

## Focus on revisions to the GMS contract 2006/07

This guidance note has been produced by the General Practitioners Committee (GPC) to help GPs and Local Medical Committees (LMCs) understand the changes and developments that have been made to the GMS contract for 2006/07. We would advise all GPs to read the contract guidance 'Revisions to the GMS contract 2006/-7 – delivering investment in general practice' available on the BMA website [www.bma.org.uk](http://www.bma.org.uk). This guidance note should be read in conjunction with the other 'focus ons' that have been, or will be, published following the contract review.

### Background and summary

As part of the original contract negotiations, the GPC and NHS Employers agreed that the GMS contract, as implemented on 1 April 2004, would be reviewed for 2006/07. The changes have been agreed by the GPC, NHS Employers and the health departments of England, Scotland, Wales and Northern Ireland. The key changes include:

- a review of the Quality and Outcomes Framework (QOF), with several new or revised areas
- in England, new directed enhanced services (DEs) for practice based commissioning, access, information management and technology, and patient choice and booking
- in England, the introduction of a new patient experience survey
- in Scotland, new directed enhanced services for cardiovascular disease risk database, learning disabilities, carers and cancer referral and re-badging of the 50 QOF points for access into a new directed enhanced service
- in Wales, new directed enhanced services for access, information technology, learning disabilities and severe mental health
- in Northern Ireland, new directed enhanced services for access and long-term chronic disease
- in England and Wales, a new system for paying dispensing doctors and more transparent arrangements for reimbursing VAT.

The GPC has aimed to protect current earnings. The participation in the delivery of Government priorities, through the DEs, has ensured that there is some level of new investment available. Although the GPC appreciates that many practices would not see these as priorities in terms of providing enhanced patient care directly, we believe that they provide the opportunity for practices to obtain resources with which to implement activities that many practices would get involved with regardless.

The growing financial crisis in the NHS, and subsequent pressure from the Treasury has created a particularly difficult climate for these negotiations and pressure to claw back some of the 2003-2006 new earnings has been severe and constant. Due to the fact that the cost of the introduction of nGMS was far more than the Treasury and the Department of Health had anticipated, seeking new investment and uplift to already existing contract funding streams was always going to be an extremely difficult task. The GPC agreed to work with NHS Employers to ensure that any changes to the contract were fair to the profession, provided a better service for patients and represented good value for money. The GPC agreed to this on the basis that any agreement would address the perceived value for money issues associated with the original nGMS contract and these will not be visited in future negotiations.

Separate 'focus on' guidance notes will be available on all the DESs in each country as well as a further guidance note on the dispensing review. A focus on revisions to the QOF is also available. It is intended that this guidance note provides some overall information on the general changes that have been made to the contract, as well as any financial implications.

### **Two-stage review**

This guidance note, as well as the joint GPC/NHS Employers guidance 'Revisions to the GMS contract 2006/07' relates to the changes that will be made to the contract from 1 April 2006. It has been agreed that negotiations for stage 2 of the review, for implementation in 2007, will take place in light of the publication of the White Paper 'Our health, our care, our say: A new directions for community services' in England (and similar in the other three countries) and following the conclusion of the Formula Review Group discussions and recommendations.

### **Inflationary cost pressures**

There will be no uplift to any existing element of the contract for inflation or cost pressures in 2006/07. It was agreed that all new investment would be via the new DESs. Although we appreciate that not all practices will wish to participate in the DESs, and therefore may not have access to this new investment, due to the context in which the negotiations took place it was not possible to secure any additional funding for existing contract funding streams.

### **Efficiency savings**

The absence of inflation or cost pressure increase and the release of 138 QOF points, to be either redistributed throughout the QOF or replaced with new work, represents a level of efficiency savings. All negotiating parties have agreed that the 2006/07 contract review package addresses the perceived value for money issues associated with the original nGMS contract. These will not be revisited in future negotiations.

