
General Practitioners

Dear Colleague

8 January 2008

IMPORTANT NEWS ON CONTRACT NEGOTIATIONS – PLEASE READ IN ITS ENTIRETY

Further to my letter of 20 December, I am writing again to update you on the current situation with GMS contract negotiations for 2008/09. General Practice is facing a period of considerable turmoil and potential conflict. It is therefore essential that all GPs, whether principals, sessional GPs or trainees, and whatever their contractual arrangement, are fully informed about the issues. This letter sets out the background of how the present situation has been reached and details the matters GPs should consider. **The GPC will be writing to the profession again shortly to seek the opinion of all GPs.**

Background to the GMS contract

The current UK-wide GMS contract was introduced in 2004, following two years of negotiations between the GPC and the 4 national governments. This was against a background of difficulty in recruiting and retaining GPs, low morale in the profession and an acknowledgement that GP income had fallen behind other professions. It followed an extensive survey of the profession and the results of this were used to inform the negotiations.

The contract changed from one where funding was related to the number of registered patients, item of service payments and the number of principals and did not reflect the quality of service a practice provided, to one which had far greater emphasis on rewarding the quality that was already being delivered. Most practices continued to improve the quality and range of services they provided through the Quality and Outcomes Framework (QOF). This resulted in significant increases in GP income but also considerable investment in their practices in terms of additional GPs and nurses and increases in practice productivity.

In 2006/7 the governments negotiated changes to the Quality and Outcome Framework (QOF) with the GPC on the understanding that this would address, **once and for all**, the perceived over-delivery concerns that government had with the contract. It is worth quoting the relevant paragraph from the UK Contract Agreement 2006/07.

“NHS Employers and GPC negotiating teams agree, with the full support of the four Departments of Health, that the 06/07 GMS review contract package addresses the perceived value for money issues associated with the original nGMS contract. These will not be revisited in future negotiations.”

This agreement introduced some new clinical areas such as Chronic Kidney Disease, Depression and Dementia and reallocated 138 points to these areas. Since the introduction of the contract in 2004, there has been no uplift to global sum payments and since 2005/06, no uplift in the value of the QOF points.

continued overleaf

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Registered office: BMA House, Tavistock Square, London, WC1H 9JP.
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2008-09 GMS contract negotiations

Since early October, negotiations have been ongoing between the GPC and the NHS Employers for proposed changes to the contract for 2008/9. Negotiations had been proceeding on the understanding that any changes made to the national contract would be dependent on agreement being reached in all four countries, with the devolved administrations free to negotiate access arrangements with their respective GPCs. At this stage the notice of imposition has been given in England only and the effect that this will have on Scotland, Wales and Northern Ireland is being clarified.

The Prime Minister has made it clear that extended opening is his only priority for General Practice. Whilst the GPC had significant concerns about discussing extended opening, it recognised the political reality of the current situation and it was prepared for the GPC negotiators to continue with discussions with NHS Employers and the departments of health.

The GPC made a number of proposals to try to reach an agreement with NHS Employers, negotiating on behalf of the government, which would allow practices to have the option to provide extended opening whilst preserving a good service to the large majority of patients who want to attend during normal hours. The GPC was prepared to discuss a package that would have offered extended opening hours and improved quality for the current level of funding. Unfortunately, NHS Employers, having taken further instructions from the Government, was not prepared to proceed on this basis and insisted on seeking further extended doctor consultation time with limited flexibility and the sacrifice of evidence-based potential new areas of work in exchange for non-evidence-based government-driven politically-motivated access targets.

The GPC was presented with an ultimatum from the English government that it should agree, on behalf of the profession, to their proposal. If it did not agree, then further, radical changes to the contract would be imposed in April 2008 which were significantly more damaging than the original proposals. The GPC felt that it was unable to accept what was being proposed and, in the light of the government's tactics, explicitly rejected their gun-barrel method of negotiation, and decided to seek the view of the profession. Therefore, as expected, on 21 December 2007 the English government moved to impose changes to the GP contract under a 13 weeks' notice period. In the event that there is no agreement between the GPC and NHS Employers on extended opening hours, or that the final version of the government's offer is unacceptable to a majority of the profession, these changes will be imposed from 1 April 2008, certainly in England. The information that follows is largely a result of the English government's agenda, although there will also be implications for the devolved nations.

