



## To All London Practices supported by Londonwide LMCs

Dear Colleague,

### The National GP Contract and Primary Care Networks

Together with your LMC, Londonwide LMCs strongly supports the development of your Primary Care Network (PCN) as part of the implementation of the new National GP Contract, which has been negotiated in the form of a DES within the Statement of Financial Entitlement (SFE), ensuring the protection of the law and the integral involvement of the LMC.

We want to help you ensure that under the contract, your PCN of fellow practices is focussed on:

- a) developing services around you that support your patient flows to wider community and care services to help you manage your workload, and
- b) providing direct support to your practice and fellow practices through additional support staff which, in the first year will include clinical pharmacists in many cases in post, and 'social prescriber linkworkers'.

In essence the desire is that your PCN focusses on creating a wider multi-disciplinary primary care team to support your practices to manage demand to improve staff well-being, and meet the needs of patients. That is the prime purpose and function of the PCN. Whilst it is for practices to agree the configuration of a PCN, it is essential that we all work to the principle of 'function over form' if we are to get the best out of this contractual opportunity that has been nationally negotiated by the GPC with the Government. In London we already have a helpful springboard in the recently published [Next Steps to the Strategic Commissioning Framework](#), on which Londonwide LMCs worked closely with NHS England London, and the 32 CCGs within the five STPs. We are clear on our objective; to create an environment which can [sustain the values](#) of general practice in the future system. Our role in London is to support our PCNs and federations so that they can align to form strong GP-values based relationships in order to secure the future of general practice within the new collaborative world of integrated care systems.

Our staff and elected LMC officers have a wealth of knowledge and experience across the whole spectrum of primary care, as well as access to a national network of specialist advice and support, and we can offer independent and impartial expert advice on:

- Government policy and initiatives and how they are likely to impact locally – the LMC has specific roles and responsibilities set out in the GP Contract working with CCGs and NHS England with regard to the establishment of PCNs.
- All contractual matters, including implementation of the new GP Contract.
- Practice stability and resilience in terms of workforce, workflow and cashflow.
- Practice relationships with the emerging PCNs.
- The configuration of PCNs, network agreements and governance arrangements within PCNs.
- Employment issues, including arrangements for the recruitment of the new staff groups across the PCNs – we have expert HR and employment law support.

**Londonwide LMCs** is the brand name of Londonwide Local Medical Committees Limited

Registered and office address: Tavistock House South, Tavistock Square, London WC1H 9LG. T. 020 7387 2034/7418

F. 020 7383 7442 E. [info@lmc.org.uk](mailto:info@lmc.org.uk) [www.lmc.org.uk](http://www.lmc.org.uk)

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**Chief Executive:** Dr Michelle Drage



- Organisational development work to build relationships and trust between the staff groups and organisations involved in the existing localities / integrated neighbourhood teams /integrated care centres as they transform into PCNs.
- Training – we currently operate a portfolio of training initiatives and could tailor training to the emerging needs of PCNs.

It continues to be our aim to work collaboratively with all general practice entities in London, and to offer our continued support and advice to meet your specific needs as individuals, practices and PCNs. In the meantime, please do read the attached guidance on each aspect of the new contract arrangements.

We will continue to update these documents as new details are released. The devil is in the detail; ensure that you have a practice lead manager or colleague who is on top of it, and as always, please do not hesitate to [contact me](#).

Yours sincerely,

**Dr Michelle Drage**  
**CEO, Londonwide LMCs**

Briefings include:

- Practice Funding Settlement
- The Primary Care Networks (PCNs) and the Primary Care Network Contract DES
- Additional Roles Reimbursement Scheme (ARRS) and Other Workforce Support
- Indemnity and the Clinical Negligence Scheme for General Practice (CNSGP)
- Network National Service Specifications and the NHS Long Term Plan
- QOF
- Integrating Urgent Care Services
- IT/'Digital First'
- Miscellaneous Contract Changes



### For All London Practices supported by Londonwide LMCs

Uniquely, this year's national contract agreement represents a five-year deal. Under this settlement core practice contract funding will rise as below:

	2019/20	2020/21	2021/22	2022/23	2023/24
Cumulative Increase	£109m	£296m	£525m	£741m	£978m
% annual increase	1.4%	2.3%	2.8%	2.5%	2.7%

Overall, this settlement covers:

- A 'one-off' adjustment to the Global Sum to secure the state-backed indemnity scheme,
- The 1% uplift deferred from the 2018/19 Contract Agreement, payable within the Network Participation Payment, alongside Global Sum, as part of the Network Contract DES reimbursement,
- Extended Hours DES/111 practice appointments Global Sum uplift consequent on the transfer to Primary Care Networks (PCNs) of the responsibility for this DES (£30 million),
- Subject Access Requests related Global Sum uplift (£20 million).

The Global Sum for 2019/20 will rise to £89.88 from the current (2018/19) £88.96, with the OOHs deduction falling to 4.82% (£4.33) from the current 4.87%.

Practices will be paid £1.76 per weighted patient annually (which incorporates the 1% uplift deferred from 2018/19) as the Network Participation Payment, in instalments via the SFE, once a practice has signed up to the (Primary Care) Network Contract DES.

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

The contract also equalises immunisation payments at £10.06, and the MMR catch-up programme. Finally, the Government has committed to reimbursing the 6.3% increase in NHS employers' superannuation costs, and further details of this will follow.

As a consequence of the Contract Agreement, the Doctors and Dentists Pay Review Body (DDRB) will not be asked to make recommendations on GP contractor income for the next five years, and exceptionally not for salaried GPs for 2019/20. The DDRB will continue to make recommendations for GP trainees, trainers, and appraisers, and for salaried GPs from 2020/21 onwards.

