March 2018

Summary of 2018/19 General Medical Services agreement

This note sets out a summary of the key changes to the General Medical Services (GMS) contract in England for 2018/19. These changes have been agreed between NHS Employers, on behalf of NHS England and the General Practitioners Committee (GPC) of the British Medical Association (BMA).

Contract uplift

The contract for 2018/19 will see an investment of £256.3 million, which is an overall increase of 3.4 per cent.

This additional investment is to uplift the contract and to take into account other agreed changes, covering:

- an investment of £60 million to cover GP indemnity costs for 2017/18
- an uplift to allow an increase to the Item of Service (IoS) fee for certain vaccination and immunisations (V&I) from £9.80 to £10.06, in line with consumer price index inflation
- an uplift of £22 million to allow a change in the value of a Quality and Outcomes Framework (QOF) point as a result of a Contractor Population Index (CPI) adjustment
- a non-recurrent investment of £10 million to recognise additional workload associated with the implementation of e-Referral contractual requirements.

This investment will be added to the global sum allocation with no out-of-hours (OOH) deduction applied. Funding to cover indemnity payments is unweighted. All other uplift payments are on a weighted basis.

This will provide a one per cent uplift to pay and a three per cent uplift to expenses in line with consumer price index inflation.

A further uplift may be made following the Government's response to any recommendations by the Review Body on Doctors' and Dentists' remuneration (DDRB). The DDRB recommendation is expected in May 2018.

The maximum figure practices can be reimbursed for locum costs will increase by one per cent, along with other changes to locum reimbursement set out below.

Indemnity costs

There will be a non-recurrent investment of £60 million, paid in March 2018, to cover the increased costs of indemnity for the year 2017/18. This will be distributed directly to practices, mirroring the arrangements for the indemnity payments made in March 2017.

NHS England and GPC have agreed to work constructively on any contractual implications of a state-funded scheme for indemnity which will cover all GPs (contractors, salaried, locums and trainees) and all practice staff for NHS work.

Premises Costs Directions

NHS England and GPC have recently agreed changes to the 2013 Premises Costs Directions.

It is recognised that there is a need to undertake a further review of premises used to provide primary medical care in England. This review (to commence by the early summer of 2018) will also address some outstanding issues from the review of the Premises Costs Directions.

The premises review will include, but not be limited to, helping to ensure that premises used for primary medical care are fit for purpose into the future bearing in mind likely service and other developments, and that they promote the recruitment and retention of GP contractors as well as representing value for money. The review will also provide a better picture of the overall position on primary care estates and help to ensure better integration of services into the future.

The review will be led by NHS England and the Department of Health and Social Care (DHSC) working with GPC and other key stakeholders, and will be underpinned by as clear an understanding of the evidence base as can be collated. It is likely to take six months and will make recommendations on next steps as soon as possible. The recommendations will be taken into account in any further national premises negotiations.

Direct booking

GPC has noted NHS England's stated intention that direct booking by clinicians from 111 CAS (clinical assessment service) into practice systems should be rolled out universally as soon as possible. GPC also notes that potential benefits and implications of direct booking into practice systems for patients and practices will be demonstrated as this work progresses. Over the next year, NHS England and GPC will work together to support further use of 111 direct booking where agreed with practices, to fully evaluate benefits and address any concerns about its implementation and potential consequences. Lessons learned, and the solutions reached, will inform a discussion in the 2019/20 contract negotiations.

Advertising

NHS England and GPC agree that NHS-commissioned practices must not advertise private providers of GP services which the practices should be providing free of charge on the NHS. NHS England and GPC will work together, supporting the local clinical commissioning group (CCG) and Local Medical Committee (LMC), to ensure this does not happen. If necessary, this will be reinforced by a contractual clarification for 2019/20.

Contractual changes

Electronic prescription service

Regulations will be amended[1] to implement electronic prescription service (EPS) Phase 4, allowing an initial phase of implementation to support a planned roll-out during 2018/19. The pharmaceutical regulations will also be amended to cover all pharmacists as patients may go outside of the area to get their prescription. The initial phase of implementation is yet to be agreed but it is anticipated to include a limited selection of practices.

It will be important to learn the lessons from the initial phase to ensure that issues identified are resolved, to enable practices to be properly supported where they have implementation challenges. An NHS patient awareness campaign (including resources to help practices to manage patient concerns) will be undertaken to ensure patients are aware of the changes and to reduce any burden on practices in this regard. There will be a local fall-back process if the system is not operational and NHS England and GPC have also agreed to explore how secondary care providers might begin to make use of the EPS system to benefit patients.

NHS e-Referral service

The target for this programme is to have all health systems using the NHS e-Referral Service (e-RS) for all their practice to first, consultant-led outpatient appointments, from October 2018 – and to have switched off paper referrals.

Where paper switch off has been achieved, practices will be expected, through a contractual change, to use e-RS for these referrals from October.

