surrey and sussex lmcs

To: ALL GP PRACTICES IN THE LMC CONFEDERATION

23rd February 2016

Dear Colleagues

GP Contract Negotiations 2016/17

I am writing to all colleagues now that the negotiations about the GP Contract changes for 2016/217 have been agreed, and were accepted by a vote at GPC at last week's meeting.

Ironically, although the substance of these contractual changes are fewer than in recent years, this letter is much longer than usual, as I wanted to outline to all GP colleagues the LMC's approach to the next year, shaped as it will be by the LMC Special Conference in January and concurrent discussions that are on-going within GPC, NHS England, and the Department of Health about the future of General Practice.

There are two parts of the Contract Agreement; the first is the 'bare bones' contractual changes, the second 'sets the scene' for potential future changes to the GP Contract beyond 2016/17. I also wanted to note to colleagues progress in terms of other issues, such as the 'alternative GP Contract', that are being widely discussed.

Contract Uplift and Expenses

The GPC has negotiated an investment of £220 million into the GP Contract for 2016/17, representing an approximately 3.2% overall uplift, the largest for some years. This includes an absolute 1% increase in contract value, but, additionally, contributions towards the rising costs of medical indemnity, national insurance and superannuation, CQC fees, and utility and other costs. The 1% uplift will be subject to the current 5.34% OOHs deduction, but the monies supporting expenses reimbursements will not.

This contribution to expenses sets a significant precedent for future years; colleagues will be aware of the mounting dis-satisfaction within the profession with the DDRB (Doctors and Dentists Pay Review Board) which in recent years has demonstrated all the independence of a puppet, and has admitted its calculations relating to GP expenses are inadequate. This year GPC has negotiated directly with NHS England to obtain reimbursement for the rising expenses paid by practices.

Vaccinations and Immunisations

The current item of service fee paid for all immunisations and vaccinations will rise from £7.64 to £9.80, an increase of 28%. This is long overdue and very welcome, and a matter Surrey and Sussex LMCs has contacted GPC over several times in recent years.

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Apropos this increase the LMC would urge all practices to be proactive in their planning and publicity for their immunisation campaigns over the coming year. Patients have considerable support for their GP practices and in turn practices have a 'willing pool' of eligiblet patients. Although many colleagues have expressed concerns about the impact of the Community Pharmacy contract for flu immunisation, data does not suggest a significant migration of patients to Community Pharmacists and that the natural first port of call for patients for all immunisations remains their GP practice. Colleagues need to capitalise on this and make it an easy process for patients.

All other immunisation programmes remain the same, except:

- the catch-up element of the Meningococcal B programme, and the delivery of Paracetamol, are being withdrawn
- the infant dose of Men. C will be withdrawn from the Childhood Immunisation Programme from April 2016
- the Men. ACWY programme is to be extended to allow for the opportunistic vaccination of non-fresher 19-25 year olds.

QOF

There are no changes at all to QOF, in terms of indicators or thresholds for 2016/17. The QOF point value in 2016/17 will be £165.18, this is not a real uplift, it simply takes into account the changes in CPI (Contractor Population Index) as a result of the growth in average practice list size and also the overall population.

In addition, GPC and NHS Employers have agreed to explore the future of QOF for 2017/18 with one option being to cease the Framework altogether. This has already occurred in Scotland, and clearly there has been a decline in the overall QOF value in recent years, with a concommitant transfer of this resource into GMS Global Sum [and Global Sum Equivalent (GSE)]. However, although this process increases the value of the core primary medical services contract, which is appropriate and indeed necessary, it also results in the application of the Carr-Hill Formula to this income which does significantly disadvantage many practices. Any further transfer of QOF monies to core income is likely to require a further negotiation on this point.

Direct Enhanced Services

The Dementia DES will end on March 2016 and the associated funding [approximately £42 million] will be transferred to Global Sum (and GSE) without the out-of-hours deduction being applied.

Dementia diagnosis rates will continue to be monitored, as this remains an important political and health priority within England.

All other DESs will continue, including the Extended Hours DES for a further year, with no change in specification or funding.

This includes the AUA (Avoiding Unplanned Admissions) DES, about which there are considerable concerns over the bureaucratic burden it represents, together with its usefulness. Although GPC would have liked to negotiate the end of this DES for 2016/17, and was unsuccessful in this, there is a commitment to discuss this outcome with NHS Employers for 2017/18.