# National GP Contract Agreement 2019: Update

Practice Funding Settlement / Version 2 (April 2019)



In the context of this year's Contract Agreement, GPC England is recommending, and expecting, that practice staff receive an increase of 2% in 2019/20.

**Dr Michelle Drage, CEO of Londonwide LMCs - with thanks to Dr Julius Parker, CEO of Surrey and Sussex LMCs; Dr Matt Mayer, CEO of BBOLMCs, and Alex Orton and Sam Dowling of Londonwide LMCs.**





### **For All London Practices supported by Londonwide LMCs**

There has been more discussion about Primary Care Networks (PCNs) than any other element of the Contract Agreement; PCNs are in effect the contractualised incentivisation, through a Direct Enhanced Service (DES), of a process of collaboration and joint working between most practices that has been taking place for a number of years. The concept extends back to the establishment of OOHs GP co-ops in the 1990s, community fundholding, Primary Care Homes ('PCH' as per the NAPC model), and the London Tomlinson Collaborative Working Arrangements (originally termed 'Network Arrangements' subsequent to that).

### **The Primary Care Network Contract DES.**

As a DES, all practices are eligible to participate; and if doing so will receive an annual, weighted Network Participation Payment of £1.76 for doing so, paid alongside Global Sum, from the commencement of the DES on 1 July 2019.

The DES has three elements:

- National Service Specifications: the first of these will not commence until April 2020, and these must be nationally negotiated,
- Supplementary Network Services: developed locally by CCGs and PCNs,
- Network Financial Entitlements (NFEs), these being:
  - The Additional Roles Reimbursement Scheme (ARRS),
  - Funding towards the role of Clinical Director (4.37, Contract),
  - £1.50 per head recurrent funding from CCG allocation,
  - £1.76 Network Participation Payment (which is paid directly to the practice, and not to the Network).

Clarification is being sought as to the definition of “closed” with regard to the DES contract specification reading “no PCN member GP Practice will be closed for half a day on a weekly basis and all patients must be able to access essential services, which meet the reasonable needs of patients during core hours, from their own practice or from any sub-contractor.”

Guidance released in March 2019 references increased collaboration between practices and other community health and social care bodies, stating “to support this, the Network Contract DES will be amended from 2019/20 to include collaboration with non-GP providers as a requirement.”

### **Establishment of a Primary Care Network**

The target is to ensure 100% geographical coverage of the DES from 1 July 2019; the first key date is the submission to CCGs by 15 May 2019 of a Network Registration form. This comprises of six items:



- The names and ODS codes of the PCN member practices,
- The PCN list size, which is the sum of the member practices lists as of 1 January 2019,
- A map marking the PCN area, aggregating member practices' boundary areas,
- The Network Agreement signed by member practices. A template National Agreement is available, PCNs should not develop local ones,
- The 'account-holder' that will receive funding on behalf of the PCN,
- The named PCN Clinical Director.

On 31 May 2019 the CCGs will be asked to confirm that registration requirements for all PCNs within the CCG area are agreed. If there are any difficulties in achieving full PCN registration for all practices, LMCs have been asked to work with CCGs and NHS England to try and resolve these, so that the Network Contract DES for all practices can go live on 1 July 2019.

'Form follows function' is an essential guiding principle of PCNs:

- **Collaboration**

To ease workload pressures on GPs and GPNs by practices being in a PCN with a wide range of health and social care professionals.

- **Coordination**

To enable patients to access the care they need from the right services, allowing patient flow to wider primary, community, mental and social services.

- **PCN member practices**

Many areas already have collaborative arrangements between practices, as Primary Care Homes, CCG or localities, networks, or neighbourhoods. These can, but do not have to, form the basis of PCNs. Membership of a particular PCN cannot be imposed on a practice, and although current arrangements may be appropriate, this should not be an assumption made either by CCGs, or the leadership or management of such organisations. It must be a positive choice, or reconfirmation, made by signing the Network Agreement. Practice colleagues should not feel pressurised to rush into such arrangements. In some areas current arrangements are likely to be too large to achieve the close working relationships and affiliation that are envisaged between PCN members. A single practice, with a list size of >30,000, may register as a PCN.

The contract does state that PCNs must have 100% coverage of patients even when practices have not signed up. In those circumstances, the PCN would need to make provision through member practices or other means. The Mandatory Network Agreement says that whilst commissioner approval is not required for a Core Network Practice to cease to be signed up to the Network Contract DES, or to the PCN itself, "there will need to be commissioner involvement in the process" but they "may not unreasonably withhold consent to any changes."



- **PCN list size**

The aim is for PCNs to serve populations of between 30-50k. The upper list size is indicative and not a strict requirement, PCNs much larger than 50k are likely to defeat the purpose of locally focussed, close working relationships between people who can get to know each other as a team. PCNs will be able to collaborate amongst themselves for wider service delivery and so this should not be seen as a criterion justifying a larger PCN size.

- **PCN patients**

Guidance released in March 2019 (the Network Agreement Contract Specification) references an expectation that the PCN will engage with “seldom heard groups” and assist commissioners “in the performance of [its] duties to engage patients in the provision of and/or reconfiguration of services where applicable to the registered population.”

- **Role of Federations**

Each PCN will decide which provider organisation will employ the PCN’s staff. This could be a lead practice, community or other provider, or existing Federation or network. Each PCN will also determine the most suitable delivery model for itself, which could be through a Federation.

- **PCN area**

PCNs should have boundaries that 'make sense' in terms of constituent practices, and “other community services, who configure their teams accordingly” (3.7, Network Contract DES Specification). Practices boundaries may overlap across more than one PCN (as they do now between CCGs or boroughs), but it would be exceptional for a practice to join more than one PCN.

