BMA

England

Important message to all GPs in England on changes to the GP contract for 2018/19, from Dr Richard Vautrey GPC England Chair

Dear Colleague,

The BMA GPs committee (GPC) England has concluded negotiations and reached agreement with NHS Employers on changes to the GP contract for 2018/19.

While we know that these amendments will not resolve many of the fundamental issues impacting general practice, our aim has been to provide stability to GMS/PMS contracts where possible, to deliver much needed funding to address current GP practice expenses and increase core resources, and to work towards securing a long overdue pay increase.

We have agreed that **£256m** will be invested into the contract, which is significantly more than last year. This will be increased further should we achieve a positive outcome from the DDRB process. However it is also important to note, that we have also commenced several major areas of work to resolve the many problems we highlighted in Saving General Practice, which combined should provide much needed provision for practices to better manage their daily working lives.

2018/19 contract agreement

Contractual changes

GP pay and expenses

We have not agreed to accept a further pay uplift of 1% this year. Instead we have agreed that from 1 April 2018, an interim payment for GP pay and expenses will be made whilst we await the outcome of the DDRB process. Therefore, pay will be initially uplifted by 1% and expenses funding will be uplifted in line with CPI. This will mean that, together with the annual recycling of correction factor and seniority payments, global sum with initially rise from £85.35 to **£87.92.**

These figures will be reviewed following the recommendation from the Review Body for Doctors and Dentists Remuneration (DDRB) and subsequent government decision, where there is potential for further increases. The BMA's submission to the DDRB calls for a significant uplift to GP pay and expenses, of RPI plus 2%. Any increased uplift secured through the DDRB process will be back-dated to 1 April 2018, recognising the significant delays to this process for the current session.

Indemnity increase cover

We have agreed a sum of £60m to cover the average uplift in indemnity for the last two years. This will both be paid to practices in 2018/19 on a per-patient (unweighted) basis. Practices should ensure that an appropriate equivalent amount is passed on to any salaried GP and/or partner that pays for some or all of their indemnity cover.

As with last year, locum GPs should ensure their charges reflect their costs (including indemnity costs).

SFE amendments

In order to ensure all real expenses are covered, we have agreed that vaccinations and immunisations that are reimbursed through the SFE will be uplifted by CPI[1]. The item of service fee for these immunisations will be uplifted from £9.80 to £10.06. It is our intention to secure a similar inflationary increase for other immunisations as soon as possible.

Amendments to V&I schedule

In addition to the above financial changes, we have agreed some amendments to the clinical aspects of vaccinations and immunisations through the SFE. These are summarised below:

- the three month dose of pneumococcal has been removed from the targeted childhood immunisations scheme, based on the recommendation from the JCVI. The funding for this element of the childhood immunisation will be unaffected.
- Meningococcal ACWY (MenACWY) completing dose - the date of eligibility has changed from 1/4/15 to 1/4/12 therefore all patients within the age range are now eligible. Practices are not required to proactively offer or encourage patients to be vaccinated. Vaccination of 14-16 years is only where the patient has missed schools provision.
- Meningococcal B – there are no changes to the vaccinations programme, however the requirements are now defined in the SFE rather than in a service specification.

[1] Increase to £10.06: Hepatitis B at-risk (new-born babies), HPV completing dose, Meningococcal ACWY freshers, Meningococcal B, Meningococcal completing dose, MMR, Rotavirus, Shingles routine, Shingles catch-up
Remaining as previously: Pneumococcal (PCV – remaining at £15.02), Childhood seasonal influenza, Pertussis, Seasonal influenza and pneumococcal polysaccharide

Amendments to reimbursements for locum cover for parental and sickness leave

Following our success at securing guaranteed payments for parental leave and sickness cover in recent years, we have now agreed that these payments should both be increased to avoid their value eroding with inflation. As such, parental leave payments will increase from £1,131.74 to £1,143.06 for the first two weeks[2] and £1,734.18 to £1,751.52 for subsequent weeks and the upper amount for sickness payments will increase from £1734.18 to £1751.52.

In addition to this, we have agreed to clarify the rules for locum cover reimbursement such that from 1 April 2018, if a contractor chooses to employ a salaried GP on a fixed-term contract to provide cover, NHS England will reimburse the cost of that cover to the same level as provided for locum cover, or a performer or partner already employed or engaged by the contractor.

Electronic referral service

Following changes to the NHS standard contract (between the CCG and local hospitals), from October 2018 hospitals will only receive payment for standard referrals if they are made through e-RS. As such, most CCGs are already implementing a programme to move to full use of e-RS for all 1st consultant referrals. As of December 2017, 62% of referrals were made in this way and the use is now likely to be much higher. However, despite many areas of the country already routinely using e-RS, there is wide variation across local health economies; there are some areas were there has been little or no support to use this system or there are system-wide issues that have yet to be resolved. We expect CCGs to work with LMCs and practices to resolve local system issues.

While it will be a contractual requirement to use e-RS for all GP practice referrals to 1st consultant led outpatient appointments, we have secured agreement that NHS England will take a supportive not punitive approach where circumstance dictates that practices are unable to realise this. Guidance will be clear that this does not mean that individual GPs have to use the e-RS system themselves. There are a variety of models that practices could adopt, and it is for practices to determine how much of the e-RS process is done by administrative staff.

In addition, practices will not be penalised if e-RS is not fully implemented in their locality, for example, where services are not available to refer into or IT infrastructure is incapable of delivering an effective platform. These system-wide issues will be dealt with, including listening to and working with practices and LMCs in the area who will be kept involved in agreeing any revised paper switch off date.

