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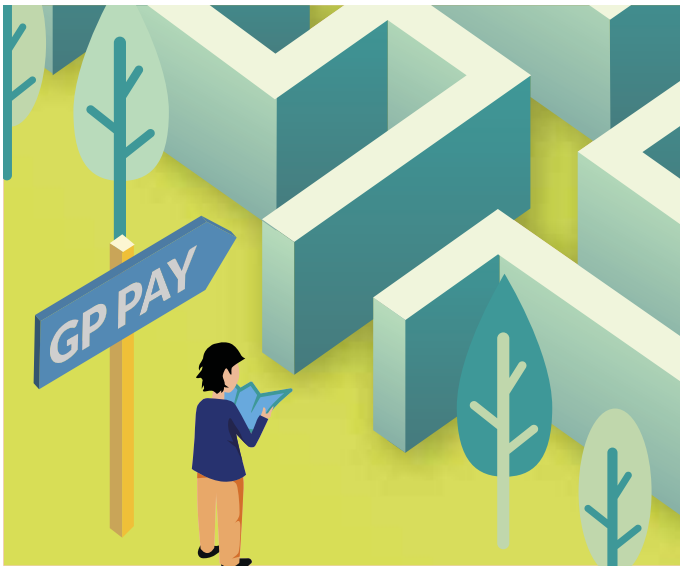
CONTRACT SPECIAL

How the GP pay and contract changes 2018-19 will affect you

The GP pay system has never been simple and on top of a delayed award this year there are many tweaks and updates for practices to get familiar with. AISMA's **Deborah Wood*** guides you through the money maze



The Government's announcement last month of its pay review for doctors in England has generally fallen short of the Doctors' and Dentists' Review Body (DDRB) recommendations.

A minimum 2% increase for all salaried doctors and an additional 2% above that minimum, net of expenses, was recommended for GP partners by the pay board.

But instead, the Government's response has been a below inflationary increase – and that is a further pay cut in real terms.

The actual award announced by the new Secretary of State Matt Hancock included a one year pay deal of 1.5% for consultants, 2% for trainees, 3% for speciality doctors and 2% for GPs.

But only the GPs' award is backdated to April 2018. The other medical professionals will see their award take effect from 1 October 2018. For those doctors not receiving their money until October this will effectively halve the benefit of the uplift for 2018-19.

For GPs the 2% increase includes the 1% interim pay uplift announced previously. This

therefore increases the contract baseline overall by 4.2% compared to 2017-18.

The additional backdated uplift for 2018-19 for a GP contractor with median taxable income of £100,000 will be around £2,000 a year.

However, little of this additional funding will find its way into the monthly drawings of many GPs. At this level of earnings, it is likely that tax, NIC and contributions into the NHS Pension Scheme will absorb around 60%, leaving just £65-£70 a month in additional personal drawings.

For salaried GPs the uplift does not apply until 1 October 2018.

GPs will also benefit from a 3% uplift to their appraiser fees and trainer grants, from 1 October 2018.

The Government has also instigated a move for contract reform and the development of a multi-year agreement from 2019-20. The carrot for this idea is a further 1% uplift to be paid for 2019-20 on top of any negotiated settlement for the contract for that year.

This 1% is anticipated to be reflected into the element of the contract paid towards practice staff as well as for the GPs' own remuneration, and there will be a similar uplift for salaried doctors.

Plans for the new multi-year contract will deliver investment linked to improved services.

The Government has stated that it was unable to honour the DDRB recommendations in full due to the need to recruit large numbers to expand the GP workforce.

But the lack of investment in the existing workforce will surely just mean even more senior and experienced GPs decide to leave the profession early as they continue to feel undervalued for the work they do.

Now it's time to assess the impact

With the 2018-19 financial year now underway, practices must be fully aware of contract changes and the impact these could have on funding and workload

It is difficult for GPs and managers to plan for the financial impact on their practices when the Government only confirmed the pay award as late as the end of July 2018.

The monetary effects will not start to come in to practices until October 2018, over half way through the financial year.

From 1 April 2018 an interim 1% allowance for the pay award has been included for practices in England. This has now been increased to 2% following the July announcement and will be backdated to 1 April.

Statistics published by NHS Digital for 2015-16 in September 2017, the latest available, show that average expenses are increasing faster than gross income.