- **The Network Agreement**

The published guidance accompanying the Mandatory Network Agreement template states clearly that “nothing in this Network Agreement is intended to vary, relax or waive any rights or obligations contained in the Core Network Practices primary medical services contract relating to the provision of essential services under those contracts.”

The template Network Agreement was published at the end of March 2019. The Agreement contains several schedules which must be agreed and completed by Core Network Members. In general terms it includes:

- Arrangements to claim the PCNs collective financial entitlements.
- How individual practices will collaborate to share resources and deliver PCN services; under the DES, all practices must be active participants.



- How decision-making will occur within the PCN including agreement on quorum, voting, decision making, attendance, expulsion of members.
- Arrangements for employing and supervising/appraising staff.
- How PCNs will work with other community services.
- Identification of the account-holder, which could be a lead practice, Federation, NHS provider or social enterprise partner, but not the CCG.

Information is pending regarding a new patient data sharing agreement, and an agreement to share data within the PCN and with the CCG; contributing to the National Dashboard.

The Agreement will need to be clear that the nominated fund holder reclaiming the Network payment from commissioners receives and holds that payment “on trust from commissioners as a disclosed agent so that payment of those fees by the fund-holder will not have a negative VAT impact on the lead practice or other Network partner or agent receiving them.

All PCNs will have to sign a Network Agreement, even if they only comprise of one practice. The Agreement should make clear what measures will be in place to manage the departure of one or more members.

- **Appointment of a PCN Clinical Director**

Much of the LMCs advice in relation to PCN membership (above) applies to the appointment of the PCN Clinical Director; only a PCN can appoint their Clinical Director, current leadership roles cannot be assumed to map over to the PCN Clinical Director post. There should effectively be a newly confirmed appointment and PCNs themselves are responsible for deciding not only who is appointed, but also how that will be done. The Clinical Director should be a local clinician, likely to be a GP, who once in post, will have two key roles:

- Encouraging and being accountable to PCN members for the successful delivery of PCN services and working relationships amongst constituent PCN member practices. They should also avoid any Conflicts of Interest (for example, being current CCG governing body/board members).
- Supporting the PCNs in the wider integrated healthcare system, given that PCNs are integral to the delivery of community services to the local population.

See Annex 1 for a more detailed description of the role and responsibilities as set out in the January BMA/NHS England Contract.



Whilst in some areas establishing PCNs may be straightforward, current arrangements should not be a 'shoe-in'; they should be confirmed only if member practices believe they are appropriate and the LMC recommends there must be an open process for any candidate wishing to be appointed as a PCN Clinical Director. Colleagues should not accept CCG involvement except on request. If local arrangements need to be reformed, or in some areas created from scratch, this will require practice-led meetings. The LMC is available to provide support for this process if there are difficulties, and colleagues in practices who anticipate not being able to sign a Network Agreement by 15 May 2019 are asked to contact us.

The aim is for other community services, including district and community nursing, midwifery, and health visiting services, to align themselves with PCNs.

There are outstanding questions in terms of, for example, employment liability, indemnity arrangements, VAT implications, and TUPE, in relation to existing staff, about which further guidance is awaited.

- **PCN Support**

Participation in PCNs will attract network funding through the DES, in the form of:

- The Additional Roles Reimbursement Scheme; rising from £110 million in 2019/20 to £891 million in 2023/24.
- PCN Clinical Director funding; at 0.25 FTE per 50,000 population size, based on the average national GP salary.
- £1.50 per head from CCGs.
- £1.76 Network Participation Payment (which is however paid to the practice directly, and not to the Network).

- **Other Support**

NHS England is to establish, in collaboration with the BMA, RCGP and NAPC, a significant development programme for both PCNs and PCN Clinical Directors.

Dr Michelle Drage, CEO of Londonwide LMCs - with thanks to Dr Julius Parker, CEO of Surrey and Sussex LMCs; Dr Matt Mayer, CEO of BBOLMCs, and Alex Orton and Sam Dowling of Londonwide LMCs



### Annex 1

#### Network Clinical Director

##### Description of role/core responsibilities

Each PCN will have a named accountable Clinical Director, supporting delivery. They provide leadership for networks' strategic plans, through working with member practices and the wider PCN to improve the quality and effectiveness of the network services.

Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System (ICS), helping to ensure full engagement of primary care in developing and implementing local system plans to implement the NHS Long Term Plan. These local plans will go much further than the national parts of the Network Contract DES in addressing how each ICS will integrate care. The role of the clinical lead will vary according to the particular characteristics of the network, including its maturity and local context, but the key responsibilities may include:

- Providing strategic and clinical leadership to the network, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices (including professional leadership of the Quality and Outcomes Framework Quality Improvement activity across the network).
- Influencing, leading and supporting the development of excellent relationships across the network to enable collaboration for better patient outcomes.
- Providing strategic leadership for workforce development, through assessment of clinical skill-mix and development of network workforce strategy.
- Supporting network implementation of agreed service changes and pathways, working closely with member practices, the wider PCN and the commissioner to develop, support and deliver local improvement programmes aligned to national and local priorities.
- Developing relationships and working closely with other network Clinical Directors, clinical leaders of other health and social care providers, local commissioners and Local Medical Committees (LMCs).
- Facilitating practices within the network to take part in research studies and will act as a link between the network and local primary care research networks and research institutions.
- Representing the network at CCG-level clinical meetings and the ICS/STP, contributing to the strategy and wider work of the ICS.
- The Clinical Director would not be solely responsible for the operational delivery of services. This will also be a collective responsibility of the network.

As outlined in section 4, each PCN will receive an additional ongoing entitlement equivalent to 0.25 WTE funding per 50,000 population size. This entitlement is a contribution towards the costs and not a reflection of the time commitment required to undertake the role.