We have secured £10m investment into the contract this year to ensure practices are financially supported to implement the system. NHS England and GPC England have also agreed guidance for practices.

A national implementation team is in place which is working with all CCGs across the country to assist with implementation and training activity and will work with individual practices to ensure any issues are resolved in order to ensure an effective and efficient

[2] We previously reported (in error) that this was for the first week when it is actually for the first two weeks.

system that that minimises workload for the practice. We have agreed that NHS England will work with GPC to conduct a post-implementation review to identify implementation challenges, including any workload implications, and this will inform the next round of negotiations.

We know that there are many issues that need to be resolved to ensure practices have a better referral system in the future than they currently do now. IT infrastructure, inadequate bandwidth, local contingency processes, appropriate referral pathways, delays in hospitals dealing with referrals and inappropriately declining referrals are just some of the many issues we will be working to resolve.

QOF

As with last year, and while the national QOF review is ongoing, there will be no changes to QOF indicators for the coming year. The contractor population index (CPI) will be adjusted to reflect the changes in list size and population growth, with the value of a QOF point being adjusted to take account of this. This will mean the value of a QOF point increasing from £171.20 to £179.26.

Violent patient removal provisions

We have agreed to clarify the regulations that already allow for patients to be refused registration where there are 'reasonable grounds' for doing so – having a violent patient flag on the patient's record is consider to be a reasonable ground for refusing to register.

We are further strengthening these regulations to allow a practice to remove a patient who has joined them from a previous practice who removed them because of a violent incident and placed a violent patient flag on their record.

Where a patient is removed under the violent patient regulations, they will be put onto the appropriate 'Special Allocation Scheme' unless that patient refuses to be registered at any practice (remembering that they will still have a flag on their record and can be refused registration as outlined above).

Premises Cost Directions

We have secured many positive changes to the premises cost directions (PCDs) which are outlined in the FAQ below and will be expanded upon in a specific 'Focus on changes to the PCDs' to be published shortly.

While the changes we have secured are important and positive, we have been very clear that there needs to be a more fundamental review of GP premises, as in many areas in the country it is premises problems that are leading practices to hand back their contract, as well as this being a major disincentive to becoming a GP partner. We have therefore, in line with one of our key goals in Saving General Practice, agreed with NHS England and the Department of Health and Social Care, that a major review of GP premises will be conducted.

In addition to the above changes, we have also agreed for the global sum to be increased to represent increases in the size of the population. Taken together, this package will deliver a minimum of £256m of new funding in to the contract, but this may increase through the DDRB process. This compares favourably with funding uplifts agreed in recent years.

Non-contractual changes

As in previous years, we have agreed a number of areas on which we will work with NHS England, but which are not contractual.

Electronic Prescribing Service (Phase 4)

We have agreed for a number of pilots to move to phase 4 of EPS roll-out. This would require regulatory changes but would only involve a number of practices who agree to the pilots. This moves to a fully electronic prescribing service, with no option to opt-out for patients.

Out of Hours KPIs

We have agreed to discuss and test new Out of Hours key performance indicators (KPIs) which will replace the current National Quality Requirements later in the year..

Social prescribing services

We will encourage the development and use of social prescribing which could help to reduce practice workload and improve patient services.

Patient access to online services

Support will be offered for the minority of practices who have less than 10% of patients signed up to use practice online services.

Advertising private GP providers

NHS England has been made aware of a practice that has been advertising a private GP provider within their building and which could be considered as promoting an alternative to their own NHS service. NHS England and GPC England are committed to ensuring GP services are free of charge to all patients and have agreed that the practice of directing patients to private providers for services that they themselves are commissioned to provide is inappropriate.

NHS England and GPC will work together with CCGs and LMCs, to ensure this practice stops.

In addition to the above, we will encourage the uptake of the NHS Diabetes Prevention Programme, the sharing of appropriate information with social care providers and, when

appropriate, for practices to remind overseas patients when they are referred of charges in secondary care.

Other agreements as part of the package

We have secured agreement on two areas that frequently arise as problems. These are for Hepatitis B immunisations for renal patients and for medical students.

- NHS England has committed to work with specialised commissioning and secondary care colleagues, to ensure that it is clear that the responsibility to deliver hepatitis B vaccination to renal patients lies with the renal service and not with general practice.
- GPC, NHS England and HEE will work together to ensure all medical schools provide services for the provision of hepatitis B vaccines for medical students, to ensure that this burden does not fall to practices without appropriate funding arrangements being in place.

Finally, we have agreed to work with NHS England on:

- a replacement for NHS Digital's General Practice Extraction Service (GPES)
- use of GP appointments data which is already being extracted
- support for practices wishing to work at scale
- the potential of a basic practice allowance
- the implications of the EU falsified medicines directive
- reducing the administrative burden on practices
- research into locum usage (working with GPC's Sessional GPs subcommittee)
- appropriate and agreed systems for 'freedom to speak up' whistleblowing arrangements

Next steps

Whilst this agreement will provide much needed additional funding and contract stability, we are under no illusion that it will solve all the issues we raised in Saving General Practice, but it does build on the important progress we have made in the last 2 years.

It is therefore, important to recognise that we are already working on potentially major changes for 2019. We have secured a significant commitment to a state backed indemnity scheme to be introduced from April 2019 and we are currently engaged with the process of designing and delivering such a scheme.

Likewise we have secured agreement for a fundamental review of practice premises, we are currently engaged in a wholesale review of QOF and have commenced a review into how to reinvigorate the partnership model of delivering general practice. We are also working with NHS England and others on further workforce initiatives. These will all inform negotiations next year.