Expenses rose by 2.8% while gross income went up by only 1.02%. The expenses to income ratio rose by 0.7% to 64.9%.

Given the fact that the new award is set at only 2% - which is below the expected level of inflation for 2018-19 - it is difficult to envisage that the expenses to income ratio will fall in the current year.

Contract uplift

There was an initial investment of £256.3m into the core contract to cover:

- a 1% interim pay uplift for GPs
- a 3% inflationary increase to cover expenses
- a 1% increase in locum allowances
- increases to vaccination/immunisation payments
- QOF point values changed to reflect population ratios, and
- a new electronic referrals system payment.

Given a population total for registered patients across GP practices in England of 58.9m at 1 January 2018 this amounts to a total investment of £4.35 per patient.

The new global sum per weighted patient rose by £2.57 from the 2017-18 figure of £85.35 to the current year's figure of £87.92.

Following the latest pay award confirmation, the global sum per weighted patient will be further increased by £1.04 to £88.96. This will be implemented in the contract payments from 1 October 2018.

Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS)

Any changes announced to the core GMS contract are mirrored via PMS and APMS.

PMS and APMS payments will also be uplifted by a further £1.04 per weighted patient backdated to 1 April 2018.

Locum allowances

First week £1,143.06, then £1,751.52.

From 1 April 2018, if a contractor chooses to employ a salaried GP on a fixed-term contract to provide locum cover, NHS England (NHSE) 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.

Quality and Outcomes Framework (QOF)

The value of a QOF point will be adjusted in 2018-19 to consider population growth and relative changes in practice list size using data at 1 January 2018.

Based on the data at January 2018 compared to January 2017, there has been an increase in average list size from 7,732 to 8,096. This means the value of a QOF point will rise from £171.20 to £179.26.

There are no changes to QOF thresholds in 2018-19.

QOF indicators continue unchanged except for a minor change to the clinical codes that make up the register for learning disabilities.

Indemnity costs

There was a non-recurrent investment of £60m based on unweighted patient numbers, to be paid before the end of March 2018 to cover the increased costs of indemnity for the year 2017-18.

This is a payment of £1.017 per registered patient which follows on from the £30m paid towards indemnity costs in March 2017.

Enhanced services

The learning disabilities health check scheme continues unchanged except for a minor alteration to the clinical codes that make up the register.

All other Directed Enhanced Services (DESs) continue unchanged.

Vaccinations and immunisations

The item of service fees for the following programmes are 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, the following programme changes are made from April 2018:

- Hepatitis B (new-born babies) – programme name changed to Hepatitis B at-risk (new-born 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. The eligibility is 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 two and three-year olds
- Seasonal influenza and pneumococcal polysaccharide.

The item of service fee for nine vaccinations and immunisations programmes increased by 26p from £9.80 to £10.06. These are:

- 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.

Seniority

As previously agreed, seniority payments will cease on 31 March 2020 and there will be a 15% reduction in seniority payments year on year.

Those GPs being paid or eligible for seniority payments on 31 March 2014 will continue to receive payments and progress as currently set out in the SFE during the phasing out process.

The money from the seniority pot is recycled into the global sum.

There is still a time lag in finalising the amount of seniority a GP may be entitled to due to the link with final average superannuation and the problems being experienced with the GP payment system.

In theory the final factors are known to 2014-15 but Primary Care Services England (PCSE) may not yet have updated its systems to that date.

Interim seniority factors based on average NHS superannuable earnings

- 2014-15 £96,097 (England) £84,012 (Wales)
- 2015-16 £95,001 (England) £86,926 (Wales)
- 2016-17 £94,982 (England) £87,219 (Wales)
- 2017-18 £93,540 (England) £89,047 (Wales).

Final seniority factors

2014-15 £89,573 (England) £82,155 (Wales).

Get ready for more changes ...on the way from October

There have been a few changes announced that will not take place until October 2018:

1 Electronic referrals system (e-RS)

A non-recurrent payment of £0.17 per weighted patient from an investment of £10m has been agreed for 2018-19, distributed directly to practices to support the full transition to 100% e-Referrals.

The national programme aims for near 100% delivery of e-RS by October 2018. Latest utilisation figures are 62% for December 2017. This 62% figure masks large differences between local areas and between practices.

Programme resources are supporting these areas with their local project delivery. Some, but not all, providers are ready for this and all have plans in place.

