

Important Message to all GPs in England on changes to the GP contract for 2017/18, from the Chair of the GPC, Dr Chaand Nagpaul

Dear Colleague,

I am writing to let you know that the BMA GPs committee (GPC) England has concluded negotiations and reached agreement with NHS Employers on changes to the GP contract for 2017/18.

In line with policy from the 2016 LMC conference and the views of GPs including through our [survey of the profession](#), our aim in these contract negotiations has been to:

- provide stability to GMS/PMS contracts where possible
- secure much needed funding to address GP practice expenses and increase core resources
- tackle unnecessary bureaucratic workload, which takes vital time away from clinical care for our patients.

We have fought hard for changes which we believe offer significant improvements to the contract and will benefit and better support GPs and practice teams

While we welcome the positives secured in this agreement, the crisis facing general practice cannot be solved by such contractual revisions alone, and which is largely a result of wider pressures *outside* our contract – with soaring demand, a critical shortage of GPs, inadequate NHS funding, excessive regulatory and bureaucratic burdens, and unresourced and inappropriate workload shift.

We have therefore been in parallel discussions with NHS England and the Department of Health on tackling these wider issues, through ensuring that NHS England honours its commitments in the [General Practice Forward View](#), as well as those we are taking forward through our [Urgent Prescription](#).

GMS contract changes for 2017/18

The BMA's General Practitioners Committee England (GPC England) has overwhelmingly voted to accept the negotiated contract changes for 2017/18 as outlined below.

Avoiding Unplanned Admissions DES (AUA)

We have consistently and strongly expressed our concerns regarding the bureaucracy surrounding the unpopular Avoiding Unplanned Admissions (AUA) DES. We have therefore negotiated that the **AUA DES will be discontinued** on 31 March 2017 and that **£156.7 million will be added to the global sum**.

This is something which most of you have asked for, as reflected in our recent GP survey, and which will reduce significant bureaucratic workload for practices.

There will instead be a contractual requirement for practices to focus on the management of patients with severe frailty. From 1 July 2017 practices will use an appropriate tool to identify patients aged 65 and over who are living with moderate and severe frailty. For those patients identified as living with severe frailty, the practice will deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions. In addition, where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this seeking informed patient consent to activate the enriched SCR.

Practices will code clinical interventions for this group appropriately. **There will be no additional reports to produce or claims to make.** This agreement ensures that practices are empowered to apply their own clinical judgement in the management of severely frail patients, as part of good clinical care, thereby ending the significant associated bureaucratic burden on practices under the current enhanced service. The percentage of patients with severe frailty is estimated to be significantly smaller cohort than that of the enhanced service.

Data will be collected (using an automated extraction) on the number of patients recorded with a diagnosis of moderate frailty, the number of patients with severe frailty, the number of patients with severe frailty with an annual medication review, the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months and the number of severely frail patients who provided explicit consent to activate their enriched SCR. NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This data will **not** be used for performance management purposes.

CQC fees

We have secured, for the first time, **full reimbursement of practices' total CQC fees**. Although the GP Forward View suggested compensating practices for future CQC fee increases, we have gone further and negotiated that the **entire** CQC practice fee will be reimbursed for 2017-18. This means that CQCs recently announced exorbitant fees rises will not impact on practices, since the total CQC cost will be paid for by NHS England

Unlike last year, this funding will not be added into global sum, and will therefore not be weighted with the Carr-Hill formula. A system of direct reimbursement will be introduced whereby practices will submit their paid invoices to NHS England or their CCG (under delegated commissioning) and will receive full reimbursement of their actual costs.

