP service providers including out-of-hours provision will be eligible to become members of the Scheme. They will not have to pay a subscription for membership, either now or in future. Instead, the future costs of this scheme will be met by NHS England, through a centrally-held primary care allocation;

Coverage of the scheme will extend to all GPs and all other staff working in delivery of primary medical services, as defined in forthcoming regulations. It will automatically cover contractor and salaried GPs, GP locums, prison GPs, nurses, Allied Health Professionals and all other professional groups delivering those services; and

It will also cover their wider NHS primary care work, including out-of-hours cover. This will remove the perverse limitation to participation, and serve to ease the out-of-hours participation challenge.

In Plain English…

The Government and NHS Resolution will provide further details on next steps that practices and professionals need to take to ensure that they are covered after 1 April 2019. Practices and staff will still need to take out separate medical defence organisation cover for professional practice, additional advisory services, and private work.

The LMC suggests -

There had been hints that the global sum would be decreased to fund the indemnity scheme. But, under the scheme, the NHS will cover indemnity costs for all GPs and practice

staff. This will be on top of the global sum increases every year for the next five years. In reality forget the five years of this contract agreement – this is the end of GPs paying for indemnity and puts you in line with hospital doctors etc. All future increases will be borne by the state.

All GPs are covered including salaried and locum GPs and other staff working in general practice. All work is covered including OOH, local authority and public health work. Individuals will still need MDO cover for GMC representation, private work, help with responding to complaint letters and the like. Claims prior to April 2019 will need run-off cover from your MDO.

Talk to your accountants and calculate the impact on your practice. Locums will no longer need to pay indemnity when working for GP practices or networks. The cost of locums for practices should therefore be adjusted accordingly.

QOF Indicator Changes

Description:

QOF is being reformed to remove 'unnecessary' indicators under the new GP contract. The framework is being reformed 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.

How much?

QOF currently comprises 559 points. It has been agreed that 28 indicators worth 175 points in total – 31% of the complete scheme - will be retired from 1 April 2019. Of these 175 points, 101 points will be recycled into 15 more 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:

Starts 1 April 2019.

How this scheme can help

The changes described represent the first steps in implementing the recommendations of the QOF Review. NHS England and GPC England have agreed to an ongoing programme of indicator review in key priority areas, including heart failure, asthma and COPD care in 19/20, and mental health in 2020/21 for any subsequent changes to be implemented as soon as possible. Work is ongoing on other indicators. Some of these could become available for potential use in the last four years of the five-year agreement.

Criteria

QOF implementation guidance will be issued by the end of March 2019, with full details about the 2019/20 changes. Associated changes to the Statement of Financial Entitlements will also be completed by end March 2019. Annex A to the new GP contract agreement lists all the indicator changes.

Exclusions

Exception reporting is a necessary feature of the QOF system but the existing system fails to distinguish between those patients who have not received, or been offered care, and those who have done so declined care on the basis of informed choices. As a result, high levels of exception reporting are often unhelpfully perceived to equate to poor quality care. Personalised care adjustments will be introduced to replace exception reporting. This will allow practices to differentiate between 5 reasons for adjusting care and removing a patient from indicator denominator. Also practices will only need to send two not three invitations for care.

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). NHS England and GPC England are working with the Royal College of General Practitioners, NICE and the Health Foundation to develop these. For 2019/20, the modules will cover:

— Prescribing safety: This module will cover the safe prescribing of NSAIDs, lithium and valproate in women of child bearing age and will dovetail with the expansion of clinical pharmacists in general practice;

— End-of-life care. The current QOF indicator on end of life care has been retired, and instead this module will focus on the wider aspects of care for patients who are expected to die within the coming months as well as support for their carers.

Further modules are in development.

How much?

Funding will change marginally. QOF point value will be amended and changes to the Statement of Financial Entitlements will be completed by end March 2019. Further details will be released shortly.

Timeframe:

Commences 1 April 2019.