From now until October the e-RS team will work closely with Clinical Commissioning Groups (CCGs) and GPs to target support for primary care and practices.

The national e-RS implementation team is also working on national products to raise awareness and understanding of e-RS.

These include guidance which has been co-created with the GPC, as well as videos and training materials, that will outline the different ways practices can implement e-RS - including what support can be given by other members of the practice team.

The target for this programme is to have all CCGs and trusts using e-RS for all their practices for first, consultant-led, outpatient appointments from October 2018, and to have switched off paper referrals.

Where paper switch off has been achieved then practices will be expected, through a contractual change, to use e-RS for these referrals from October 2018.

Where a practice is struggling to use e-RS, there will 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 incapable of delivering an effective platform.

NHS England will work with the GPC to conduct a post-implementation review to identify implementation challenges, including any workload savings or burdens, and this will inform the next round of contract negotiations.

2 Electronic prescription services: (EPS)

The relevant regulations will be amended to allow an initial phase of implementation to support a planned roll-out during 2018-19. The pharmaceutical regulations will need to 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 decided as we went to press but it is anticipated to include a limited selection of practices at this stage.

"NHS England will work with the GPC to conduct a post-implementation review to identify implementation challenges, including any workload savings or burdens, and this will inform the next round of contract negotiations."

It will be important to learn the lessons from the initial phase to ensure any identified issues are resolved so practices are properly supported where they have implementation challenges.

An NHS patient awareness campaign, including resources for practices to manage patient concerns, will be run to ensure patients are aware of the changes and to reduce any consequent burden on practices.

It has been agreed there must be a local fall-back process if the system is not operational.

Practices that have not achieved a minimum of 10% of patients registered for online services will work with NHSE towards the target.

3 OOH key performance indicators (KPIs)

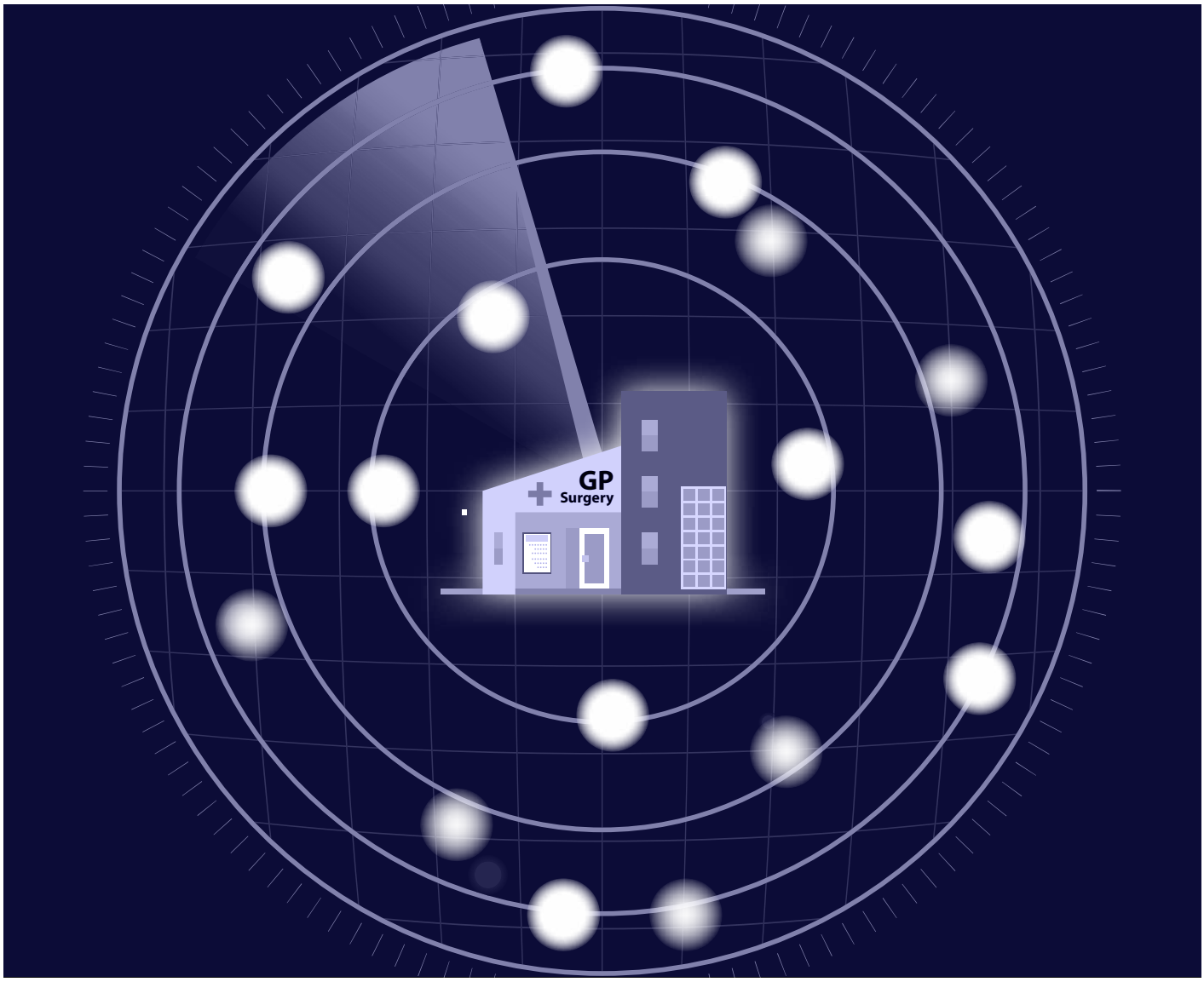
The National Quality Requirements (NQR) will be replaced with new KPIs. NHSE will work with the GPC to test the new indicators and thresholds with the intention of amending the regulations by October 2018 when reference to the NQR will be replaced with a reference to the new urgent care KPIs.

