

**To all Surrey and Sussex LMCs practices**

11th March 2020

Dear Colleagues

**Financial Considerations in relation to the 2020/21 GP Contract Agreement**

I am writing to draw colleagues attention to the GMS ‘Ready Reckoner’ developed by the GPC in collaboration with NHS England, to enable GP practices to better understand the changes in practice income streams as a result of this year’s GP Contract Agreement.

This is available at

<https://www.england.nhs.uk/publication/general-medical-services-gms-ready-reckoner-2020-21/>

The key changes are: -

* Global Sum [Global Sum Equivalent for PMS practices] will rise from £89.88 to £93.46 from 1.4.20 (4.0%), noting this includes MPIG and Seniority recycling
* The OOHs deduction is being reduced from 4.82% (£4.33) to 4.77% (£4.46), as the deduction is not applied to recycled MPIG and Seniority Funding entering the Global Sum.
* 2020/21 is the final year of the seven year phasing out of MPIG (Minimum Practice Income Guarantee Correction Factor), and Seniority payments with both residual funding pools now entering Global Sum
* The QOF point value rises from £187.74 to £194.83 on 1.4.20 (3.8%), reflecting the increase in the average practice list from 8479 to 8799 on 1.1.20; however, the number of QOF points is also rising from 559 to 567
* The PCN DES Network Participation Payment (£1.76) paid to practices remains the same
* The CCG funding of £1.50 per head paid to PCNs remains unchanged
* There are two new income streams associated with PCNs
	+ The ‘PCN QOF’ paid for via the Investment and Impact Fund, worth 67p per head to a PCN if all incentives are achieved
	+ The PCN Care Home Premium of £120 per annum; paid from 1.10.20 if the Care Home specifications are met, and therefore £60 for the 2020/21 financial year
* The Additional Roles Reimbursement Scheme (ARRS) has been changed such that there will be 100% reimbursement of all roles, to the ceiling described in the specification, and the total allocated funding for each PCN is significantly increasing. An average PCN will have an ARRS allocation of £344k in 2020/21, rising to £1.13 million by 2023/24
* The Extended Hours funding remains the same at £1.45 per head
* The PCN Clinical Director funding contribution remains unchanged

These calculations do not take into account the potential increase in funding achieved by the changes in the Vaccination and Immunisation arrangements, which will be partially introduced in 2020/21 and fully implemented in 2021/22. An additional £30 million is being added to the funding for this service.

Using the “Ready Reckoner” (for which weighted figures will be needed, for your practice population and the PCN of which your practice is a member) will be give colleagues a calculation of potential income for both their practice and PCN, noting that the ARRS reimbursement is based upon actual recruitment.

Calculating the cost of any commitment to delivering the PCN DES specifications cannot be exact but will depend upon

* The extent to which the work described in the three service specifications is already being undertaken by the practice; it is highly unlikely, in relation to each specification, any practices current commitment is zero
* The extent to which the ARRS roles can be recruited, and the proportion of their working time that PCNs will choose to deploy to PCN DES specification workload as opposed to current practice workload; the LMC would expect the latter to be the primary commitment for all ARRS staff.
* The extent to which Community Provider staff will undertake elements of the PCN DES service specification: this will be a contractual requirement for Community Providers from April 2020 and they will need to work with PCNs to agree the joint delivery of the Care Home specification; it is not expected a PCN will deliver this specification without Community Provider staff being actively involved
* The extent to which PCN member practices invest in available incentives; the PCN QOF is new funding, but it is only worthwhile pursuing if the incentive reward exceeds any investment required to secure it; this is entirely down to PCN membership discretion.

The LMC anticipates PCN member practices would expect, by default, the Care Home Premium and PCN QOF incentive payments to be paid in full and equitably to member practices, but this will need to be written into PCN Network Agreements.

In addition, I enclose an example of how a PCN financial outcome may look; noting this serves as a scenario; each PCN is able to make alternative financial decisions.

The LMC encourages all practices to consider these points when deciding whether or not continuing participation in the PCN DES is in their practice and patients’ best interests.

I hope the LMCs advice letters, answers to individual queries, and the forthcoming Roadshows will also address any queries colleagues may have.

With best wishes



Dr Julius Parker

**Chief Executive**

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