Access Survey

General Practices will have to provide six monthly data on the availability for their registered patients of routine evening and weekend GP appointments locally. This will include appointments available at sites other than the practice itself, and there is no requirement for practices to offer such appointments unless via other contractual means, such as the Extended Hours DES. The exact form of this data return is to be agreed.

This constitutes the only new workload for practices within the 2016/17 Agreement.

PMS Practices

As in previous years, although these national negotiations technically relate to the GMS Contract, NHS England is committed to an equal uplift to the PMS Contract baseline [Global Sum Equivalent] and that the implementation of the QOF, DES, and other contract changes via the SFE [Statement of Financial Entitlement] will also apply to PMS Contractors.

Clearly PMS Contractors within the Surrey and Sussex LMC Confederation are in the midst of PMS Reviews; these negotiations will be unaffected by the contract agreement in that the generic PMS Contract price will be the same as the uplifted GMS Global Sum, and the PMS Premium floats above this. Practices in Surrey and Sussex now have a clear financial offer from NHS England and a commitment from their CCGs to reinvent any released PMS premium into the Locally Commissioned Services budget. Negotiations within Kingston, Richmond and Croydon CCG are at a less advanced stage and are likely to be individual to each CCG, as each CCG's circumstances are different.

Non-Contractual Areas of Agreement

In addition to the above areas of contractual change which are legally based, the GPC has a commitment from NHS England to the following:

- a national approach to reducing bureaucracy and workload management
- revising arrangements for sickness payments under the SFE during GP absences
- a national promotion of self-care and appropriate use of GP services, to manage demand
- a commitment to establishing a fair way of interpreting and managing practice expenses

I appreciate that, reading this, some colleagues may call to mind the proverb 'fine words butter no parsnips' and I agree, the proof of the parsnip is indeed in the eating, but at least this approach focusses everyone's minds on what both sides are, and know what they are going, to talk about. It sets an agenda.

NHS England and GPC have agreed the following will be aspired to or discussed during 2016/17.

- IT: There is a tranche of non-contractual commitments in relation to the GP Systems of Choice (GPSoC) process under which primary care IT is delivered.

    - GP2GP compliant practices should continue to use this process. NHS England have agreed to amend the GMS Regulations so that NHS England's permission to not print out records, in the context of a successful GP2GP record transfer, is no longer required.
    - to aim for at least 80% of repeat prescriptions to be transmitted electronically by EPS Release 2 by March 2017.
    - to aim for at least 10% of registered patients to be using one or more on-line services by March 2017
    - from April 2016 GP practices will be required to be able to receive all discharge summaries and subsequent post-event messages electronically [sadly there is no contractual commitment to the quality of the content of these]
    - NHS England and GPC will jointly develop a template data-sharing agreement, to facilitate local information sharing between agencies/providers
    - NHS England and GPC will consider ways in which GP practices can be resourced to offer patients the opportunity to add additional information to their Summary Care Record [SCR]
    - practices will receive guidance on signposting the availability of apps approved through GPSoC to all patients to book on-line appointments, order repeat prescriptions, and access their GP record
    - GP practices will be encouraged to provide patients with on-line access to clinical correspondence, such as discharge summaries, outpatient letters and referral letters, if clinically appropriate
    - NHS England and GPC will promote the completion of the Health and Social Care Information Centre (HSCIC) information governance toolkit.

Clearly, reading this, many colleagues are likely to feel their practices are undertaking much of this already; these aims are aspirational and designed to encourage all practices to do so.

Named GP

NHS England, or possibly, the Secretary of State, seemed to have a fascination with the concept of the 'named accountable GP' which harks back to the reality of 50's or 60's General Practice, but it is hardly relevant to the way many practices, unless they are single-handed or run strict personal lists, now operate. NHS England wish to discuss how meaningful and appropriate data relating to the named accountable GP can be made available at a practice level via automatic extraction. This could be a long conversation.