4 Violent patients (VP)

Regulations already allow practices to refuse registration where there are reasonable grounds to do so. A 'VP flag' against a patient record would constitute reasonable grounds.

The regulations should be amended to allow a practice which has mistakenly registered a patient with a 'VP flag' to be able to deregister that patient by following the same procedures for removing patients who are violent from a practice list.

If a patient is removed under the violent patient provisions further care will be managed in line with agreed national policies. This includes, where appropriate, special allocation schemes.



On your radar! 17 big issues to keep an eye on

The 2018-19 contract documentation also sets out several agreed principles that all parties are working towards:

1 Direct booking

Over the next year, the GPC and NHSE 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.

2 Advertising

NHSE and the 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.

The GPC and NHSE will work together, supporting the local CCG and LMC, to ensure this does not happen. If necessary, this will be reinforced by a contractual clarification for 2019-20.

3 Working at scale

GPC and NHSE 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 both to provide benefits to patients and greater resilience for practices.

4 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 Card (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. The implementation of this agreement will be reviewed in the 2019-20 negotiations.

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

5 Electronic repeat dispensing

Promote continued uptake of electronic repeat dispensing to a target of 25 per cent, with reference to CCG use of medicines management and coordination with the community pharmacy.

6 Patient access to online services and clinical correspondence

Non-contractual changes to joint guidance that will promote uptake of patient use of one or more online services to 30 per cent including, where possible, applications to access those services and increased access to clinical correspondence online.

7 Cyber and data security

Building on the work of the 2017-18 agreement, practices are encouraged to complete the NHS Digital Information Governance toolkit (IGT), including adherence to requirements, and attain Level 2 accreditation.

Building on the work of the 2017-18 agreement, practices are encouraged to implement the National Data Guardian's (NDG) 10 data security standards.

8 GP data

NHS Digital and the GPC will work together to develop a framework for the delivery of a new general practice data service to replace the 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.