### Annex 2

#### Network Implementation Timetable

Date	Action
Jan-Apr 2019	Practices liaise with each other and LMC re: forming networks
By 29 March 2019	GPC and NHS England release Network Agreement and 2019/20 DES specification details
By 15 May 2019	Networks submit registration information to their CCGs
By 31 May 2019	CCGs confirm network coverage footprints
Early June	GPC and NHS England work with CCGs and LMCs to resolve any issues
1 July 2019	Network DES goes live and financial entitlements paid



### **For All London Practices supported by Londonwide LMCs**

The Additional Roles Reimbursement Scheme (ARRS) is the most significant financial investment element within the Network Contract DES; it is designed to provide financial reimbursement for Primary Care Networks (PCNs) to build workforce capacity. This will be done via an investment mechanism first used as part of the General Practice Charter in 1966, when 70% staff reimbursement of nursing and reception staff was introduced, and is now widely recognised as having been a pivotal part of the revitalisation of UK general practice at that time.

The ARRS investment sum will rise from £110 million in 2019/20 to £891 million in 2023/24, which for an average 50,000 sized network equates to £92,000 in 2019/20 rising to £726,000 by 2023/24, with an estimated 20,000+ reimbursable additional posts providing workforce capacity to support practices.

The ARRS will increase incrementally over five years; 70% of the on-going salary costs of these posts, except for social prescribing link-workers' 100%, will be met by the scheme.

The eligible maximum reimbursable pay that can be claimed by a PCN will be (section 1.26):

- Weighted average salary on the Agenda for Change band,
- Associated employer on-costs.

The five reimbursable roles are:

- Clinical pharmacists from 2019,
- Social prescribing link workers from 2019,
- Physician associates from 2020,
- First contact physiotherapists from 2020,
- First contact community paramedics from 2021.

These posts have been identified as ones for which personnel will be available, which already provide proven benefit within some practices, and their role links to delivering relevant elements of the NHS Long Term Plan, via the National Service Specifications.

A description of the intended role/core responsibilities for these posts is attached, although it will be for PCNs to decide the job description of their own staff. PCNs will have flexibility to choose to recruit across their roles, noting that NHS England intends that every GP practice should have access to a pharmacist. To support this the existing Clinical Pharmacists in General Practice Scheme, will be subsumed into the ARRS.



The scheme cannot be used to fund existing workforce with the exception of clinical pharmacists employed as part of it. This prior scheme has tapered rather than recurrent funding and these staff can be transferred into the new scheme. PCNs will decide who will be the actual employer; this may be a lead practice, GP federation, NHS provider or social enterprise partner.

In 2019/20 introductory arrangements will apply; every network >30,000 population will be able to claim 70% funding for one WTE clinical pharmacist and 100% funding for a WTE social prescribing link-worker, unless the CCG agrees to a different request, ie, two clinical pharmacists or two social prescribing link-workers. For 2020/21, each PCN will be allocated a single combined maximum reimbursement sum covering all five roles. This will be based on weighted capitation, with the exact weighting mechanism confirmed during this year. Detailed guidance on payments, data monitoring and assurance will be published during 2019. This expenditure will only occur if PCNs recruit to these posts.

Other workforce support agreed within the Contract Agreement includes continuing the following programmes:

- GP retained and retention schemes,
- Practitioner Health Programme across England,
- GP Forward View Practice Resilience Scheme.

During 2019 NHS England is introducing a two-year Primary Care Fellowship Programme available to newly qualified GPs and nurses entering general practice; further details of this programme are awaited.

**Dr Michelle Drage, CEO of Londonwide LMCs - with thanks to Dr Julius Parker, CEO of Surrey and Sussex LMCs; Dr Matt Mayer, CEO of BBOLMCs, and Alex Orton and Sam Dowling of Londonwide LMCs.**



### Annex

**Workforce (National Level):** New workforce will be introduced gradually via the following national levels:

Role	AfC Scale	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical pharmacists	7-8a	2,083	3,700	5,000	5,500	7,500
Social prescribers	5	1,300	2,100	2,900	3,600	4,500
First contact physios	7-8a	0	500	1,200	3,000	5,000
Physicians associates	7	0	500	1,250	2,100	3,000
Community paramedics	6	0	0	500	1,200	2,000
<b>Total</b>		<b>3,483</b>	<b>6,800</b>	<b>10,850</b>	<b>15,400</b>	<b>22,000</b>

### Workforce (Network Level):

- The above table shows the national maximum allocations for each role, NHS England have not so far committed to any funding over and above these numbers.
- GPC and NHS England base all examples and stats on approximations; 1,200 PCNs of average 50,000 patients each across the whole of England.
- Based on that, the average maximum network level funding for additional staff shown above, year on year over the next five years together with total national funding is shown on the table below.

	2019/20	2020/21	2021/22	2022/23	2023/24
National total	£110m	£257m	£415m	£634m	£891m
Avg. max funding per network	£92,000	£213,000	£342,000	£519,000	£726,000

- A network may choose to hire more of one type of role in exchange for less of another, subject to CCG approval.
- Similarly, based on a 50,000 network, the following will be the maximum numbers of staff that each network will be able to hire.

	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical pharmacists	1-2	3	4	4-5	6
Social prescribing link workers	1	1-2	2-3	3	3-4
First contact physios		0-1	1	2-3	4
Physicians associates		0-1	1	2	2-3
Community paramedics			0-1	1	1-2



### **For All London Practices supported by Londonwide LMCs**

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 Resolution.

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.

#### **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.

#### **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 are 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).

#### **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.



### **What is not covered**

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.

Clarification is being sought regarding the need for cover for a range of services and procedures including hospice work.

### **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 1 April 2019, 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 – eg, 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.