Indemnity costs

We have also agreed **£30m to cover the rises this year in indemnity insurance costs**. This has been based on figures received from medical indemnity organisations, to cover GMS work. This will be paid to practices on a per patient basis, set out under the Statement of Financial Entitlements (SFE), and will not be weighted as a result of the Carr-Hill formula. As this funding will be paid direct to practices, GPC is clear that GP principals must ensure that the appropriate amount of funding reaches their salaried GP colleagues. Locum GPs will need to ensure that their invoices/agreements with practices are uplifted appropriately to take account of this business expense if they have not already done so. NHS England and GPC England are working on practical guidance to facilitate the appropriate dispersal of this resource to all sectors of the GP workforce.

Sickness cover reimbursement for GPs

We have also negotiated important beneficial changes to **sickness cover reimbursement**. Practices are currently at considerable financial risk of paying for sickness absence of GPs, due to discretionary reimbursement, outdated list-size criteria and the need for cover to be provided by an external locum.

We have secured that sickness cover reimbursement will no longer be a discretionary payment, but a practice entitlement. The qualifying criteria based on list size, which often prevents a practice from being able to claim a payment to cover locum costs, has been removed. Payments will be made after 2 weeks of a GP being absent from the practice due to sick leave. As part of our agreement, existing GPs within the practice can now be used to cover sickness, mirroring existing maternity cover arrangements. The amount payable for sickness cover has also been uplifted to £1734.18 per week in line with current maternity cover arrangements. There will be no medical exclusion criteria for this sickness reimbursement, which we believe will be a very significant benefit to GPs with long-term conditions who currently find sickness cover difficult or expensive to source. It should also reduce practice locum insurance cover expenses, and enable practices to offer better sickness absence terms for salaried GPs.

Maternity cover reimbursement

We have secured agreement that maternity payments **will not be subject to a pro-rata application** and that in order to secure the payment practices will need only to submit an invoice and either the full amount or maximum payable will be paid. We have heard from a number of practices across the country that the application of pro-rata payments is having a significant impact on their ability to provide cover in their practice and are pleased that this has been resolved on a national level.

Learning Disabilities DES

We have negotiated that NHS England will invest more in the **Learning Disabilities DES** to support an increase uptake in the number of medicals done, with the sum paid per health check uplifted from **£116 to £140**. NHS England has also developed a voluntary template, which is available for practices to use should they choose to do so, but there is no obligation to use this.

Expenses and pay uplift

We have also agreed an increase in expenses that should deliver a **pay uplift of 1%**, which will be added to global sum. There will also be an uplift of **£3.8 million** to recognise **increased superannuation costs of 0.08%** as a result of changes to the NHS pension scheme to take effect in April 2017.

£2 million will be added to the contract to account for increases in practices' workload as a result of **changes to the primary care support services, provided by Capita**. This is to cover the extra work involved in bagging and labelling patient records as the current pilot is extended across England.

£58.9 million will be added to the contract to cover the estimated cost of increased population growth.

Agreement has also been reached for eligible practices to be reimbursed for all costs relating to levies incurred as a result of being in a Business Improvement District. The reimbursement is to be made via the Premises Costs Directions.

Workforce census

We have agreed that completion of the **workforce census** will be a contractual requirement for every practice. This is something that most practices are already doing, and which was already a requirement on practices. As a result, **£1.5 million** will be added to global sum to recognise the workload involved. This data is required to be able to gain a better understanding of how the GP workforce is changing, and how this varies by region.

Quality and Outcomes Framework (QOF)

There will be no changes to the indicators in QOF or the total number of points. There will be an increase to the value of a QOF point as a result of the Contractor Population Index (CPI) adjustment to take into account of the growth in the population, as well as any increase in average practice list size. We have also agreed that a working group will be set up immediately following these negotiations to discuss the future of QOF after April 2018.

Core opening hours and Extended Hours DES

We have committed to working with NHS England to ensure locally responsive, safe and appropriate access to general practice for all patients in England during contracted hours, with a particular focus on the minority of practices which currently close for a half day on a weekly basis. Local Medical Committees should be integral partners in working with local commissioners in ensuring practices are fulfilling their contractual requirements.

