To all practices Surrey & Sussex LMCs

15th November 2013

Dear Colleagues

GP Contract Agreement 2014/15

I am writing to advise colleagues that an Agreement has been reached between the GPC and NHS Employers, acting under a mandate from NHS England, with the collaboration of the Department of Health, for the GP Contract for 2014/15.

As colleagues will appreciate from the length of this letter, this Agreement includes substantial changes, particularly to QOF. At recent LMC meetings local GPC representatives have been uncharacteristically reticent, unable to discuss the detailed progress of the negotiations, which have been taking place against the continuing backdrop of financial constraints, the shadow cast by the 2013/14 Contract Imposition, and mounting concern about GP workload and the sustainability of patient care.

This year GPC were asked to vote on the Agreement; it received overwhelming support, including that of GPC representatives covering Surrey and Sussex LMCs. GPC believes this Agreement will start to address the most pressing issues facing General Practitioners, most particularly:

- The inappropriate workload created by elements of QOF
- The need to increase core GP funding
- The need to embed funding into the contract and reduce the year-on-year changes to GP workloads

However, any Agreement involves compromise and there are elements of this one that will be unpalatable. None, however, were felt to be deal breakers in the way that certain original proposals could have been.

Colleagues should note this letter gives the headline changes: there will be considerable detailed guidance available over the coming months but the timely nature of this Agreement will also give practices an opportunity to plan for the forthcoming year.

QOF

The most substantive changes to QOF since its introduction have been agreed; these will see the removal of 341 points from QOF, which will now total 559 points. Of the 341 points, 238 points will be transferred to Global Sum. This money will not be subject to the 6% OOHs deduction, nor

will MPIG be adjusted (for those practices that receive it) in a compensatory way. The remaining 103 points are transferred to Enhanced Services (see below). The absolute monetary value is based on QOF achievement for 2012/13; this will be aggregated and the transfer will occur nationally, it is **NOT** based on an individual practices 2012/13 QOF Achievement.

Appendix 1 to this letter gives the full list of indicators being removed from QOF. These include almost all the imposed 2013/14 QOF indicator changes including threshold adjustments, many requirements for annual testing, which should instead be based on professional judgement, many remaining timeframes have been adjusted, and many indicators almost all practices were achieving, as this money is more securely embedded within core contract payments.

The QOF QP domain has been removed; this was causing significant workload in some areas and if CCGs wish this type of work to be undertaken by practices in the future it will need to be resourced by local negotiation.

In financial terms, approximately two thirds of practices will gain, and one third will lose. This modelling is for GMS contractors only. However, the GPC believes all practices will gain in terms of a reduction in workload and the unwelcome QOF pop-up boxes, and the more subtle but welcome return to professional judgement.

Avoiding Unplanned Admissions DES

A new Enhanced Service is to be introduced; this is funded by 100 QOF points and the retirement of the risk profiling Enhanced Service (representing about £160 million in total). The new DES will comprise much of the work already being conducted under QOF QP and the risk profiling Enhanced Service, but streamline this and remove both the need for multidisciplinary meetings for case management and the opportunity for locally imposed variation.

Under the DES practices will be asked to use a risk stratification tool to identify the 2% of the practice adult population who are the highest risk of admission; these will include the vulnerable elderly and patients receiving end-of-life care. This will create a 'case management' register for whom a nationally templated personalised care plan will be developed. Each care plan will have a named GP, and 'care-co-ordinator' (who may be different) and such patients will be entitled to same day discussions of clinical issues (if urgent), post discharge follow up, and reviews of the care plan if an admission has occurred. Each care plan will need to be reviewed monthly but not by a multidisciplinary team.

Practices will also have to report (via a nationally agreed template) a number of outcomes for patients on their case-management register.

