Important Message to all GPs in England from the Chair of the GPC, Dr Chaand Nagpaul

Dear Colleague,

I am writing to let you know that GPC has concluded negotiations with NHS Employers on changes to the GP contract for 2016/17.

Before setting out the detail of the changes, I would like to stress from the outset that we were clear that these annual revisions to the contract could not address the overwhelming pressures affecting general practice.

Many of the pressures on general practice relate to the environment we are working in, with soaring demand, inadequate numbers of GPs, excessive regulatory and bureaucratic burden, and unresourced and inappropriate workload shift, with many of these issues being locally determined. We have therefore been in parallel discussions with NHS England on tackling these wider issues, and will build upon this on the back of the special LMC conference demanding that government puts in place clear tangible plans to sustain general practice in the immediate and longer term. The BMA's 'Urgent Prescription for General Practice' will further widely publicise the challenges we face as well as offering the solutions we feel are necessary to government.

GMS contract changes for 2016/17

The BMA's General Practitioners Committee (GPC) has voted to accept the negotiated contract changes for 2016/17 as outlined below. We set out in these contract negotiations to put an end to the funding cuts of recent years by securing meaningful funding of expenses, particularly to take into account the rises in National Insurance costs, CQC fees and indemnity insurance fees; to reduce workload and bureaucracy and to not accept any further QOF additions or changes to contracted hours of availability.

These changes are far fewer than in previous years, and in keeping with the special conference resolution, to minimise the disruption of annual contract changes to practices. The agreement additionally sets the scene for potential future changes to the contract and for general practice more widely beyond 2016/17.

Contract uplift and expenses

We have negotiated an **investment of £220 million into the GP contract** for 2016/17, in recognition of rising financial pressures facing practices. This figure is more than double last year's investment and seven times the investment compared to 2014/15.

The DDRB were not confident of their formula to calculate GP expenses, and rather than risk another year of under delivery and a pay cut for GPs, we negotiated this uplift directly with NHS England for this year. For the first time, there has been explicit recognition of the specific components of our expenses, relating to additional Care Quality Commission (CQC) fees, indemnity insurance fees,

national insurance contributions, superannuation and increased utility and other charges. The uplift is designed to result in a pay uplift of 1% above expenses, likely to be the ceiling for all NHS staff. We intend to involve DDRB in discussions on building upon this methodology to calculate GP expenses and uplifts in future years.

This uplift will include a 28% increase to the item of service fee for vaccinations and immunisations which will rise from the current £7.64 to £9.80. 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 the growth in the population, as well as any increase in average practice list size.

Quality and Outcomes Framework (QOF)

Responding to the widespread concerns of GPs about unnecessary box ticking and micromanagement, GPC and NHS Employers have agreed that negotiations for 2017/18 will explore, among other possibilities, ending QOF in its entirety. For 2016/17 there will be no change to the number of QOF points available, and we have resisted introduction of any new NICE indicators or further increases to QOF thresholds. As stated earlier, CPI will be adjusted to increase the value of QOF points to reflect the changes in list size and growth in the overall registered population.

Enhanced Services (ESs)

We have negotiated that the **Dementia ES will end in March 2016** with the associated money transferred into core GP funding, without any out of hours deduction being applied. This ES was previously imposed and its removal will reduce bureaucratic workload as well as address concerns expressed by GPs regarding the scheme. During 2016, dementia diagnosis rates will be monitored and if necessary the position will be reviewed for 2017/18 if there is a significant change.

All other nationally determined enhanced services (ESs) will continue unchanged for a further year.

We have strongly expressed our concerns regarding the bureaucracy surrounding the Avoiding Unplanned Admissions (AUA) ES. As with QOF, we have agreed with NHS Employers to discuss during the next round of negotiations our wish for its discontinuation from April 2017 so that unnecessary workload burden for practices can be minimised.

Vaccinations and Immunisations

As previously stated, the item of service fee for vaccinations and immunisations will rise to £9.80. All vaccinations and immunisation programmes are to continue in 2016/17 with the exception of changes to meningococcal B, meningococcal C and meningococcal ACWY.

For meningococcal B, NHS Employers and GPC have agreed to withdraw the catch-up element of the programme, as well as to withdraw the delivery of paracetamol as this is no longer centrally supplied.

NHS Employers and GPC have agreed to implement the JCVI recommendation to remove the infant dose of MenC from the Childhood Immunisation Programme from April 2016.

NHS Employers and GPC have also agreed to extend the MenACWY 18 years to allow for the opportunistic vaccination of 19-25 year old non-freshers who self-present for vaccination.

Access survey

GP practices will be contractually required to provide data to inform NHS England of the availability of evening and weekend opening for routine appointments that patients could access in the local area (not necessarily at practice level) and is to be collected until 2020/21. The data will be collected every six months.