Following the publication of the recent National Audit Office report, NHS England made clear its intention to address the instances where practices are closing for half-days on a weekly basis and are also being paid under the Extended Hours DES to offer additional appointments. New conditions will therefore be introduced from October 2017 which will mean that practices who regularly close for a half day, on a weekly basis, will not ordinarily qualify to deliver the DES.

We have managed to secure that **no changes will be made to the qualifying criteria of the DES until October 2017** to allow any affected practices time to make appropriate arrangements. In addition we have agreed that there may be exceptions – for example, where it is locally agreed for some branch sites or small rural practices to close.

Access to healthcare

As part of the agreement last year to take this work forward, we have now agreed with NHS Employers contractual changes that will help to identify patients with a non-UK issued EHIC (European Health Insurance Card or S1 form or who may be subject to the NHS (Charges to Overseas Visitors) Regulations 2015. New recurrent investment of **£5 million will be added to global sum** to support any associated administrative workload.

Once available, practices will use a revised GMS1 form for new patient registrations. This will require patients **to self-declare** that they hold either a non-UK issued EHIC or a S1 form. For these patients, practices will be required to manually record that the patient holds either a non-UK issued EHIC or a S1 form in the patient's medical record and then send the form and supplementary questions to NHS Digital (for non-UK issued EHIC cards) or the Overseas Healthcare Team (for S1 forms) via email or post. Practices will be provided with hardcopy patient leaflets which will explain the rules and entitlements for overseas patients accessing the NHS in England.

Under this system, the **patient's country of origin will be charged** where relevant. **Patients themselves will not be charged.**

Agreement has also been reached for NHS England and GPC to work with GP system suppliers to put in place an automated process, as soon as possible, to replace the manual process. This would include discussions on development of systems to support collection of GP appointment data for these patients. Once the technical solution to automatically collect this data is in place, we have agreed that further discussions on implementing the system to support collection of the data will take place.

National diabetes audit (NDA)

Whilst most practices are already taking part in this annual audit, from July 2017 all practices will be contractually required to allow collection of data relating to the NDA.

Data collection

Most practices are also enabling the extraction of data collection for a selection of agreed indicators no longer in QOF (INLIQ) and retired ESs. From July 2017 this will become a contractual requirement for all practices. This data will not be used for performance management processes and practices should not be focusing on recording data on indicators that are not in QOF unless it is clinically appropriate to do so.

Registration of prisoners

A contractual change will be introduced from 1 July 2017 to allow prisoners to register with a practice before they leave prison. The intention is for the timely transfer of clinical information, with an emphasis on medication history and substance misuse management plans, to the

practice from the prison to enable better care when a new patient first presents at the practice.

Vaccinations and Immunisations

We have agreed to the following vaccination and immunisation programme changes from April 2017:

- Childhood seasonal influenza – the removal of four year olds from enhanced service patient cohort (transferring to schools programme) and the removal of the requirement to use Child Health Information Systems (CHIS).
- Seasonal influenza – the inclusion of morbidly obese patients as an at-risk cohort and a reminder for practices that it is a contractual requirement to record all influenza vaccinations on ImmForm. Funding to cover this new cohort will be from Section 7A. £6.2m has been added to the contract to cover this expansion of the target group.
- Pertussis or pregnant women – a reduction in the eligibility of patients for vaccination from 20 weeks to 16 weeks.
- MenACWY programmes – a reduction in the upper age limit from ‘up to 26th birthday’ to ‘up to 25th birthday’ (in line with the Green Book).
- Shingles (routine) – a change in patient eligibility to the date the patient turns 70 rather than on 1 September.
- Shingles (catch-up) – a change in patient eligibility to the date the patient turns 78 rather than on 1 September.

The following programmes have been agreed to roll-over unchanged:

- hepatitis B (newborn babies)
- HPV for adolescent girls
- measles mumps and rubella (aged 16 and over)
- meningococcal B
- pneumococcal polysaccharide
- rotavirus.