Whilst significant, many practices are currently being asked to undertake this work in a piecemeal way, and under this DES a more reliable funding stream is introduced. This DES was one of the two sine qua nox sticking points with the other side in the negotiations, the other was:

Seniority

Colleagues who have read my previous letters will know that seniority payments have since 2004 represented the only individual payment within the GP Contract; this has always made such

payments look vulnerable, and increasingly so as approximately 40% of the GP workforce, salaried and locum GPs, are not entitled to receive them.

The Government is committed to ending all age (service) duration related increments within the public sector and GP seniority payments fall into this category. This was included in the Chancellors summer statement. The GPC has negotiated based on this outcome. The Dental Seniority Scheme closed to new members in March 2011.

The GP seniority scheme will close to new entrants on 1st April 2014. During the six years after 31st March 2014, all GPs in receipt of seniority payments will continue to receive these; however, there will be reduction in total payments from the seniority pool of 15% per year over each of the six years. If the rate of attrition (that is, the number of GPs receiving seniority payments who retire) creates less than a 15% reduction in spend, a reduction in total seniority payments will have to be made (probably spread amongst all current recipients) to achieve a 15% figure annually. These calculations cannot be made until two years into the six year period.

All monies currently paid as seniority will be recycled, year-on-year, into Global Sum under the same arrangements as QOF.

Clearly this decision is likely to be unpopular amongst a cohort of GPs; the GPC made the decision to negotiate a phased end to the seniority scheme and retain the money within the GP contract spend knowing it was most unlikely the scheme would continue into the future and with the intention of mitigating the process, and ensuring the money remained within primary care.

IT Changes

The following IT related changes have been agreed.

Referral including the NHS Number; this will be a contractual requirement after April 2014.

Electronic Booking of Appointments and ordering repeat prescriptions.

GP practices will be required to offer and (in an as yet unspecified way) promote these options under their contract after April 2014, subject to system functionality.

Summary Care Record

Uploading the information currently included in the SCR or making plans to do so by March 2015 will become a contractual requirement. This would be subject to patient dissent, that is, an assumed opt-in process will apply.

Utilisation of the GP2GP facility

This will become a contractual requirement under the same terms as the SCR, although there are a number of operational issues to be agreed.

Patient Access to their GP Record

After April 2014 practices will be required to offer, promote, or work towards this option but in the first instance this record will be represented by the SCR upload information.

The GPC has also given a commitment to discuss the following in the future; these items represent NHS England's aspirations:

- Access by users in other care settings to the GP record, subject to appropriate Information Governance controls.
- Access by patients to more of their records
- The option for patients to communicate with practices on-line

Direct Enhanced Services

The following Enhanced Services will cease:

- **Remote Care Monitoring,** with transfer of £12 million into the Global Sum
- **Patient on-line Access,** with transfer of £24million in to the Global Sum
- **Risk Profiling,** with transfer of £42 million into the Avoiding Unplanned Admissions DES

The Patient Participation DES is being modified: £40million spend is being transferred into Global Sum, with the balance (£20 million) remaining. The requirement for a local practice survey is being removed (as the 'Friends and Family Test' is being made a contractual requirement (see below))

The following Enhanced Services will continue, with limited changes:

- **Dementia**
- **Learning Disability**
- **Alcohol**
- **Extended Hours** (with practices now having the option to combine with others locally if they wish)

Friends and Family Test
Practices will be expected to offer a nationally agreed question and one practice option to patients. The national question will be (along the lines of): "How likely are you to recommend our practice to friends or family if they needed similar care or treatment?"

A monthly reporting template will be agreed.

This will become a contractual requirement for all GP practices.

Named GP for patients aged 75 and over

All patients in this age cohort will be entitled to have a named GP; and be told this by the most appropriate means. This will be a contractual requirement. For practices that currently run personal lists this should be straight forward. This GP will have the responsibility for ensuring this cohort of patients receive contractual services: there is no vicarious responsibility for others (such

as community nursing or OOHs services) nor any requirement to be contactable during the OOHs period. They will need to be able to work with nursing and social care professionals in co-ordinating the care such patients receive: this is hardly novel but provides a political sound-bite.