How this scheme can help…

The current system of exception reporting will be replaced with a more precise 'personalised care adjustment'. It will allow practices to differentiate between five different reasons for adjusting care and removing a patient from the indicator denominator including;

i. The QOF-prescribed care being unsuitable for the patient
ii. Patient choosing not to receive the prescribed care
iii. Patient not responding to invitations
iv. Where the specific service is not available (in relation to a limited number of indicators only)
v. Newly diagnosed or newly registered patients, as per existing rules.

NHS England and GPC England have agreed to an ongoing programme of indicator review in key priority areas, including heart failure, asthma and COPD care for changes in 2020/21, and mental health for changes in 2021/22.

In Plain English

The broad aims of the English reform of QOF are unarguable: to deliver better, more holistic, patient-centered care with continuous improvement; to ensure sustainable, professionally-led general practice; and to support practices to be involved in wider system reform.

But the devil is of course always in the detail. Four major changes are proposed:

1. Personalising indicators to better reflect individual circumstances—for example, by incentivising individualised targets for risk factor control.
2. Reform and rebranding of exception reporting into “personalised care adjustment.”
3. Creating a quality improvement domain to rapidly deploy incentives to tackle national and local priorities.
4. A transparent process for retiring indicators to redeploy resource to new areas.

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 simply need to join networks and appoint a Clinical Lead. Following that they will have to work towards seven 'service specifications' based on the aims of the NHS Long Term Plan

How much?

Practices will be given £1.50 per patient to join networks under the new DES. Additional money for the Clinical Lead role takes this up to around £2.01 in 2019/20.

Timeframe:

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

How this DES can help…

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

Many PCNs will hopefully find it easy to meet these requirements. For others, significant discussion may be needed during the first quarter of 2019. Like existing GMS contracts, the Network Contract DES will be backed by financial entitlements. If every network takes up 100% of the national Network Entitlements it is intended (including a recurrent £1.50/patient support, plus a new contribution to clinical leadership) that £1.799 billion would flow nationally through the Network Contract DES by 2023/24. CCGs COULD also add local investment through Supplementary Network Services. Each network must have a named accountable Clinical Director and a Network Agreement setting out the collaboration between its members. A new Primary Care Network development programme will be centrally funded and delivered through Integrated Care Systems.

Criteria

GPC England and NHS England are committed to 100% geographical coverage of the Network Contract DES by 1 July 2019 'go live' date. Close working is needed between Clinical Commissioning Groups and Local Medical Committees to help ensure this goal is met. 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.

Apply

Check with your CCG but the application form is part of the contract agreement detail now freely available.

The LMC comment -

This is the biggest topic for you to address as a practice. While forming a Primary Care Network has been mooted as “optional”, what is already clear is that the Network Contract will include approximately 40% of General Practice income (40% for top performing Practices and less for those who perform less well, where I have seen it as low as 30%), meaning it is far from optional. Indeed, in all our conversations we have yet to find a Practice that could manage on core contract alone.

Practices are going to have to find a way to come together to attract the additional income in the Network Contract. It is therefore now essential that General Practice takes the time to explore its future model and how locally you want to work “at scale”. It is also essential that CCGs ensure the funding intended to support The Primary Care Networks development, arrives with the Networks.

There are 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 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.

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 across all practices in every network until March 2021. A wider review of access arrangements in general practice will also be carried out. Using your PCN (and potentially your GP federation) you can access this funding for your patients. Starts in 2019.

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 30,000 and 50,000 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 50,000 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 100,000, can we be a network on our own?

There will be some practices with patients' lists in excess of the suggested 30,000 – 50,000, 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 30,000-50,000 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.

Help from the LMC

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

Our pastoral 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 bids

We are also currently provide the following within our resources –

Think Tank Session

An hour-long session with an experienced LMC member or officer focused on developing your ideas. This session can be used early in your thinking process before you start writing a bid 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. 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.

Reference List

BMA contract guidance
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/

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NHS England (2016) General Practice Forward View. Available from:
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NHS Digital (2019) GP Systems of Choice. Available from:
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.

Cheshire Local Medical Committee Ltd
The Weston Centre Weston Road
Crewe Cheshire
CW1 6FL
Tel: 01244 313 483 Email: WGreenwood@cheshirelmc.org.uk
Website: www.cheshirelmcs.org.uk Twitter: coming soon

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