**Dr Michelle Drage, CEO of Londonwide LMCs - with thanks to Dr Hannah Theodorou and Sam Dowling of Londonwide LMCs.**





### **For All London Practices supported by Londonwide LMCs**

The Primary Care Network DES has three main components:

- The Network Financial Entitlements (NFE), including the Additional Roles Reimbursement Scheme (ARRS), funding for Primary Care Network (PCN) Clinical Directors and the CCG £1.50 per head support payment,
- National Service Specifications, and
- Supplementary Service Specifications, developed locally by CCGs and PCNs.

The seven National Service Specifications are designed to deliver most of the NHS Long Term Plan goals for primary care, other than those introduced by Quality Outcomes Framework (QOF), IT changes, and Urgent Care Access arrangements. The detailed specifications will be negotiated nationally during 2019 and 2020, and the additional funding available via the ARRS is designed to support the workforce anticipated as being needed to deliver these specifications. In addition, priority will be given to QOF Quality Improvement modules which support the National Service Specifications.

The seven proposed national service specifications are:

2020/21:

- Structured Medicines Review and Optimisation (Section 6.11 and 6.12),
- Enhanced Health in Care Homes (Section 6.13 - 6.16).

During 2020/21 onwards:

- Anticipatory care requirements [for high need typically multi-morbidity patients, jointly with community care] (Section 6.17-6.21),
- Personalised Care (Section 6.22-6.25),
- Supporting Early Cancer diagnosis (Section 6.26 – 6.28).

From 2021/22 onwards:

- CVD Prevention and Diagnosis (Section 6.29 – 6.31),
- Tackling Neighbourhood Inequalities (Section 6.32 and 6.33).

This section of the Contract Agreement sketches out the general landscape and the details have yet to be agreed. NHS England will also be creating a national Network Investment and Impact Fund, from 2020/21, which will be overseen by local Integrated Care Systems (ICS).

# National GP Contract Agreement 2019: Update

Network National Service Specifications and the NHS Long Term Plan / Version 2 (April 2019)



Current thoughts on this are in Section 6.40 – 6.42 of the Contract Agreement. PCNs will need to agree how to spend any monies earned from the Fund with their ICS.

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### **For All London Practices supported by Londonwide LMCs**

This update covers the agreed changes to QOF for 2019/20; in England these changes to QOF follow a substantial NHS England/GPC led QOF Review during 2017/18 which recommended retention and evolution of the QOF structure. The full 559 points, and QOF financial envelope, are being retained, unlike in Scotland and Wales where QOF has been partially or completely abolished.

#### **Retirement of Indicators**

28 Indicators (comprising 175 points, 31% of the total) are being retired.

#### **Introduction of New Indicators**

15 new indicators (101 points) are being introduced, these being (Section 3.10):

- 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),
- Offering pulmonary rehabilitation for patients with COPD (2 points).

A full list of the retired and new indicators is given in the annex to this document.

#### **Focusing on Quality Improvement**

The remaining 74 points are being used to create two Quality Improvement Modules developed in conjunction with the RCGP and NICE. In 2019/20 the modules (each 37 points) will be (Section 3.16):

- 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 (PCN).

Quality Improvement Modules will be supported within QOF for one year, and (Section 3.2.2) then future modules will link with the seven National Service Specifications being developed for the Network Contract DES.



### **Payment Thresholds**

No new threshold changes will apply in 2019/20 to continuing QOF indicators.

### **QOF Point Value**

This will rise by 4.7% from £179.26 to £187.74, to reflect the increase in to the average practice list size (CPI: Contractor Population Index).

### **Personalised Care Adjustment**

This will replace the current exception-reporting process, which is a blunt instrument, and practices with high levels of exception reporting have been criticised (for example by CQC) as potentially indicating the presence of poor quality care.

Patients will now be differentiated as being removed from the indicator denominator because (Section 3.12) of:

- Unsuitability (eg, medicine intolerance),
- Patient choice,
- Failure to respond to recorded offers of care (which will now usually be two invitations rather than three),
- The specific service is not available locally (in relation to certain indicators),
- Newly diagnosed/registered patients (as now).

### **INLIQ Mandatory Extraction (Indicators no longer incentivised in QOF)**

There are minor changes to the INLIQ Suite with four being added, and six being removed, leaving 23 INLIQ indicator extractions. The continuing and retiring INLIQ indicators are also listed in the annex to this document.

### **Future Developments**

Over the next two years a review of heart failure, asthma and COPD (2020) and mental health (2021) indicators is planned, together with the development of further Quality Improvement Modules.

The full QOF implementation guidance, indicating changes to the Statement of Financial Entitlements (SFE) was issued in late March 2019.

Dr Michelle Drage, CEO of Londonwide LMCs - with thanks to Dr Julius Parker, CEO of Surrey and Sussex LMCs; Dr Matt Mayer, CEO of BBOLMCs, and Alex Orton and Sam Dowling of Londonwide LMCs.



### Annex

#### Summary of QOF changes

<u>RETIRED</u>		<u>NEW</u>	
Indicator	Description	Indicator	Description
CHD002 (17 points)	The % of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.	CS005 (NICE ID NM 154) (7 points)	The proportion of women eligible for screening and aged 25-49 years at the end of the reporting period whose notes record that an adequate cervical screening test has been performed in the preceding 3 years and 6 months.
CON001 (4 points)	The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or clinically appropriate interval eg, last 5 years.	CS006 (NICE ID NM 155) (4 points)	The proportion of women eligible for screening and aged 50-64 years and the end of reporting period whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months.
CON003 (3 points)	The % of women on the register prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible contraception at the time or within one month of the prescription.	COPD008 (NICE ID NM 47) (2 points)	The % of patients with COPD and Medical Research Council (MRC) dyspnoea scale >3 at any time in the preceding 12 months with a subsequent record of an offer of referral to a pulmonary rehabilitation programme.
COPD004 (7 points)	The % of patients with COPD with a record of FEV in the preceding 12 months.	DM019 (NICE ID NM 159) (10 points)	The % of patients with diabetes without moderate or severe frailty on the register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.
COPD005 (5 points)	The % of patients with COPD and medical research council dyspnoea grade >3 at any time	DM020 (NICE ID NM 157)	The % of patients with diabetes without moderate or severe frailty on the register in



