Contract agreement 2019/20 – FAQs

Funding

Does the money provided to cover staff uplift incorporate the 6% increase in employers 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 a 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 is 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.

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 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?

175 points in total have been retired following extensive analysis of all indicators. 101 have been recycled into new indicators and the remaining 74 will be used to create two Quality Improvements modules:

- Prescribing safety
- End-of-life care

Therefore, the number of points has remained the same.