All parties recognised the responsibility of the four health departments and NHS Employers to demonstrate ongoing improvements in efficiency as part of ongoing negotiations or commissioning processes within the NHS. This normal process of refinement will apply to future GMS negotiations as it applies other NHS services. The GPC believes that this process of continuing efficiency should apply to the expenses element only.

### **Contractor Population Index (CPI) (England and Wales)**

The CPI reflects the national average list size. It is used primarily to allocate QOF payments to practices relative to their list size. Because estimates of this figure have increased between 2003/04 and 2005/06 there has throughout negotiations been a constant pressure, from the Department of Health, to increase the CPI value. This would have the effect of decreasing QOF payments to practices with static list sizes for reaching the same level of achievement by creating a fixed 'pool' of payments systems that would not reflect the increased QOF workload created by rising populations. The GPC's consistent policy has been to resist moves towards a fixed 'pool' system.

The result of negotiations on this matter is that there will be no change to CPI this year, with the proviso that the SFE will be amended so that from 1 April 2007, the CPI mechanism becomes an in-year resource-neutral redistributive tool based on an average list size updated in January each financial year. Such a change however will be dependent upon a separate mechanism being agreed and funded as appropriate as an integral element of GMS negotiations to recognise changes to the QOF workload as a result of a change in population numbers. The GPC will be negotiating this mechanism over the coming months.

### **Normalisation**

Normalisation of weighted practice populations will now take place quarterly on a national basis, rather than at PCO level. This will hopefully address some of the problems which

practices experienced during 2005/06 when normalisation was applied annually at a national level, which led to unpredictable and destabilising changes in practice global sum payments.

### **Enhanced services floors**

#### Existing enhanced services

Enhanced services floors (ESFs) for 2006/07 will be frozen at 2005/06 levels. The GPC is aware that ESFs remain a constant and vexed issue, particularly in terms of how PCOs can be encouraged, or even forced, to spend up to the floor. It is of concern that PCOs have stated that they will not spend up to their floor, but instead use underspends to help offset their deficits. Although there has been no formal national negotiation with respect to 2005/06 enhanced services floors underspends, LMCs should encourage PCOs to roll forward this funding into the 2006/07 floors.

The GPC's position remains that the ESF should be spent on contestable enhanced services, as a minimum, and we will continue to press the Department of Health and NHS Employers to instruct, encourage and performance-manage PCOs to spend up to the floor. However, on a local level, if PCOs are refusing to spend up to their floors, the GPC advises that practices should not provide unfunded services. The GPC's position remains firm that PCOs cannot expect enhanced services to be provided where they do not properly resource this work. If practices feel that funding is insufficient to provide such services they should, in consultation with their Local Medical Committee (LMC), no longer provide such services.

#### New enhanced services

Expenditure on the new DESs in all four countries will be monitored over and above the 2006/07 enhanced services floor. Funding for these new DESs is already in PCO's budgets as part of the 2006/07 allocations. It should also be noted that as practices may not elect to provide services under these DESs, or as they may not achieve target payment levels, the 2006/07 funding can only be an indicative figure.

In England, expenditure on the new access DES will be apportioned so that the 2006/07 ESF still includes the full value of the previous access DES and that expenditure on the 2006/07 access DES above this level (i.e. utilising the funding transferred from the 50 QOF access points) should be recorded against the 2006/07 that includes the new DESs.

For all enhanced services, the established criteria according to which a service can be funded from the ESF, - that it directly provides patient services and is contestable, remains unchanged. Any local disputes regarding investment in GMS should first be discussed between LMCs and PCOs and, where all local routes have been exhausted, be referred by the LMC (or SHA) to the NHS Employers/GPC/DoH Implementation Coordination Group (ICG).

### **Maternity**

Improved arrangements have been agreed for providing maternity cover to GP practices with access to increased resources. The maximum maternity, paternity and adoptive leave payment for locum reimbursement will be increased from £980.00 to £1500.00 from the third week of the potential entitlement onwards although PCO discretion will remain. The Department of Health will monitor, as part of the normal FIMS returns, the extent of PCO discretion exercised in making these payments in 2006/07. LMCs are encouraged to discuss this matter with their PCO and to try and ensure that practices are receiving the maximum amount possible. PCOs should also be reminded of their obligation, under the Statement of Financial Entitlements, to update their protocol in respect of locum cover payments.