The national e-RS programme continues to support local systems in delivery of e-RS by October 2018. Latest utilisation figures are 62 per cent for December 2017. Utilisation varies across local health economies and in some areas is lower than others. Programme resources are supporting these areas with their local project delivery. Some, but not all providers are ready and all have plans in place. From now until October, the e-RS team will work closely with CCGs and practices to target support for primary care and practices.

Where there are concerns from local GPs, the CCG will meet with them, to listen and understand those concerns and jointly develop and deliver action plans to address any issues. In addition, the national e-RS implementation team is working on national products to raise awareness and understanding of e-RS. These include guidance which has been co-created with GPC, as well as videos and training materials, which outline the different ways practices can implement e-RS including what support can be given by other members of the practice team.

Overall, NHS England’s approach to e-RS implementation will be a supportive one with any contractual action being a last resort. Where a practice is struggling to use e-RS, there would be a contractual requirement to agree a plan between the practice and CCG to resolve issues in a supportive way as soon as possible.

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

[1] Changes to regulations are expected in October 2018

incapable of delivering an effective platform. These system-wide issues will be dealt with, including listening to and working with practices and GPs in the area who will be kept involved in agreeing any revised paper switch off date.

While the majority of practice referrals are now already being made by e-referral, NHS England is aware that there is still concern by some GPs about aspects of e-RS rollout and the implications for practices. Therefore, a major part of the implementation approach will be to work with local systems, including those practices, to clarify this, resolve the issues and support their adoption of e-RS. NHS England and GPC are committed to work together to continuously improve the referral process and to deliver an ever more efficient and effective system that minimises workload for the practice. 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 contract negotiations.

Violent patients

Regulations already allow practices to refuse registration where there are reasonable grounds for doing so, and NHS England and GPC have agreed that a “violent patient” flag against a patient record would constitute reasonable grounds.

Regulations will also be amended to allow a practice which has mistakenly registered a patient with a “violent patient” flag to be able to deregister that patient by following the same procedures for removing patients from a practice list who are violent.

Where patients are removed under violent patient provisions, further care will be managed in line with agreed national policies, including where appropriate special allocation schemes.

Patient access to online services

There will be a contractual change so that practices that have not achieved a minimum of 10 per cent of patients registered for online services – online ordering of repeat prescriptions, online appointment booking or online access to patient records – will work with NHS England to help them achieve greater use of those online services.

Out-of-hours key performance indicators

The National Quality Requirements (NQR) will be replaced with new key performance indicators (KPIs). NHS England and GPC will work together to test the new indicators and thresholds, with the intention of amending the regulations when reference to the NQR will be replaced with a reference to the new urgent care KPIs.

Reimbursement of locum cover

Locum reimbursement for parental leave and sickness absence will be simplified. 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 cover provided by a locum, or a performer or partner already employed or engaged by the contractor.

Vaccination and immunisations (V&I)

We have agreed an uplift to the IoS fee for the following programmes, from £9.80 to £10.06, from 1 April 2018.

- 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

The IoS fee for the following programmes is unchanged at £9.80 per dose.

- Childhood seasonal influenza
- Pertussis
- Seasonal influenza and pneumococcal polysaccharide

The payment for pneumococcal PCV will remain at £15.02.

In addition to these increases to the IoS fee, NHS Employers and GPC have agreed to the following V&I programme changes from April 2018.

- Hepatitis B (newborn babies) – programme name changed to Hepatitis B at-risk (newborn babies). Vaccine changes and number of recommended doses reduced to three, therefore the payment of the second dose has now been uncoupled from the third dose. This was an in-year change effective 30 October 2017, included for completeness.
- MenACWY 18 years on 31 August – programme removed.
- Meningococcal completing dose – cohort extended to include eligible school leavers previously covered by the 18 years programme. Eligibility now 1 April 2012.
- Meningococcal B – programme moved in to the Statement of Financial Entitlements (SFE), but is not included in the childhood targeted programme (Annex I of the SFE). There are no changes to eligibility of payment requirements.
- Pneumococcal PCV three-month dose – removed from the targeted childhood programme, the date this change is effective from will be confirmed. The funding for the remaining dose will remain at £15.02.

The following programmes will roll forward unchanged.

Programmes in SFE

- Shingles routine programme for 70-year olds
- MMR over 16-year olds
- HPV completing dose for girls 14-18 years
- Rotavirus

- Pertussis.

Programmes with service specifications

- Shingles catch-up for 78 and 79-year olds
- MenACWY freshers
- Childhood influenza 2 and 3-year olds
- Seasonal influenza and pneumococcal polysaccharide.

Non-contractual changes from April 2018

Quality and Outcomes Framework

The average practice list size (CPI) had risen from 7,732 as at 1 January 2017 to 8,096 at 1 January 2018. As such, the value of a Quality and Outcomes Framework (QOF) point will increase by £8.06 or 4.7 per cent from £171.20 in 2017/18 to £179.26 in 2018/19.

QOF indicators continue unchanged with the exception of a minor change to the clinical codes that make up the register for learning disabilities. As such, the indicator ID had changed from LD003 to LD004. See QOF FAQs[2] on the NHS Employers website for further details.

