FAQs

How will the contract changes this year affect practice funding?

The agreement this year delivers an important investment which, for the first time in recent years, recognises the components of rising GP expenses, specifically in the coming year relating to additional Care Quality Commission (CQC) fees, indemnity insurance fees, national insurance contributions, superannuation and increased utility and other charges. It also provides an intended 1% pay uplift, and also a long overdue 28% rise to item of service vaccination payments. The uplift to the overall contract value is more than twice that of last year, and seven times more than in 2014/15. It also ends the bureaucracy and workload of the previously imposed dementia enhanced service, with resources going into global sum, as well as preventing any changes to GP contracted hours and further QOF additions

How will these contract changes affect the wider pressures on general practice?

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.

There is also a commitment to work with NHS England to implement a national strategy to manage demand through self-care and appropriate signposting of patients to other services. It has also been agreed with NHS Employers that negotiations for 2017/18 will explore, among other possibilities, ending QOF in its entirety, as well as ending the Avoiding Unplanned Admissions enhanced service.

These changes will, however, not address wider overwhelming pressures in general practice, many of which relate to the environment GPs are working in, with soaring demand, inadequate numbers of GPs, excessive regulatory and bureaucratic burden, unresourced and inappropriate workload shift, with many of these issues being locally determined. GPC is therefore 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.

Will these changes equally apply to PMS practices?

Yes. The changes will be reflected for PMS practices and the £220 million covers investment for both GMS and PMS practices.

Will practices be required to do any new clinical work as part of the contract changes in 2016/17?

No, there are no new clinical requirements and no changes to QOF indicators in 2016/17. There will in fact be a reduction in the workload relating to the Dementia ES which will end and with the corresponding resource being transferred to global sum.

Will DDRB be used in the future to recommend pay uplifts to practices?

The DDRB were not confident of their formula to calculate GP expenses, and rather than risk another year of under delivery and a further pay cut for GPs, GPC negotiated this uplift directly with NHS England for 2016/17.

The £220 million investment into the contract for 2016/17, which includes an intended 1% pay uplift, is a much needed recognition of the rising financial pressures facing practices.

This agreement covers the 2016/17 year only and does not impact on the potential future use of the DDRB as an independent pay review body. We will be looking to discuss the development of a robust methodology for calculating GP expenses and uplifts in future years.

Will the money transferred to core general practice funding benefit all practices?

The £220 million investment into the contract for 2016/17 covers a number of elements, including an increase to the global sum for all practices to include an intended 1% pay uplift, rising Care Quality Commission (CQC) fees, indemnity insurance costs, national insurance contributions, superannuation and increased utility and other charges. All practices will also receive an increase to the item of service fee for vaccinations and immunisations (from £7.64 to £9.80) and an increase to the value of a QOF point as a result of a Contractor Population Index (CPI) adjustment to take in to account the growth in the population, as well as any increase in average practice list size.

Those practices who receive correction factor payments will also have their budget uplifted by receiving the increased global sum payments. They will however still be subject to the government's imposed removal and recycling of correction factor until 2020. As stated above, the contract revisions will also be applied to PMS practices. Changes to PMS funding will also continue in line with local agreements.

Will the money transferred to core general practice funding be subject to the 5.34% out-of-hours deduction?

Only the 1% pay uplift component will be subject to the 5.34% out-of-hours deduction, as in previous years' uplifts. The remainder of the investment, along with the funding transferred into global sum as a result of the cessation of the Dementia ES, will not be. The percentage deduction for OOH opt-out will be reduced as in previous years to deliver this.

What is the requirement on practices for the access survey?

Practices will be required as part of the contract to provide data on whether patients have access to routine evening and weekend appointments. This information would be provided to NHS England twice a year and is to be collected until 2020/21. These appointments do not need to be practice based and could apply to access to a locality or challenge fund hub.

There are no changes to contractual opening hours and there is no requirement for practices to themselves offer evening and weekend appointments.

Are there any contractual changes linked to 7 day working?

Contractual hours and the Extended Hours ES will remain the same. There is no requirement for practices to themselves offer evening and/or weekend appointments.

If NHS England is able to set maximum indicative rates for locum doctors' pay, what will this mean for practices and locums?

If NHS England is able to set an indicative rate for locum doctors' pay, practices will be asked on an annual basis to declare on the electronic declaration system the number of times they have had to exceed this rate when employing locum GPs.

It is important to note that this does not mean that practices will be limited in the amount that they are able to pay for a locum or the amount a locum can charge. Locum GPs and practices will continue to be able to agree the appropriate rate for the work done.

Information produced from this could be used to inform assessing practice expenses in the future.

What will the implications be for practices if they are asked to identify EHIC, S1 and S2 patients? Will these patients be charged by the practice?

The detail of this proposal is subject to agreement between NHS Employers and GPC and will not take effect prior to December 2016.

These proposals will only apply to patients registering who have moved from a European nation. Further discussion will take place between GPC, the DH and NHS England to develop arrangements for identifying patients with European Health Insurance Card (EHIC) and S1 and S2 status. It has been agreed that identification of these patients will take place through patient self-declaration at the point of registration.

Discussions will cover how to address any increase in practice workload as a result of this.

Practices will not be responsible for charging these patients for accessing primary care services. NHS Employers and NHS England have confirmed that patients will not be responsible for meeting charges directly and instead this information will be used to seek recovery of primary care costs from their home nations, as appropriate.

What are the implications for practices regarding data extraction on named GP? Is the information provided to the practice about named GP to be shared more widely or just for internal peer review?

This proposal from NHS Employers has no detail as yet and will form part of discussions during 2016/17. It is therefore not part of contractual change in the coming year. The intention from NHS England is that this data will enable quality improvement through internal reflection and peer review.

GPC has been clear in our discussions with NHS Employers that any data which is extracted from practices in relation to the named GP must be appropriate and meaningful. It has been agreed

that this data will be made available for internal use within practices, for example for peer review.

Discussions will take place between GPC and NHS England during the coming year about how such extraction could take place and what exactly the data would be used for internally. It is clear that careful consideration must be given to any system issues that may need to be overcome. Further, any workload implications for practices would need to be taken into account, as well as the need to resource this.

Practices are reminded of the GPC guidance on the 'named accountable GP for all patients' requirement, which was extended to all patients from 1 April 2015.

What happens if my practice does not achieve the IT targets that have been set?

These changes are **non-contractual** and there are no additional contractual IT requirements for practices to meet in 2016/17. Practices will be supported by NHS England and GPC to make increased use of these IT systems. We expect uptake to be encouraged at a pace that suits individual practices and their patients. Many of these initiatives could reduce practice workload and enhance patient experience.

However, it's worth noting that some of the targets serve as a reminder of existing contractual requirements. For example, since April 2014 practices have been required under the GMS regulations to utilise GP2GP for the electronic transfer of patient records between practices (subject the certain conditions).

The IT requirements introduced to the GP contract in 2014/15 and 2015/16 are outlined within separate BMA guidance.