OOHs Quality Monitoring

The GP Contract will be amended to include:

"GP practices who have opted out of out-of-hours services shall monitor the quality of OOHs services offered to their patients and report any concerns to NHS England (or a delegated body). In monitoring the quality of OOHs activity for registered patients, practices will have regard for the nationally agreed standards and any reported patient feedback, including reported patient complaints made to practices about the OOH provider. GP practices that have opted out of OOH services shall cooperate with OOH providers.

Building on the existing contractual requirements, the cooperation will be extended to include reviewing the clinical details of all OOH consultations received from the OOH provider on the same working day they are received by a clinician within the practice (or exceptionally the following working day), responding to any information requests by the OOH provider in respect of such consultations – on the same day or within one working day where that is requested by the OOH provider. GP practices are to take reasonable steps to comply with systems the OOH provider puts in place for rapid and effective transmission of OOH patient data, in particular, agreeing the system for transmission of information about patients with special needs. Agreement with the OOH provider will need to be sought around timely sharing of patient data"

The LMC anticipates local OOHs services will wish to proactively engage with practices to assist in achieving these aims.

Choice of GP Practice

This scheme, which had the impact of a stray sock, is to be extended across England by either October 2014 or April 2015; this is dependent on NHS England resolving a number of what are described as practical issues.

CQC Inspection Reports

In common with other providers and when the CQC inspection arrangements indicate this must happen; GP practices will be obliged to display their Inspection Report in their waiting room(s) and on their website.

Publication of GP Earnings

The GPC has agreed in principle to this, and a working group will be set up to ensure the calculation and publication of earnings is on a like-for-like basis with other healthcare professionals and that the published information will represent only GP NHS net earnings from NHS contracts. This will be implemented in 2015/16, using data from 2014/15.

Patients needing access to a practice clinician after assessment

The wording is:

"Where a patient has been assessed as needing contact with a practice clinician, the practice will ensure that when the patient contacts the practice a practice clinician will agree appropriate next steps having regard to the patient's condition and circumstances"

This obviously has relevance in terms of 111, but also in terms of practice contact after an OOHs assessment.

PMS Practices

GPC does not have a mandate to negotiate for PMS Contractors, however, as in previous years; the Agreement reached with NHS England "will be equally and consistently applied to PMS Contractors".

Changes to GMS Global Sum

Based on the addition of QOF funding and the reduction in MPIG for GMS Contractors (which under a seven year transition (see below) will start in 2014/15) it is estimated GMS Global Sum per weighted patient will be £72.02 in 2014/15. This does not take into account the changes in seniority and monies transferred from DESs.

The Seven Year Transition to a common contract value per patient

This transition was part of last year's Contract Imposition and was scheduled to begin in 2014/15. For GMS Practices, this represents a loss of MPIG, in equal stages, and this money will be recycled year-on-year into Global Sum. This is a straight-forward calculation and will commence next April, as planned. This process was not part of this year's contract negotiations.

For PMS practices the original discussions, last year, suggested that PMS spend would be aggregated, combined with Global Sum and MPIG, and this combined sum used in the seven year redistribution. This would be the GPCs preferred option, as it would ensure all current contract spend was retained in GP practices, and would lead to a higher contract price at the end of seven years because PMS practice have a disproportionately higher contract value. However, it has become increasingly obvious this is not NHS England's preferred outcome, in part because of the difficulties in negotiating such a transition as a variation in each PMS contract. At present it is unclear what process will be applied to PMS contractors; NHS England completed an exercise analysing spend on PMS contracts nationally seeking to identify the "added benefit" of above Global Sum contract values.

There are a small number of GMS Contractors whose MPIG is a relatively high proportion of total practice income; at present the LMC has asked such practices to identify this but no further action is as yet needed, although such practices should be aware this remuneration is vulnerable to transitional change.

OOHs and 7 day working

These did not form a part of this Agreement, although discussions continue.