Extraction of Former QOF and Enhanced Services data

As QOF indicators (and Direct Enhanced Services) have been retired, there has been pressure on practices to continue to allow extraction of such data under the HSCIC INLIQ [Indicators no longer in QOF] service. The 2016/17 Agreement encourages practices to make this data available. Surrey and Sussex LMC does not support this aspect of the Agreement, however, the LMC will be seeking further advice on this issue. There are a number of points to consider: clearly in any agreement there must be an element of compromise, but the LMC is concerned that by allowing the continuing extraction of such data, it may be used for monitoring processes, for example, by CCGs or CQC. As this data becomes historical and more inconsistently recorded, it will become both more inaccurate as a comparator across practices, and as a measure of quality

However, if there are to be further future substantive changes, for example, to QOF, it is inevitable there will be pressure for some previous QOF indicators to be available nationally as proxies for the quality and standards of care offered to patients. There must therefore be a balance in terms of agreeing to some data extraction even if this information no longer represents a remunerated target.

Locum GP Indicative Rates

In keeping with NHS England's efforts in terms of secondary case Agency costs; NHS England have proposed setting a maximum indicative rate for locum GP pay. There will be scope for some regional variation within this. I am confident colleagues will not allow the irony of a strongly free-market Government seeking to intervene in this way to pass them by. If NHS England are successful in establishing such a rate, they will amend the current annual electronic declaration system to include recording the number of instances in which a practice has paid a locum doctor more than the maximum indicative rate.

The most important point about this proposal is that there is no bar on practices paying above such a rate, nor of locum colleagues setting their rates as they see fit. However, there may be advantages in ensuring NHS England do understand the true burden of locum costs being borne by practices and also why locum colleagues have become so essential in continuing to ensure practices can provide appropriate care.

I suspect this proposal may end up in the 'too difficult' box.

Access to Healthcare

NHS England and the Department of Health apparently wish to develop arrangements for identifying patients who have an EHIC [European Health Insurance Card] and S1 and S2 forms, the latter relate to EU arrangements for pensioners and EEA residents respectively. It is unclear how this scheme will operate, but clearly the GPC will work to avoid this process being an unresourced administrative burden for practices. These proposals should be seen in the context of the current DH consultations on charges for overseas visitors and migrants to access primary care services.

What next

The first important point to make at the outset is that the 2016/17 GP Contract Agreement, whilst favourable, is clearly not a solution to the challenges facing General Practice and it is not designed to be. It is one piece of a complex chessboard of workload demand, dwindling workforce, excessive regulatory burden and unresourced workload shift, all against a background of inadequate and falling investment. However, it does represent a step in the right direction, and it signals a commitment to negotiate improvements for the next few years by both NHS England and GPC.

Both the Department of Health and NHS England have promised further supportive change this year; it is likely that during 2016/17 what has been characterised as an 'alternative GP Contract' will be negotiated. This term is misleading, as any contractual offer is likely to "sit above" the current National GMS Contract, and, although ostensibly local, in reality, following the completion of PMS Reviews, just as generic a PMS Contract. By 2020/21 the MPIG redistribution will be completed and therefore GMS and PMS core contracts will have the same price. It is likely that any completely new GMS Contract negotiations are some way off; they have certainly not been suggested by NHS England and the 2004 nGMS Contract took almost two years to negotiate.

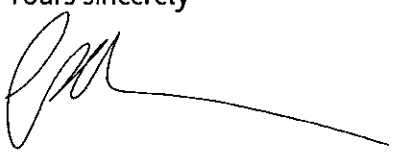
If substantive support is not provided to General Practice, then GP colleagues must be prepared to consider the types of measures discussed at the LMC Special Conference. Indeed, the LMC has for years encouraged GP practices to decline to undertake unfunded or underfunded NHS commissioned services. This is best done through collective CCG wide action, and the LMC can support and advise practices, but will not be able to achieve change unless the majority of practices are willing to take what I fully appreciate are unpalatable steps for some colleagues. However, these are short-term measures for a long term purpose, which is appropriate investment in General Practice.

The LMC has also recently provided advice to practices on wider approaches, such as deregistration, and capping or closing practice lists. The GPC (as part of the BMA and a Trade Union) will lead on other areas which focus on the long term sustainability of General Practice. Colleagues are encouraged to ensure the public are aware of the current crisis in General Practice, and support GPC campaigns such as the 'Urgent Prescription for General Practice.'

Finally, I hope this background is helpful, any GP colleague interested in the LMC's work can find more details via our website: (www.sslmcs.co.uk) and I would welcome your comments and suggestions (Julius.Parker@sslmcs.co.uk).

With best wishes

Yours sincerely



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