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To: PCT Chief Executives
SHA Chief Executive

Gateway Ref: 18276

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Dear Colleague,

GENERAL MEDICAL SERVICES (GMS) CONTRACT 2013/14

The Department of Health is writing to the BMA General Practitioners Committee today to set out some proposed changes to the GMS contract in England for 2013/14. As this is likely to raise a number of questions for GP practices, I am writing to explain the context for the Department's proposals and to provide further information.

The reason for writing to the BMA in this way is that it has not yet proved possible to reach a negotiated settlement on the 2013/14 contract. This means that the Department of Health may need to vary the contract without agreement from the BMA. Should this be the case, we would need to have undertaken a consultation process with them. This letter signals the beginning of this process and identifies the range of changes which may be made. Of course, it is still possible that agreement can be reached before the end of this period.

The Department has proposed a 1.5% uplift in GP practice income, which it considers would allow for an average pay increase of up to 1% for GPs and practice staff, in line with wider public sector pay policy for 2013/14, and a wide margin for increases in non-staff expenses. If a negotiated settlement cannot be reached, however, the Doctors and Dentists Review Body will be invited to make recommendations on overall uplift.

Given the significant efficiency savings that will continue to be expected of all other NHS healthcare providers, the Department regards it as essential to secure improvements in the GMS contract that will help support continuous improvements in quality of care and health outcomes.

The Department's proposals are outlined further in the attached note but the key proposals are

- delivering equitable 'core' funding between GP practices over a seven year period starting in April 2014 to reflect proposals that the BMA and NHS Employers have developed

- making changes to the Quality and Outcomes Framework (QOF) to incorporate all the new or replacement clinical indicators recommended by the National Institute for Health and Clinical Excellence (NICE) and raising QOF thresholds so that more patients benefit from evidence-based care that enhances quality of life and reduces mortality

- discontinuing QOF organisational indicators, on the basis that they reflect basic standards of good organisational practice that should not need financial incentives

- using the expenditure freed up from these organisational indicators to help pay for the new QOF indicators recommended by NICE and to introduce new enhanced services that support quality improvement and promote innovation.

The Department is aware of concerns about practice workload and proposes to design these potential new enhanced services in ways that will support general practice to make most effective and efficient use of resources to improve quality of care, for instance in relation to diagnosis and care for people with dementia, care for frail or seriously ill patients, enabling patients to have on-line access to services, and helping people with long term conditions monitor their health. The Department has signalled that it would want to ensure that these arrangements support GP practices in working collaboratively and with peer support – through their clinical commissioning group – to achieve these improvements and to help improve overall use of NHS resources.

The proposals set out in the letter concern GMS contracts, but we anticipate that the Department and the NHS Commissioning Board (NHSCB) would wish to ensure a consistent and equitable approach in relation to Personal Medical Services (PMS) agreements. Naturally, the NHSCB has been involved in discussions about both GMS and PMS potential changes.

The Department is encouraging BMA to continue to work with NHS Employers (who act on behalf of DH) to continue discussions with a view to reaching a negotiated settlement. We will provide further information if a negotiated settlement is reached.

Yours sincerely,

Dame Barbara Hakin
National Managing Director of Commissioning Development
Department of Health

GMS CONTRACT 2013/14

The Department's proposals are set out below. If a negotiated settlement cannot be reached, the Government will make final decisions in the light of the BMA's response to consultation on these proposals.

Increases in investment

The Department proposes that, if it is possible to reach a negotiated settlement, overall investment in the GMS contract should increase by 1.5% to allow for average pay increases of up to 1% for GPs and practice staff and increases in non-staff expenses. If a negotiated settlement cannot be reached, the Doctors and Dentists Review Body would be invited to make recommendations on uplift.

Equitable 'core' funding

The Department proposes to invite the NHS Commissioning Board to take forward proposals that the BMA and NHS Employers have developed for phasing out the Minimum Practice Income Guarantee (MPIG) and achieving equitable 'core' funding.

This would involve calculating a single weighted capitation price, based on current average expenditure on 'global sum' payments, correction factor payments (under MPIG) and basic elements of PMS funding. GMS practices would then move over a seven-year period to that common capitation price. We understand that the NHS Commissioning Board, which will take over responsibility for PMS agreements on the abolition of PCTs, would wish to follow the same approach for PMS agreements, subject to consultation with the individual contractors involved.

This would mean moving in a controlled and phased way towards equitable funding for all GP practices, based on the numbers of patients they serve with an appropriate weighting for demographic factors that affect relative patient needs and practice workload. Given the work needed to prepare for these changes, these changes would begin from April 2014 and would not affect the 2013/14 contract.

The Department intends that these changes should include appropriate adjustments to the capitation formula to ensure that sufficient weight is given to deprivation factors.

Quality and Outcomes Framework: clinical indicators

The Department proposes to implement in full the recommendations made by NICE for new clinical indicators for the QOF and for retiring or replacing some existing indicators. This will help ensure that the QOF reflects the most up-to-date evidence on those interventions that have the greatest impact on quality of care, particularly in relation to people with complex health and care problems and people with conditions that put them at greater risk of premature mortality.

The Department proposes to raise the upper thresholds for QOF indicators so as to promote improvements in the numbers of patients who benefit from the evidence-based care reflected in the QOF. At present, these upper thresholds (i.e. the % of patients with a given condition or risk factor for whom practices have to offer the relevant interventions to get maximum QOF payments) are below average achievement levels. Independent research has shown that, when the QOF was first introduced in 2004, it is likely that it reduced mortality by 11 lives per 100,000 people, but that providing the same interventions for all relevant patients could save 56 lives per 100,000 people each year. The Department proposes to raise upper

thresholds over a two-year period so that they are in line with the upper quartile of current performance and maintain that link in setting future thresholds.

QOF organisational indicators and Quality and Productivity indicators
The Department proposes to:

- retain the existing Quality and Productivity indicators for a further year in 2013/14

- discontinue the organisational domain of the Quality and Outcomes Framework, on the basis that the areas for which it rewards GP practices (e.g. record-keeping, staff training) should be regarded as standard practice and should not require financial incentives

- propose to reinvest fully into the contract the money released from the organisational domain, with some used to help fund the new clinical indicators recommended by NICE and the remaining money used for enhanced services to support practices in providing better care and support to patients.

The Department would propose to design these enhanced services in ways that will:

- support general practice to make most effective and efficient use of resources to improve quality of care in certain priority areas, such as in relation to diagnosis and care for people with dementia, care for frail or seriously ill patients, enabling patients to have on-line access to services, and helping people with long term conditions monitor their health

- ensure that the arrangements also support GP practices in working collaboratively and with peer support – through their clinical commissioning group – to achieve these improvements and to help improve overall use of NHS resources

- support practices to achieve the desired improvements over a phased two-year implementation period.

Correcting QOF anomalies
The Department proposes to amend the QOF indicator wording and business rules to reflect better the annual nature of most QOF interventions, thereby preventing the unintended anomaly of some practices being rewarded for two years for interventions only carried out (or offered) in one.

The Department also proposes to correct an anomaly in relation to the Contractor Population Index that is used to adjust QOF payments to reflect comparative list size. Its proposal is that the Index should be based on the actual average practice list size at the start of the final quarter before the financial year in question. This would ensure that there is a clear, transparent relationship between QOF payments and relative list size and that year-to-year changes in the Index reflect actual changes in average list size. The face value price per point in 2013/14 would be increased by 16% in 2013/14 to recognise the price that is actually paid to the average practice.