GP retention scheme

We have negotiated improvements to the GP retainer scheme. A new scheme has been agreed to replace the existing one, with the key changes being as follows:

- Tighter criteria for those who are joining the new scheme. The scheme is aimed at those GPs who are seriously considering leaving or have left general practice due to personal reasons, approaching retirement, or require greater flexibility.
- In 2016, under an interim scheme, the practice payment rose from £59.18 to £76.92 per session, an increase of approximately 30 per cent. NHS England will fund the 2017 scheme wholly from within the primary care allocation budget and the practice payment and professional expenses supplement will remain the same as the 2016 scheme. The practice payment is to be used by the practice as an incentive to provide flexibility for the retained GP and should be used towards the retained GP’s salary, to cover human resources administration costs and to provide funding to cover any educational support required from the practice, including course fees where relevant.
- A professional expenses supplement will be payable to the GP via the practice (on a sliding scale) and is to go towards the costs of the GP’s indemnity cover, professional expenses and Continuing Professional Development (CPD) needs.
- The option of reducing the practice payment back to the original amount of £59.18 per session has been discounted as the practice payment for the 2016 scheme was agreed with

the BMA as a suitable amount to cover the practice expenses, a contribution to the retained GPs salary and to cover any educational support for the retained GP. Keeping the remuneration the same as the 2016 scheme avoids there being two different retainer schemes running with differing payments.

- A strong element of the future scheme is around education and CPD. The retained GP would be entitled to the pro rata full time equivalent of CPD as set out within the salaried model contract. The CPD aspects would be based on the needs of the individual, as established at their appraisal and in discussion with the educational supervisor.
- GPs can be on the scheme for a period of up to five years. In exceptional circumstances an extension can be made for up to a further 24 months.

Any retainers on the 2016 Retained Doctors Scheme will continue under these arrangements until 30 June 2019 after which time they will default to the new scheme.

Retainees who have been accepted on to the Retained Doctor Scheme 2016 (where the application form has been approved by the NHS England DCO) but who are not in post before 31 March 2017, will be accepted onto the GP Retention scheme without the need to re-apply.

GMS digital – non-contractual

We have agreed the following non-contractual changes for 2017/18, which will be taken forward through non-contractual working arrangements and which will be promoted in guidance:

- practice compliance with the ten new data security standards in the National Data Guardian Security Review
- practice completion of the NHS Digital Information Governance toolkit including attainment of level 2 accreditation, and familiarization with the July 2016 Information Governance Alliance guidance
- an increased uptake of electronic repeat prescriptions to 25 per cent with reference to co-ordination with community pharmacy
- an increased uptake of electronic referrals to 90 per cent where this is enabled by secondary care
- continued uptake of electronic repeat dispensing with reference to CCG use of medicines management and co-ordination with community pharmacy
- uptake of patient use of one or more online service to 20 per cent including, where possible, apps to access those services and increased access to clinical correspondence online
- better sharing of data and patient records at local level, between practices and between primary and secondary care.

Further work

GPC and NHS England have committed to take forward discussions in the coming months on a national programme of self-care and appropriate use of GP services and information sharing between practices.

Next steps

We believe that these contract changes deliver tangible improvements in a number of vital areas that will benefit practices from greater core resources, reimbursement of expenses and a reduction in bureaucratic workload. We are now working on detailed guidance with NHS Employers, to provide more detail about some of these areas.

As stated at the beginning of this letter, GPC is fully aware that the above agreement will not in itself solve the wider pressures faced by general practice. Having concluded these negotiated changes, GPC will now be focusing on securing from NHS England the delivery of the commitments which have promised through the [General Practice Forward View as well as in our Urgent Prescription proposals](#) to help stabilise general practice, as well as ensuring its sustainability to meet future demands.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Chaand Nagpaul'. The signature is written in a cursive style with a large initial 'C' and 'N'.

Dr Chaand Nagpaul
BMA GPs committee, chair