Conclusion

Although there is considerable further detail to emerge, this Agreement represents the most significant change in the GP Contract since 2004. It should allow colleagues to stop much of the QOF bureaucracy that has clearly created an inappropriate and clinically unjustified workload, and by embedding substantial sums within baseline contract payments this hopefully safeguards practices from the year-on-year politically motivated contract changes that had little or no clinical benefit but kept frustratingly changing the goalposts.

The phasing out of seniority will be controversial, but this Agreement mitigates an almost inevitable future loss. It is open to practices to create, if they wish, and by mutual partnership agreement, alternative provision to recognise experience.

The LMC reminds practices of the importance of securing appropriate resources for any workload requests, and agreeing by local negotiation adequate funding for work undertaken outside national, including DES, or locally commissioned contracts.

I hope colleagues will feel this Agreement will start to address practice workload and recognises the value of their professionalism as the most important indicator of excellence in patient care.

With best wishes

Yours sincerely

Dr Julius Parker
Chief Executive

Appendix 1 - Full list of indicators to be removed from QOF

indicator	Summary	Points	Removed to
Clinical domain			
AF002	Atrial fibrillation - % with CHAD score	10	Global Sum
CHD003	CHD - annual cholesterol > 5mmol/l	17	Global Sum
HYP003	Hypertension - BP ≤140/90	50	Global Sum
HYP004	Hypertension - GPPAQ	5	Global Sum
HYP005	Hypertension - GPPAQ + intervention	6	Global Sum
PAD003	PAD - annual cholesterol ≤5mmol/l	3	Global Sum
STIA004	STIA - total cholesterol	2	Global Sum
STIA005	Non-haemorrhagic STIA, cholesterol ≤5mmol/l	5	Global Sum
DM005	Diabetes - albumin:creatinine test	3	Global Sum
DM011	Diabetes - retinal screening	5	Global Sum
DM013	Dietary review by suitably qualified professional	3	Global Sum
DM015	Diabetes - record of erectile dysfunction)	4	Global Sum
DM016	Erectile dysfunction to diabetic men	6	Global Sum
THY001	Thyroid register	1	Global Sum
THY002	Thyroid function tests	6	Global Sum
DEP001	Depression - bio-psychosocial assessment	21	Global Sum
MH004	Mental Health - cholesterol:hdl	5	Global Sum
MH005	Mental Health - blood glucose or HbA1c	5	Global Sum
MH006	Mental Health - record of BMI	4	Global Sum
EP002	Epilepsy – seizure free for 12 months	6	Global Sum
EP003	Epilepsy - contraception advice	3	Global Sum
LD002	Learning disability – record of blood TSH	3	LD DES
RA003	Rheumatoid arthritis - CVD risk assessment tool	7	Global Sum
RA004	Rheumatoid arthritis - fracture risk assessment tool	5	Global Sum
Clinical total removed		**185**	
Public Health domain			
CVD-PP002	CVD - lifestyle advice	5	Global Sum
SMOK001	Smoking - % over age with smoking status	11	Global Sum
CS003	Cervical screening results	2	Global Sum
CHS001	Child development checks	6	Global Sum
MAT001	Antenatal care and screening	6	Global Sum
CON002	Contraception - annual LARC advice	3	Global Sum
PH total removed		33	
TOTAL clinical/PH removed		**218**	
Quality and productivity			
QP001	Review of outpatient referrals	5	ES
QP002	Peer review of outpatient referrals	5	ES
QP003	Care pathways to avoid outpatient referrals	11	ES
QP004	Review of emergency admissions	5	ES
QP005	Peer review of review of emergency admissions	15	ES
QP006	Care pathways to avoid emergency admissions	28	ES
QP007	Review of A&E attendance	7	ES
QP008	Peer review of A&E attendance	9	ES
QP009	Care pathways to avoid A&E attendance	15	ES
QP DOMAIN TOTAL TO ES		**100**	
Patient experience			
PE001	Consultation length	33	Global Sum
TOTAL TO GS and ES		**341**	