### **Vaccinations and immunisations**

An amendment has been made to childhood immunisation target payments. Prior to the introduction of Pediacel ('5 in 1' vaccine) in September 2004, the target payment scheme consisted of four separate vaccine lines. Achievement in each vaccine line contributed equally in determining whether the target had been achieved and the level of payment awarded.

Pediacel reduced the total number of vaccine lines to two (as illustrated below) with the result that the MMR vaccine carried a weighting of 50% of the overall total in determining the calculation of achievement, making it more difficult for some practices to reach the targets and earn the target payment.

The MMR weighting will revert to 25% from April 2006, and meningitis C will be introduced into the target payment system, so from April 2006, the weighting for childhood vaccinations and immunisations targets for all four countries will be:

- Group 1: diphtheria, tetanus, polio, pertussis, haemophilus influenza type b (pediacel) (50%)
- Group 2: measles, mumps, rubella. (MMR) (25%)
- Group 3: meningitis C (25%)

The Statement of Financial Entitlements will be amended to reflect this new calculation methodology and the payments system will be updated to ensure practices target payments are calculated in line with these new arrangements from 1 April 2006. Worked examples for the calculation of the new target payments will be available in the revised SFE.

However, following the recent CMO announcement concerning pneumococcal vaccine and an additional HiB vaccine, there will have to be further negotiations to achieve full and fair resourcing of these changes which are due to be introduced later in the year. We will issue further guidance when these negotiations have been completed.

### **Managing practice lists**

The GPC guidance note 'focus on patient registration' has been replaced with a joint statement from the GPC and NHS Employers on managing practice lists. This is designed to encourage practices and PCOs to work together to ensure that patients are clear when and where they can register with a primary medical care provider. This states that:

"It is recognised that in certain circumstances there are difficulties in managing practice lists. In an attempt to offer a practical and transparent solution to patients, practices and PCOs the following advice is offered. This advice is provided in the context of promoting constructive working relationships between practices and their PCOs.

In the situation that a practice is unable routinely to accept new patients (beyond immediate family members of existing patients), a discussion between the practice and the PCO should take place to allow the situation to be explored. The PCO is expected to work constructively with the practice to try to jointly achieve resolution. This could take the form of, for example, additional support given by the PCO to the practice. In some situations, practices may wish to use the closed list procedure.

It is recognised that GMS contractors retain their freedom within the contract not to register new patients, provided they have reasonable, non-discriminatory grounds for doing so in each case."

LMCs and practices are reminded of their right to refuse to register new patients under paragraph 17 of Part 2 of Schedule 6, or its equivalent in the other three countries. The contractor does not need to make an official declaration of its intention to refuse to register

new patients. It must, however, provide the patient with a written notice of the refusal and the reason for it. The PCO may still assign patients to the contractor's list under paragraph 32 of Part 2 of Schedule 6, as its list is open to assignments within the meaning of the Regulations. A contractor should bear in mind that the PCO may ask it to justify the reasonable grounds that it has used to refuse to register a patient. There are equivalent procedures in the Regulations of the other three countries of the UK.

There is further mention of the intention to improve patients' ability to register with a primary medical care provider of choice in the English Department of Health's White Paper "Our Health, Our Care, Our Say: a new direction for community services". This may have some impact on GPC discussions with NHS Employers in the forthcoming year.

#### **What can LMCs do?**

- Refer practices to the guidance 'Revisions to the GMS contract 2006/07 – delivering investment in general practice' for further information
- Work with PCOs to ensure that enhanced services floors are spent up to the expected levels
- To discuss the maximum level for maternity reimbursement with PCOs to ensure that their protocols in respect of locum cover payments is updated, and to seek that the maximum level for reimbursement is increased to £1500 per week.
- To remind practices of their obligations when they refuse to register new patients.