surrey and sussex lmcs

To all practices Surrey and Sussex LMCs

9th February 2017

Dear Colleagues

GP Contract Agreement 2017/18

I am writing to all colleagues to summarize the details of the GP Contract Agreement 2017/18; there will be further guidance documents associated with some aspects of this Agreement, which when available will be highlighted by the LMC. Some elements of the Agreement will only apply during 2017 and not from 1st April.

To provide context, the Annual GP Contract Agreement negotiations are taking place against wider changes within General Practice, as described in the GP Forward View. These are designed to assist the challenges created by rising workload, a less available GP workforce, and excessive regulation of the "business of General Practice". The GP Contract Agreement this year is designed to reinforce GP practices as the key and, as NHS England is coming to appreciate, indispensable element of a successful and efficient NHS primary care service, and to try to support their work.

Other aims of the negotiations were:

- to provide stability in terms of contractual expectations for the coming year
- to reimburse practices for incurred costs and GP expenses
- to reduce contractually required bureaucracy

As your GP Representatives, I and Dr Russell Brown, Chair of East Sussex LMC, voted to accept this contract agreement believing it is a positive step forward for all practices and practice colleagues.

The key elements of the Agreement:

- **Direct Enhanced Services**
  The Avoiding Unplanned Admissions (AUA) DES is ceasing from 31st March 2017 and the funding associated with this, £156.7 million is being transferred to Global Sum.

  Further guidance will be issued, but from 1st July 2017 GP practices will be asked to identify those patients over 65 who have either moderate or severe frailty, using an appropriate clinical tool. Of those patients with severe frailty, which in an average practice will be a significantly smaller % than the AUA 2% cohort, an automatic data extraction will identify coded information on:

  - the number of patients recorded with a diagnosis of severe frailty
  - the number of such patients who have had an annual medication review

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- the number of such patients recorded as having had a fall in the previous year
- the number of such patients who have consented to activate their enriched Summary Care Record (SCR), which practices will be asked to promote amongst this cohort
- and the number of patients with a diagnosis of moderate frailty.

It is important to note there are no additional reports to create or submit, and no claims to make, in relation to the identification and management of such patients, and there are no threshold expectations in terms of the extracted data.

There are no changes to other current DES specifications, which will roll over into 2017/18. There is a change in practice eligibility for the Extended Hours DES from 1st October 2017 (see below)

The payment for the Learning Disability DES health check will rise from £116 to £140. NHS England are also developing a voluntary template, for use by practices if it would be helpful to do so.

- **QOF**
  There will be no changes to QOF indicators or thresholds, or to the total number of points (559) for 2017/18. The Contractor Population Index (CPI) will be adjusted to take into account the increase in the overall population in England and average practice list size, thereby resulting in an increase in the value of the QOF point.

- **Expenses Outside Global Sum**
  Two key expenses reimbursements have been agreed:

  - **CQC Fees**: Practices will receive full reimbursement of their 2017/18 CQC fees. I appreciate colleagues are currently unused to reading good news, so please feel free to read that sentence again. As colleagues, will know, CQC recently announced a significant increase in its 2017/18 fees and the full cost of each practice's CQC fees will be reimbursed on submission of a paid invoice to NHS England or CCG. This will be a direct reimbursement and paid outside Global Sum.

  - **Indemnity Costs**: This is not quite as exciting, partly because it has already been announced, but for 2017/18 all practices will receive an unweighted capitation based reimbursement (that is, outside the Carr-Hill Formula) of the average rise this year of indemnity insurance costs. This is estimated at £30 million across England. This will be paid regardless of the indemnity fee payment arrangements currently existing within practices. It is not a direct reimbursement, and thus will not adjust for individual based variation in indemnity costs. This reimbursement is practice based, though paid outside Global Sum, and GPC and NHS England anticipate will benefit both practice partners and employed General Practitioners. Further guidance on this will be issued shortly.

- **Global Sum**: Global Sum will be adjusted to include the following expenses reimbursements:

  - £2 million to support practices in relation to workload associated with the transport and labelling of patient records.

- £3.8 million to reimburse practices' expenses associated with the 0.08% increase in NHS pension costs from April 2017.
- £1.5 million to reimburse practices for completing the annual workload census, which was in fact being undertaken by most practices but which will now be mandatory.
- £5 million to reimburse for administrative expenses associated with the 'Access to Healthcare' changes noted below:

The final change in Global Sum from the current £80.59 has not yet been announced, but will be available shortly.

- **SFE Sickness and Maternity Reimbursement**

  Sickness cover reimbursement: There will be significant improvements to these arrangements from April 2017; which in part mirror changes already agreed within the maternity reimbursement arrangements. Thus, payment of sickness reimbursement is no longer discretionary, the qualifying eligibility relating to list size ceases, and existing currently less than full-time working GPs within the practice who are able to 'step-up' temporarily can be used, rather than a requirement to engage an external locum. The maximum amount payable is rising to £1,734.18 per week, the same as for maternity reimbursement, with payment being made following two weeks' sick leave.

  There are no medical exclusion criteria that apply to this scheme so as well as improving the scheme, all these changes should reduce the costs of both individual and practice sickness insurance policy costs.