Details of governments' pre-imposition proposals and the effect on practices

The governments' proposals:

- £158 million of funding from the 2007/08 Access and Choice and Booking DESs (in England) would be reinvested in extended opening as a DES including £2.80 per patient per annum for providing extended access
- 58.5 QOF points (38.5 from the holistic and organisation domains, plus 20 points from the patient experience domain) would be reallocated to support access arrangements
- Extended opening would be for 30 minutes per week per 1000 registered patients – this would need to be in blocks of 1.5 hours after 6.30pm or for one hour prior to 8.00am or on Saturday morning and would depend on agreement between the practice and the PCO reflecting local patients' wishes. This would be provided through a nationally agreed Directed Enhanced Service (DES), and practice participation would be voluntary
- Part of the funding available for access (35p per patient) would be dependent on the results of access questions contained in the QOF patient survey. This would include targets for 24/48 hours access and booking
- There would be 1.5% uplift in the contract value, although it is unclear how this would be allocated and what further practices would have to do to achieve this.

The government states that GPs are being given £158m to provide extended opening in addition to £100m of new money (in England). The reality is that the £158m is being removed from practices (from the existing Choice and Booking and Access DESs) and you are being given the opportunity to "earn" this money back. In terms of the new £100m or 1.5% uplift, should the Doctors' and Dentists' Review Body (DDRB) recommend an uplift less than this amount, the government have said that they would make good any shortfall. The details of this "promise" have not been made clear, although it is apparent that further work into extended hours would be expected. This would apply UK-wide although the nature of any extra work might vary in the four nations.

The GPC was prepared to redistribute 38.5 QOF points to new clinical areas including osteoporosis, peripheral vascular disease and a new heart failure indicator, but the government rejected this proposal in favour of allocating more QOF points to access arrangements. The government does not appear to be remotely interested in improving the quality of clinical care provided to patients.

Broadly speaking, if this offer was accepted, the financial effect on practices would be less detrimental than imposition as practices would retain a QOF of 1000 points and the potential to retain the practice funding level they had in 2007/08, with a 1.5% uplift to all contract streams. However practices should consider that to retain this funding they would need to provide extended opening hours in line with government demands which would increase expenses and thus represent a pay cut once the additional costs, including staff costs, of providing this service were met. As well as the cost, this would involve each full-time GP working, on average, an additional 51 hours per year. This would mean that it may not be economically worthwhile to participate in the DES and therefore practices could choose not to do so. Practices could also decide not to participate if they did not think patients wanted this service, or that to provide extended hours would adversely impact on the quality of in-hours services.

The 1.5% uplift would also have further conditions attached. There would be no guarantee that all the funding will be maintained, as part of the payment might be paid through DES arrangements. There would be a further risk that the government would come back in future years and seek yet more hours of work with little or no increase in resources.

Details of the government imposed contract changes and the effect this would have on practices

The imposed contract changes as detailed by the government (in England) are as follows:

- Extended opening funded via £158m from the 2007/08 Access and Choice and Booking DESs but locally agreed arrangements
- There would be 135 points permanently removed from QOF including clinical areas such as influenza vaccination and management areas such as computer security. The overall impact would be a QOF with only 865 points instead of the current 1000. Details of the points that would be removed are as follows:

QOF indicator	Points removed
Holistic care	20 points
Records 3: The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1 point
Education 4: All new staff receive induction training	3 points
Management 2: There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used	1 point
Management 4: The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care	1 point
Management 6: Person specifications and job descriptions are produced for all advertised vacancies	2 points
Management 10: There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access	2 points
Medicines 4: The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)	3 points
Medicines 11: A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%	7 points
CS05: The practice has a system for informing all women of the results of cervical smears	2 points

CHD12: The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7 points
STROKE 10: The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2 points
DM18: The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March.	3 points
COPD8: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6 points
PE2: The practice will have undertaken an approved patient survey each year	25 points
PE5: The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that: 1. Summarises the findings of the survey. 2. Summarises the findings of the previous year's survey. 3. Reports on the activities undertaken in the past year to address patient experience issues.	20 points
PE6: The practice will have undertaken a patient survey each year and, having reflected on the results, will produce an action plan that: 1. Sets priorities for the next 2 years 2. Describes how the practice will report the findings to patients (for example, posters in the practice, a meeting with a patient practice group or a PCO approved patient representative) 3. Describes the plans for achieving the priorities, including indicating the lead person in the practice. 4. Considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group.	30 points

- All lower QOF thresholds would be uniformly raised to 50%. The upper threshold would be raised to the national achieved average. In general, practices will lose money as the range gets narrower unless they are scoring above the higher threshold for that indicator
- There will be no QOF achievement payment until the end of the first quarter
- The funding, as described above, would be allocated to PCTs for them to agree local contracts for extended opening with any practices – including those newly set up private APMS practices. Experience has shown that it is likely that only a proportion of the funding would end up with any general practices if allocated to PCTs.