Indicator	Description	Indicator	Description
	in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months.	(17 points)	whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.
CS001 (7 points)	The contractor has a protocol that is in line with national guidance agreed with the NHS CB for the management of cervical screening, management of patient call/recall, exception. reporting and regular monitoring or inadequate sample rates.	DM021 (NICE ID NM 158) (10 points)	The % of patients with diabetes with moderate or severe frailty on the register in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.
CS002 (11 points)	The % of women aged 25 or over who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years.	DM022 (NICE ID NM 162) (4 points)	The % of patients with diabetes aged 40 years and over with no history of CVD and without moderate or severe frailty who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years).
CS004 (2 points)	The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample takers at least every 2 years.	DM023 (NICE ID NM 163) (2 points)	The % of patients with diabetes and a history of CVD (excluding haemorrhagic stroke) who are currently treated with a statin.
DEM005 (6 points)	The % of patient with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, Calcium, Glucose, renal and liver function tests, serum vitamin B12 and folate levels recorded between 12 months before or 6 months after entering on to the register.	HYP003 (NICE ID NM 53) (14 points)	The % of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less.



Indicator	Description	Indicator	Description
DM002 (8 points)	The % of patients with diabetes on the register in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.	HYP007 (NICE ID NM 54) (5 points)	The % of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.
DM003 (10 points)	The % of patients with diabetes on the register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.	MH006 (NICE ID NM 16) (4 points)	The % of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months.
DM004 (6 points)	The % of patients with diabetes on the register whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less.	CHD008 (NICE ID NM 68) (12 points)	The % of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less.
DM007 (17 points)	The % of patients with diabetes on the register in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.	CHD009 (NICE ID NM 86) (5 points)	The % of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or less.
DM008 (8 points)	The % of patients with diabetes on the register in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months.	STIA010 (NICE ID NM 69) (3 points)	The % of patients aged 79 years or under with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less.
DM009 (10 points)	The % of patients with diabetes on the register in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.	STIA011 (NICE ID NM 93) (2 points)	The % of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.



Indicator	Description	Indicator	Description
HYP006 (20 points)	The % of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.		<b>Prescribing safety</b>
MH007 (4 points)	The % of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months.	QI001 (27 points)	The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance.
MH008 (5 points)	The % of women aged 25 or over who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.	QI002 (10 points)	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.
MH009 (1 point)	The % of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months.		<b>End of life care</b>
MH010 (2 points)	The % of patients in lithium therapy with lithium levels in therapeutic range in the preceding 4 months.	QI003 (27 points)	The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance.
OST002 (3 points)	The % of patients aged 50 or over and who have not attained the age of 75 with fragility fracture on or after 1 April 2012 in whom osteoporosis is confirmed on DXA scan who are currently treated with an appropriate bone sparing agent.	QI004 (10 points)	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings.
OST005 (3 points)	The % of patients aged 75 or over and who have not		



Indicator	Description	Indicator	Description
	attained the age of 75 with fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis who are currently treated with a bone sparing agent.		
PAD002 (2 points)	The % of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.		
PAD003 (2 points)	The % of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken.		
PC002 (3 points)	The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.		
SMOK003 (2 points)	The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.		
STIA003 (5 points)	The % of patients with a history of a stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.		
STIA008 (2 points)	The % of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month		



Indicator	Description	Indicator	Description
	after the date of the last recorded or stroke or the first TIA.		
INLIQ CON002	The % of patients on the register prescribed an oral patch contraceptive method in the preceding 12 months who have also received information from the contractor about long acting reversible methods of contraception in the preceding 12 months.	INLIQ MH007	The % of patients with Schizophrenia bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months.
INLIQ DEP001	The % of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March who have had a biopsychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis record.	INLIQ MH008	The % of women aged 25 or over who have not attained the age of 65 with Schizophrenia bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.
INLIQ DM016	The % of male patients with diabetes on the register who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months.	INLIQ PAD008	The % of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.
INLIQ HYP004	The % of patients with hypertension aged 16 or over and who have not attained the aged of 75 in whom there is an assessment of physical activity using GPPAQ in the preceding 12 months.	INLIQ PAD003	The % of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken.
INLIQ HYP005	The % of patients with hypertension aged 16 or over and who have not attained to the age of 75 who score less		



Indicator	Description	Indicator	Description
	than active on GPPAQ in the preceding 12 months who also have a record of a brief intervention in the preceding 12 months.		
INLIQ STIA004	The % of patients with a stroke or TIA who have a record of total cholesterol in the preceding 12 months.		

**175 points**

**175 points**



### **For All London Practices supported by Londonwide LMCs**

This area of the Contract Agreement overlaps both the Primary Care Network Contract DES and the 'Digital First' IT programmes.

#### **Extended Hours DES**

The Extended Hours DES requirements and 2018/19 funding will be transferred to the Network Contract DES from 1 July 2019; this is an interim solution until the DES funding becomes incorporated into the current CCG Extended Access reimbursement programme in April 2021 as this is intended to be a Primary Care Network (PCN) responsibility.

As a PCN responsibility, the Extended Hours DES must be offered to 100% of the PCN's population. Recognising these additional costs, £30 million is being invested in the Global Sum. The Extended Hours DES appointment requirements are intended to be unchanged from the current specification.