  Maternity cover reimbursement: Following the enhancements to the scheme in 2015/16, the pro-rata element has now been removed; colleagues will be aware the LMC had raised this locally following reports that a small number of CCGs in England had agreed such arrangements, and NHS England has now agreed this will be generally applicable and the SFE Statement of Financial Entitlements will be amended.

- **Extended Hours DES and Core Opening Hours**

  NHS England has decided that practices that recurrently close for a half-day during the week should not ordinarily be eligible for payments to increase the number of appointments made under the Extended Hours DES. This criterion will be introduced on 1st October 2017. This will not apply to, for example, closing for staff training or local, often CCG organised, educational events, nor, in normal circumstances, to branch surgeries if a main site is open and accessible.

  There are three main issues for practices who currently close regularly for a half-day each week to consider:

  - whether they would prefer to open in order to retain eligibility for the Extended Hours DES; there is no requirement to offer the DES, and the balance may favour not continuing the Extended Hours service.
  - however, there is a facility within the DES to offer this jointly across one or more practices; for some practices this may be an option worth considering.

- the guidance uses the term "ordinarily" as there may be circumstances, in which small rural or isolated practices, or practices with an unusual demographic, where the Extended Hours DES may continue to be appropriately offered despite a weekly half-day closure

The delayed implementation until 1st October 2017 is to allow such practices to decide what to do; the LMC should be consulted by commissioners, either CCG or NHS England and is there to support practices, and I will write to all practices again once further information is available; in the interim if practices do currently close for a weekly half-day, please contact the LMC (clare.sieber@sslmcs.co.uk).

- **Access to Healthcare**
  As colleagues, will be aware, this is a hot political issue; if you are not aware, please buy one copy of the Daily Mail. The GMS1 new registration form is to be revised to allow patients to **self-declare** if they do not hold a non-UK issued EHIC or an S1 form. NHS England will provide practices with hard copy leaflets which explain the entitlement rules for overseas patients accessing the NHS in England.

  Practices should manually record the same information in the patients' medical record and then either email or post a copy of the completed GMS1 forms to NHS England. **These are the only administrative requirements for practices.**

  GP system suppliers are being asked to develop an automated process as soon as possible, and then an alternative data collection process can be agreed.

  It is important to note that this may be seen as heralding further changes, based on political considerations, that may mean General Practice becomes included within the NHS (Charges for Overseas Visitors) Regulations 2015, however, this is for the future and quid sit futurum cras,fuge quaerere (Horace)

- **Pre-release registration of Prisoners**
  From 1st July 2017, there will be a change in the Regulations to allow prisoners to register at an appropriate practice prior to their release from prison, to facilitate a timelier transfer of information from prison to General Practices and prevent the information desert common to such patents first presentation at their practice that currently often occurs.

- **Data Collection**

  - **National Diabetes Audit [NDA]** Most practices already participate in this but from July 2017 the relevant data extraction will be contractually required.
  - **Indicators No Longer in QOF [INLIQ]** As many practices will know SSLMCs has consistently argued that the continued data extraction of INLIQ becomes increasingly irrelevant as coding becomes more inconsistent, thus comparative data is more unreliable. However, all negotiation is a compromise and if by agreeing to this the GPC Team were able to gain traction on the more significant issues in this Agreement, well, sometimes "you've got to know when to fold 'em" [The Gambler – Don Schlitz 1976] I will write to practices separately about this issue and list the relevant retired indicators; coding is however only required if clinically relevant and appropriate to better patient care.

- **Vaccinations and Immunisation**
  There are several detailed changes to the current schedules:

    - Childhood seasonal influenza; four year olds are being transferred to the school's programme.
    - Seasonal influenza; the morbidly obese are being included as an at-risk cohort [with £6.2 million being made available to fund this programme extension]
    - Pertussis in pregnant women; a reduction in eligibility from 20 to 16 weeks
    - MenACWY programme; a reduction in eligibility from "up to 26th" to "up to 25th" birthday
    - Shingles (routine) a change in eligibility from 1st September of the relevant year to age 70
    - Shingles (catch up) a change in eligibility from 1st September of the relevant year to age 78

    The following programmes are unchanged:

    - Hepatitis B (New born)
    - HPV (girls)
    - MMR 16 years and over
    - Meningococcal B
    - Pneumococcal

- **GP Retention Scheme**
  There are significant changes being agreed to the GP retainer scheme, however, those retainers on the 2016 Scheme will remain on this until 30th June 2019, when they will default to the revised scheme.

  There will be further guidance on this issue available.

- **Non-Contractual IT**
  The Contract Agreement states a number of arrangements will be promoted.

  Many of these develop 2015/16 priorities and include:

    - Aim to increase current uptake of electronic repeat prescriptions to 25%
    - Aim to increase uptake of electronic referrals to 90% where this is enabled by secondary care
    - Aim to increase patient use of on-line services to 20%

  Further guidance will be available.

Future commitments include negotiations over the future of QOF from April 2018 and the continuing work of the Carr-Hill Formula Group.

I hope all colleagues will feel positive about the outcome of this year's contract negotiations, and that the aims supported by GPs in the GP survey, by LMCs when influencing GPC, and by LMC Conference, have taken a positive step forward under this Agreement.

I appreciate colleagues will have further detailed queries and are welcome to email me (Julius.parker@sslmcs.co.uk), although in some cases the LMC is awaiting more detailed advice from GPC and NHS England.

With best wishes

Yours sincerely

Dr Julius Parker
Chief Executive