Practices faced with the loss of the funding currently within the Choice and Booking and Access DESs and the removal of 135 QOF points would lose in the region of £36,000 per 6000 patient practice¹ or approximately £12,000 per average full-time partner. There could be the opportunity to earn some of this money back from your PCO through locally commissioned arrangements, although there is no guarantee of this, as the government has made a distinction between 60 former QOF points that could be used by PCOs for “reinvestment in primary medical care” and 75 former patient experience QOF points that should be used to “reward GP practices on the basis of levels of patient satisfaction”. This suggests that PCOs will be directed by government to use funding previously used by GP practices to support the development of local APMS practices.

How would this affect PMS and S17C Practices (in Scotland)

Although these negotiations have been about GMS contracts, it would be usual for PMS practices to be offered the same DES arrangements and that their local contracts would be modified to deliver broadly similar working patterns to GMS practices. There are already a few PCTs in England quite prepared to damage their PMS practices by imposing unacceptable conditions on them. I expect that PCOs will be instructed to enforce a contract that will be at least as onerous as the governments’ offer, if it is accepted, and similarly will have the imposition visited on them if we reject the offer.

¹ The £158 million funding from Access and Choice and Booking DES equates to approximately £3.15 per patient per practice. This leads to an approximate loss of £19,000 per 6000 patient practice. The removal of 135 QOF points equates to a further loss of approximately £17,000 (calculated based on achievement of 135 points at £124.60). This does not take into account QOF prevalence.

Wider issues for GPs to consider

GPs should consider not only the details of the proposal and the imposition but also the background of how we got to the contract negotiations for 2008/09 and the Government's method of negotiation. Broadly speaking, if the "pre-imposition" offer was accepted, the financial effect on practices would be less detrimental in the short term, as set out above. Clearly, what the government is threatening to impose this year could well be its offer next year – less points in QOF and more extended hours. However I believe the profession should view this matter in its widest terms as this is not just a problem about this year's financial settlement. The NHS is undergoing some significant and worrying changes which demonstrate a lack of value placed on the quality of General Practice. It appears that the Prime Minister is prepared to ignore the views of the vast majority of patients in order to deliver on a personal commitment, and the enforcement of a consumerist short-term ideology onto a service dedicated to delivering needs-based holistic lifelong continuity of care. The government appears to be determined to move from traditional GP partnerships to one where the private sector would play a much greater part in the future structure and running of general practice. What is at risk is not simply a practice funding increase but the personal, list-based system of general practice that is so valued by the vast majority of our patients. When responding to my request to GPs to state their opinion in a poll in the near future, GPs should consider the wider implications of the choice they make.

The next steps

The next three months will be a challenging and unsettling time for GPs, practices and patients. The GPC will continue to try to achieve a negotiated settlement and will undertake a poll of opinion to seek the view of all GPs about whether they wish to accept or reject the government's final offer. In the event that the outcome of further negotiations is unacceptable to a majority of the profession, changes will be imposed from 1 April 2008.

GPs must study the government's pre-imposition offer and the imposition as outlined above and begin to think about whether the offer, together with the wider implications of doing so, is acceptable or whether rejecting the offer would actually be the better option. Talk with your partners, colleagues and the LMC, who will be able to help you understand the issues locally, to ensure that when you receive the poll of opinion from the GPC you are as informed as possible.

The GPC negotiators are continuing to develop their strategy, including how to respond in the event that the proposed contract changes are not accepted by the profession and the imposition becomes a reality. It is clear that the government's agenda is to introduce alternative providers to compete with GPs and this issue is going to remain whatever the outcome this year. In the meantime, GPs must respond to this threat by remaining united and by engaging with patients and MPs locally and highlighting the threats facing traditional general practice and the wider NHS. GPs should also consider their response in the event of an imposition. In considering the options we must be careful that our actions are not seen as self-seeking, will not damage patient health, will not risk damaging our relationship with our patients, and will not undermine the fundamental principles of the health service.

The GPC has already raised concerns about an NHS in England that is moving to meet the demands of the articulate at the expense of those in real clinical need by writing a letter to Lord Darzi on GP access and the interim report of the Next Stages Review. The content of this letter can be accessed here: <http://www.bma.org.uk/ap.nsf/content/lettertodarzi121207>

Finally, we need to demonstrate to our patients what they are in danger of losing. As a first step, the first of a series of patient newsletters '*supporting your local GP practice*' has been developed, a copy of which can be accessed via this link [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDF49074gpnewsletter/\\$FILE/49074GPNewsletter.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDF49074gpnewsletter/$FILE/49074GPNewsletter.pdf). We would ask all practices to display copies in their surgery waiting rooms.

The GPC negotiators do not believe that you should feel intimidated by threats of imposition or its implications. Rather, we believe that you should view this offer according to the needs of your practice and your patients in both the short and long term.

I will write to you again shortly.

Yours sincerely



Dr Laurence Buckman
Chairman, General Practitioners Committee