The actual delivery of the Extended Hours appointments by the PCN will be a matter for mutual agreement; it may be that the same arrangements, at each practice within the Network, can continue. Practices can mutually agree to centralise some service appointments, or share staff, with a proportionate sharing of the financing available.

#### **CCG Extended Access Service**

This is currently delivered by CCGs on a £6 per head basis; by 2021 it is intended this, and the Extended Hours DES funding, should be combined and a single integrated service be offered through the Network Contract DES, in an equivalent manner to the National Service Specifications. The goal is for PCNs to offer both physical and digital/remote services, link with 111 and urgent treatment centres, to reduce duplication and improve what is acknowledged to be a complicated system for patients. Because there are a variety of current procurement agreements for CCG Extended Access services, the pace of this progress is expected to be incremental, and it will also involve PCNs working together at scale.

#### **Linking with 111**

In 2019/20 practices will need to offer 111 a *single* dedicated appointment per 3000 patients, eg, a practice with a list of 9,000 would offer three appointments and so on. These are not required to be additional appointments and should be spread evenly through the day. They will also only be available to patients registered at a practice and booked after 111 clinical triage. This process will be dependent on IT functionality.



Patients will be advised they have a booked appointment and that they should attend at their pre-arranged appointment time. They are also advised that the practice may contact them prior to the appointment to:

- Confirm the appointment,
- Discuss their symptoms prior to confirming any necessary appointment,
- Arrange for another healthcare professional to see the patient, if this is appropriate.

These appointments can be telephone appointments where the patient will be told that the practice may phone them in advance to re-triage them or handle the case over the phone. This facility will be subject to audit and monitoring, and, if appointments are unused by a certain time, they can be used by the practice themselves.

**Dr Michelle Drage, CEO of Londonwide LMCs - with thanks to Dr Julius Parker, CEO of Surrey and Sussex LMCs; Dr Matt Mayer, CEO of BBOLMCs, and Alex Orton and Sam Dowling of Londonwide LMCs.**



### **For All London Practices supported by Londonwide LMCs**

Nearly all these areas are non-contractual, and dependent on local functionality being available. Digital technology is seen as having “the potential to improve access, quality and outcomes including through better data, more accurate diagnosis, and support tools for patients”, and, for many patients, “digital will become the channel of choice when interacting with the NHS” (both quotes 5.6).

In terms of practice-based aspirations, these include patients having:

- The right to online and video consultation by April 2021,
- Online access to full records by April 2020 and “the ability to add their own information”,
- The option of electronic ordering of repeat prescriptions and electronic repeat dispensing, where appropriate,
- At least 25% of appointments being available for online booking by July 2019 although the nature of these appointments (eg, triage, or face-to-face) will be at the practices’ discretion, and they do not have to be a GP appointment. As per many practices’ current arrangements, these appointments can be embargoed until the same day or another unlock time/date just as with normal appointments so as not to discriminate against patients with a lack of online access,
- Access to an up-to-date and informative practice online presence,
- Access to online patient related correspondence.

And that practices:

- Have a dedicated MHRA Central Alert System receiving email address,
- Do not use fax machines for NHS or patient communication after April 2020,
- Offer new patients registered after April 2019 online access to prospective data from their health record.

Although not strictly part of the Contract Agreement, NHS England are planning to replace GPSoc (GP Systems of Choice) with a new practice IT support framework called GP IT Futures, which will support GP2GP functionality, improved cyber-security, better interoperability between IT systems and real-time secure access to data by patients and other NHS users.

NHS England are also seeking to address what they see as inappropriate incentives to digital providers; hence the changes to the Off-Formula London Adjustment and rurality index, although these in themselves will have a very small absolute financial impact on digital providers. Two further current regulatory matters will also be reviewed during 2019:

- The Out-of-Area Regulations,
- The current 46% Carr-Hill weighting for patients in their first year of registration.



However, there remains, outside this Contract Agreement, widespread NHS England willingness to see newer digital providers as being innovative demonstrators of the way the NHS might better offer digital and remote consultation services to patients.

111 access to practice appointments is seen as demonstrating both 'joined up' NHS digital services, as well as urgent access services to patients, and although trialled by practices in a number of areas, particularly in the North-East, will be a significant change for many practices; more details of this are given in the LMC update: Integrating Urgent Care Services.

### **Future Contractual Requirements**

NHS England and GPC England expect practices to make progress in 2019-20 towards the digital changes that will become contractual requirements from April 2020 and April 2021:

- All practices will be offering online consultations by April 2020 at the latest,
- All patients will have online access to their full record, as the default position from April 2020, subject to existing safeguards for vulnerable groups and third-party confidentiality and system functionality,
- All practices will need by April 2020 to have an up-to-date and informative online presence, with key information being available as metadata for other platforms to use,
- All practices will be giving all patients access online to correspondence by April 2020, as the system moves to digital by default (with patients required to opt-out rather than in),
- By April 2020, practices will no longer use facsimile machines for either NHS or patient communications,
- All practices will be offering consultations via video by April 2021 at the latest.

**With thanks to Dr Julius Parker, CEO of Surrey and Sussex LMCs, Dr Matt Mayer, CEO BBOLMCs and GPC Rep for Bucks and Oxon, and Dr Hannah Theodorou, Alex Orton and Sam Dowling of Londonwide LMCs.**





### **For All London Practices supported by Londonwide LMCs**

The highlights of the GP Contract Agreement 2019 announcement mostly relate to the introduction of the Primary Care Network DES, supporting the development of Primary Care Networks (PCNs), and the introduction of a state-backed GP Indemnity Scheme. There are also significant changes to QOF and to IT aspirations. However, there are multiple other smaller scale but important elements to this year's agreement.