There will be no changes to the contracted current hours or the Extended Hours ES.

Non-contractual areas of agreement

GPC has secured a commitment from NHS England during negotiations to take forward discussions on:

- A national approach to reducing bureaucracy and workload management in general practice;
- A national promotion of self-care and appropriate use of GP services to manage demand;
- Revising arrangements for sickness payments under the Statement of Financial Entitlements to ensure they are appropriate and fit for purpose;
- The future approach to expenses, seeking to determine an appropriate methodology that all parties might use.

IT

NHS Employers and GPC have agreed to support IT developments in general practice, and to encourage appropriate uptake and use of IT in 2016/17. These are **non-contractual changes** and many of these should benefit practice workload, as well as patient experience. The GP Systems of Choice programme is the process by which the nationally approved and funded systems necessary to provide the patient online facilities will be made available to GP practices by NHS England:

- GP2GP compliant practices will continue to utilise the GP2GP facility for the transfer of all patient records between practices, except where there are known limitations. GPC and NHS England have also agreed that the GMS regulations will be amended so that practices are no longer required to seek permission from NHS England not to print the electronic record where records successfully transfer using GP2GP v2.2;
- To aim for at least 80% of repeat prescriptions to be transmitted electronically using the Electronic Prescription Service Release 2 by 31 March 2017;

- Practices will be encouraged to make referrals electronically using the NHS e-Referral Service, aiming for at least 80% by 31 March 2017;
- GPC and NHS England will jointly consider ways in which GP practices can be resourced to offer patients the opportunity to add additional information to the Summary Care Record;
- To aim for at least 10% of registered patients to be using one or more online service by 31 March 2017;
- Practices will receive guidance on signposting the availability of apps approved through GPSoC to patients to allow them to book online appointments, order repeat prescriptions and access their GP record;
- GP practices will provide patients with online access to clinical correspondence such as discharge summaries, outpatient appointment letters, and referral letters unless it may cause harm to the patient or contains references to third parties;
- NHS England and GPC will jointly develop a national template data sharing agreement, to facilitate information sharing between practices locally for direct care purposes.
- From April 2016, GP practices will be required to receive all discharge summaries and subsequent post-event messages, electronically;
- NHS England and GPC will continue to promote the completion of the Health and Social Care Information Centre (HSCIC) information governance toolkit, including adherence to the requirements outlined within it.

Named GP

NHS England will discuss with GPC during 2016/17 how appropriate and meaningful data relating to the named accountable GP can be made available at practice level through automatic extraction. This will be particularly relevant for patients being case managed and also those aged 75 and over. The data would be shared internally within practices and used for peer review and quality improvement. It is recognised that there are a number of system issues to overcome and that any implementation can only take place once these have been resolved.

Extraction of former QOF and ES data

Practices will be reminded to make this data available for extraction, in keeping with the historic agreement on retired QOF indicators and ESs. If necessary, this will become a contractual obligation from April 2017 linked to discussions about the discontinuation of QOF.

Locum GPs

NHS England propose setting a maximum indicative rate based on a set of rates (which may have some degree of regional variation) for locum doctors pay. If NHS England are able to set a rate they will amend the electronic declaration system to include recording on the number of instances where a practice pays a locum doctor more than the maximum indicative rate. Setting an indicative rate will not prevent locums and practices agreeing the appropriate rate for the work done.

Access to healthcare

GPC will work with DH and NHS England to develop arrangements for identifying patients with European Health Insurance Card (EHIC) and S1[1] and S2[2], through patient self-declaration at the point of registration, and recording their details with the aim of implementation in December 2016. Discussions will consider how to address any additional workload for GP practices.

Next steps

As I stated at the beginning of this letter, the above agreement will not in itself solve the wider pressures faced by general practice. However, the contract changes provide increased core resources and reimbursement of expenses to an extent not achieved in recent years; a long overdue uplift to the vaccination and immunisation item of service fee, and removal of the dementia DES. There is also a commitment to work with NHS England to look at ending the current burden of QOF and the Avoiding Unplanned Admissions enhanced service, and a national approach to reducing workload and managing demand. Having concluded these negotiated changes, GPC will now be focussing on securing from NHS England and the DH a clear and urgent action plan to stabilise the current parlous state of general practice, as well as ensuring its sustainability to meet future demands.

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[1] The S1 is a European healthcare entitlement form for state pensioners living in a different European country to where their pension is paid. The S1 certificate of entitlement allows state pensioners access to the healthcare system in the European country where they have chosen to retire, and for that country to reclaim costs.

[2] The S2 form is a mechanism that entitles patients to state-funded pre-authorised treatment in another EEA country or Switzerland, with the treatment being provided under the same conditions of care and payment as for residents of that country