No indicators have been removed and there are no changes to thresholds.

Cost recovery for overseas visitors

In the 2017/18 GMS agreement, contractual changes were made to help identify patients with a non-UK issued European Health Insurance Cards (EHIC) or S1 form. These changes have yet to be fully implemented, in terms of IT systems, and the workload and practical impact have yet to be fully understood. NHS England and GPC have agreed to review the implementation of this agreement in the 2019/20 negotiations.

In the meantime, NHS England and GPC will issue joint guidance recommending that where appropriate, practices remind patients that they might be charged for NHS services outside the practice and to make available to patients the nationally produced literature on this.

GMS digital

NHS England and GPC have agreed to build on the work of recent years to develop high quality secure electronic systems and proactively encourage patients and practices to use them. These changes that we have agreed for 2018/19 will be taken forward through non-contractual working arrangements which we will jointly promote in guidance.

These include:

- continued uptake of electronic repeat dispensing to a target of 25 per cent

[2] NHS Employers. FAQs. http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/faqs-and-queries

- continued uptake of patient use of one or more online service to 30 per cent including, where possible, apps to access those services and increased access to clinical correspondence online.
- practice completion of the NHS Digital Information Governance toolkit (IGT), including adherence to requirements and Level 2 accreditation
- practice implementation of the National Data Guardian's (NDG) ten data security standards.

GP data

GPC and NHS Digital will work together to develop a framework for the delivery of a new GP data service to replace General Practice Extraction Service (GPES). The new service will improve capacity and functionality, reduce cost burdens and ensure data collection is appropriate and meaningful. It is anticipated that any new system will be operational from 2019/20 at the earliest.

GP appointment data

NHS England, GPC, NHS Digital and system suppliers will work together to facilitate appropriate collection, analysis and use of anonymised, standardised appointment data, to better understand workload pressures in general practice. We will also work together to contextualise data where possible, to ensure data is appropriately interpreted and used.

Diabetes

CCGs should ensure appropriate and funded services are in place, to allow practices to refer patients to the NHS Diabetes Prevention Programme (NHS DPP). We encourage practices make use of such services when appropriate for their patients.

Working at scale

NHS England and GPC agree on the importance of providing support to practices that wish to develop integrated and at-scale models of primary care building on the GMS contract and designed to both provide benefits to patients and greater resilience for practices. We will work collaboratively on this issue.

Social prescribing

CCGs will develop and provide funding for appropriate local social prescribing services and systems, with input from local practices and local medical committees (LMCs), to enable practices to refer patients to local social prescribing 'connector' schemes within the voluntary sector, where they exist in their locality. This may include patients who are lonely or isolated, have wider social needs, mental health needs or are struggling to manage long-term conditions. Practices will be encouraged to use such services to enable patients to connect to community support, improve prevention, address the wider determinants of health and increase their resilience and ability to self-care.

Sharing of information with partners

NHS England and GPC recognise the important role social care providers have in the provision of care for patients. We therefore encourage practices to share relevant information with social care providers, subject to the usual safeguards including confidentiality, where systems and/or procedures are in place to do so appropriately.

Freedom to speak up

In November 2016, NHS England published guidance on freedom to speak up in primary care. We have agreed that we will work together to determine the most effective way of introducing an appropriate and agreed system for general practice. We would aim to implement this no later than 1 April 2019.

Locum data

NHS England, GPC and the Department of Health and Social Care (DHSC) will work together to improve data on locum usage by undertaking a piece of research with a sample of practices. These parties, as well as the BMA's Sessional GPs subcommittee, will work together from the outset on the design, analysis and outcomes of the study.

Reducing the administrative burden

NHS England, GPC, and DHSC will work together to take urgent steps to reduce the administrative burden in general practice, taking into account issues highlighted in GPC's Urgent Prescription for General Practice and Saving General Practice.

Basic practice allowance

We discussed the possibility of introducing an unweighted element of the funding formula, something akin to the former basic practice allowance, to reflect practice costs that are not linked to the characteristics of their practice population. We agreed that this would be discussed as part of the funding formula review.

Hepatitis B (HepB) vaccination for renal patients

NHS England will work with specialised commissioning and secondary care colleagues, to ensure that it is clear the responsibility to deliver HepB vaccination to renal patients lies with the renal service and not with general practice.

HepB vaccination for medical students

NHS England, GPC and Health Education England (HEE) will work together to ensure all medical schools provide services for the provision of HepB vaccines for medical students, to ensure that this burden does not fall to practices without appropriate funding arrangements being in place.

Falsified Medicines Directive

NHS England and GPC have had some initial discussions about the implementation of the falsified medicines directive which may come in to force in February 2019. Discussions will continue in-year and will include addressing the workload and capital requirements for practices.

Private arrangements

NHS England has recently completed consultation on low value medicines. We have agreed that if NHS England decides to implement any changes to the provision of travel vaccination for patients which would involve a change in the Regulations, we would discuss this in-year rather than wait for the next round of negotiations.