### **Contractual Changes**

#### **Carr-Hill Formula**

The underlying Carr-Hill Formula is not being changed, but there are two supplementary demographic payments being altered, these being:

- A change to the rurality index payment, which will now apply to patients only if they live within the practice boundary; relatively few practices receive what is in absolute terms a very small financial sum,
- A change to the Off-Formula London Adjustment (currently £2.18 paid unweighted alongside the Global Sum) such that it will only apply to patients who reside within London, rather than to all patients registered with a practice physically based in London. This is anticipated to impact on London's highly mobile population and those practices on the boundaries of greater London. Londonwide LMCs responded to the Digital First consultation ([see it on our website](#)) highlighting concerns about the impact of the removal of the London Adjustment on practices on the border of greater London. This contract was agreed at a national level and assurances have been given that the issue will be considered as part of future contract negotiations.

#### **Data Protection Officer (DPO)**

Different models will operate in different areas. Every practice needs to have an identified, responsible and competent DPO. This DPO might be shared and be responsible for multiple practices. CCGs are required under the revised GP IT Operating Framework to provide, directly or via their IT provider service, a DPO support function (training, documentation etc). However, in view of the new contract we advise that LMCs request CCGs are fully funding DPOs covering the practices within their area. This may be a team working across an STP footprint, or at CCG level and will be dependent on local discussions.

#### **GMS Additional Service: Contraceptive Services**

Contraceptive services will no longer be an Additional Service under the Regulations but become part of Essential Services and therefore there will be no continuing opt-out option. There will be no financial impact as a result of this change.



### **Immunisation and Vaccination Programme**

The following changes have been agreed to the Vaccination and Immunisation Programme:

- Uplift of Item of Service fee from £9.80 to £10.06, to match comparable vaccine uplifts, for:
  - Seasonal influenza and pneumococcus.
  - Pertussis.
  - Childhood seasonal influenza.
  - HPV Vaccination for women aged between 18-25 (and males when added to the GP HPV catch up programme after April 2020).
- Widening of eligibility for the seasonal influenza and pneumococcus scheme to include care home and social care staff,
- MMR Catch-up for 10-11-year olds - £5 payment for a catch-up campaign for unvaccinated 10-11-year olds; the detailed specification is at Annex D Para 33 and paid in addition to the IOS fee.

### **FP10 prescriptions to treat sexually transmitted infections**

These will have to be endorsed manually until the IT suppliers have updated their systems to permit the free dispensing of such prescriptions.

### **MHRA (Medicines and Healthcare products Regulatory Agency) Central Alerting Systems (CAS)**

From October 2019 practices will need to register a practice email address with the MRHA CAS system and monitor this and provide a mobile number to be used as an emergency backup for texts if the email system is not working.

### **National NHS marketing campaigns**

GP practices will be obliged to support up to six NHS campaigns annually, by displaying NHS provided promotional and other material; these will include campaigns on public health promotion, such as immunisations or screening.

### **NHS logo**

For GP practices who choose to use the NHS logo in relation to their NHS provided services, this will then need to be used on all information and materials relating to practice NHS services and such practices must follow the NHS identity guidelines ([www.england.nhs.uk/nhsidentity](http://www.england.nhs.uk/nhsidentity)).

### **Private GP services advertising or hosting**

GP practices will not be able to either directly or via proxy advertise or host private paid-for GP services that fall within the scope of NHS funded primary medical services. The contract promises a review of other NHS providers who offer private services co-located with NHS services, but doesn't indicate when.



### **Publication of NHS earnings (transparency)**

All GPs, whatever their contractual status, with total NHS earnings above £150K per annum, commencing with 19/20 income, will be listed by name with earnings associated. The LMC is anticipating further guidance, including the definition of included 'earned' NHS work, and the basis for calculating such income. This will be published as a salary range rather than an absolute figure.

Due to the complex way GP partners are funded, non-NHS income would have to be deducted as would expenses including employer pension contributions. Only where the final figure after these deductions exceeds £150,000 would it then be published.

### **SARs (Subject Access Requests)**

A three year annual Global Sum up-lift of £20 million to acknowledge the workload burden on practices of SARs has been agreed; NHS England anticipate that after three years digitalisation of current Lloyd-George paper records will be completed, and patients will therefore have on-line access to their electronic and digitalised records, thus allowing patients direct access to SARs relevant information directly.

### **Statement of Financial Entitlements (SFE); Shared Parental Leave**

This will now be included as reimbursable leave under the SFE.

### **Capita**

£2m will be paid into the Global Sum to cover practice administration workload over Capita failings. This will remain recurrent until Capita failings are resolved.

### **Non-Contractual Changes**

These are primarily IT/digital but also include:

- Planned Roll-out of the 'Freedom to Speak Up' Guardian in Primary Care  
This has been delayed for over two years,
- Over-the Counter (OTC) Prescribing  
NHS England has provided a 'Letter of Comfort' to GPs to reassure colleagues they will not be at risk of breaching their contract when following OTC prescribing guidance,
- Debt and Mental Health Conditions  
A 'Debt and Mental Health Evidence Form' will be developed that practices must complete free of charge, if relevant, and recoup money from the bank or other debt company requesting it,
- Temporary Resident (TR) Payments  
TR payments for practices were effectively frozen at historic levels in the 2004 Global Sum and no mechanism currently exists to adjust for often seasonal fluctuations in TR requests for treatment received by practices. NHS England is to prepare guidance to CCGs in terms of any support that can be provided to practices whose workload is affected by this issue,



- Review of Vaccination and Immunisation Programmes  
This will occur in 2019 with a review of current arrangements for:
  - Procurement of seasonal influenza vaccine for adult patients.
  - Dealing with outbreaks and catch up programmes.
  - Extending the list of chargeable travel vaccinations.

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