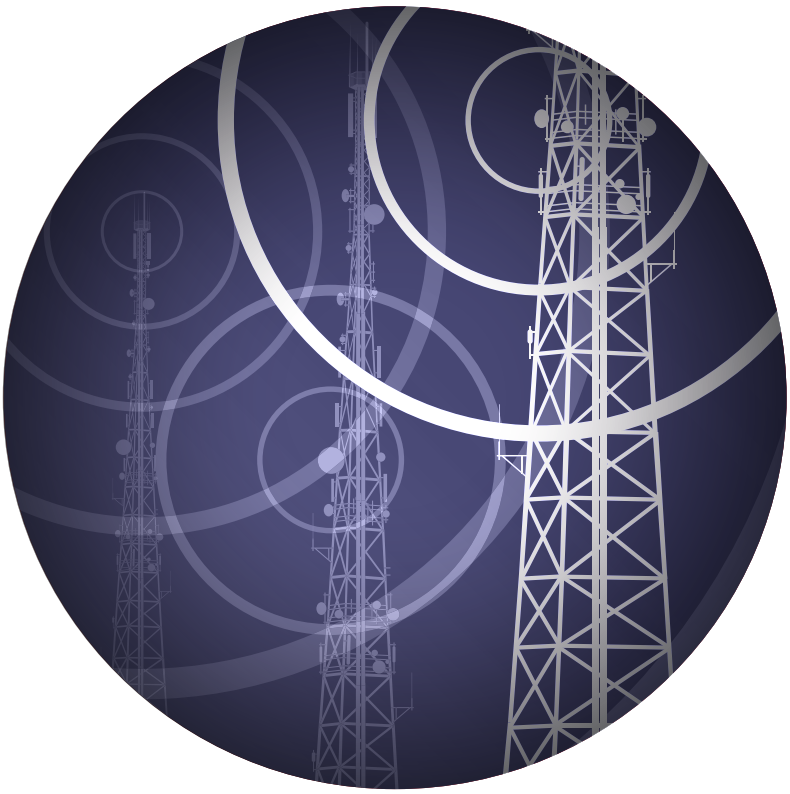
9 Practice appointment data

The GPC, NHSE, 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.

Work will be done to contextualise data where possible, to ensure data is appropriately interpreted and used.

10 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).



11 Social prescribing

CCGs will develop and provide funding for appropriate local social prescribing services and systems. There will be input from local practices and 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.

12 Sharing of information with partners

The important role that social care providers have in providing patient care is recognised. Practices are encouraged to share relevant information with social care providers, subject to the usual safeguards including confidentiality, where systems and/or procedures are in place.

13 Freedom to speak up

In November 2016 NHSE published guidance on freedom to speak up in primary care. There is a need to work together to determine the most effective way of introducing an appropriate and agreed system for general practice to be implemented no later than 1 April 2019.

14 Locum data

The GPC, NHSE and the Department of Health and Social Care (DHSC) will work together to improve data on locum usage. Research will take place 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.

15 Reducing the administrative burden

The GPC, NHSE and the DHSC will work together to take urgent steps to reduce the administrative burden in general practice, considering issues highlighted in the GPC's *Urgent prescription for general practice* and *Saving general practice*.

16 Hepatitis B (HepB) renal

NHSE will work with specialised commissioning and secondary care colleagues to ensure that it is clear the responsibility to deliver HepB vaccinations to renal patients lies with the renal service and not with general practice - unless locally agreed arrangements are in place to deliver this service.

17 HepB medical students

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

Local GP Retention Fund initiative aims to persuade would-be leavers to stay

£7m of new funding is to go to NHSE regional teams to assist with retaining GPs who are at risk of leaving general practice.

Before funds are released, each region was required to submit a proposal for how it intends to spend its initial indicative allocation by the end of June 2018.

Initiatives should focus on increasing the overall capacity of the local general practice workforce.

- For newly qualified GPs or those within their first five years of practice, the focus will be on providing a flexible career alternative to support them during their transition into the workforce. They should get greater exposure to different models of practice to inform their long-term career decisions - for example partnership working or portfolio working.
- For GPs who are seriously considering leaving general practice, or thinking of changing their role or working hours, the focus will be on supporting them to remain in clinical practice.

This might consist of establishing pooled working arrangements for experienced GPs to take on clinical sessions across the lead provider, combined with the provision of tailored support where doctors receive a range of incentives such as contributions for indemnity, educational support and greater flexibility.

- For GPs who are no longer clinically practising in the NHS in England, but remain on the National Performers List (Medical), the focus will be on support to return.

After a two-year break in practice, doctors are removed from the National Performers List (Medical) and require additional support to return to clinical practice via the Induction and Refresher Scheme.

The process for returning before two years is much simpler. Initiatives in this category should seek to support GPs through their return to clinical practice. This can be through participating in pooled working arrangements, facilitated peer support sessions or one-to-one mentoring.

Schemes should ideally seek to support GPs to work a minimum of five sessions in general practice a week, equating to a participation rate of 56%. But regions may tailor this approach to local workforce needs.

Sessions should include provision for CPD and may extend to clinical supervision in the locality or other non-clinical work. Alternative support is available, under the GP Retention Scheme, for GPs who are unable to do regular part time work and who cannot commit to working over four sessions a week.

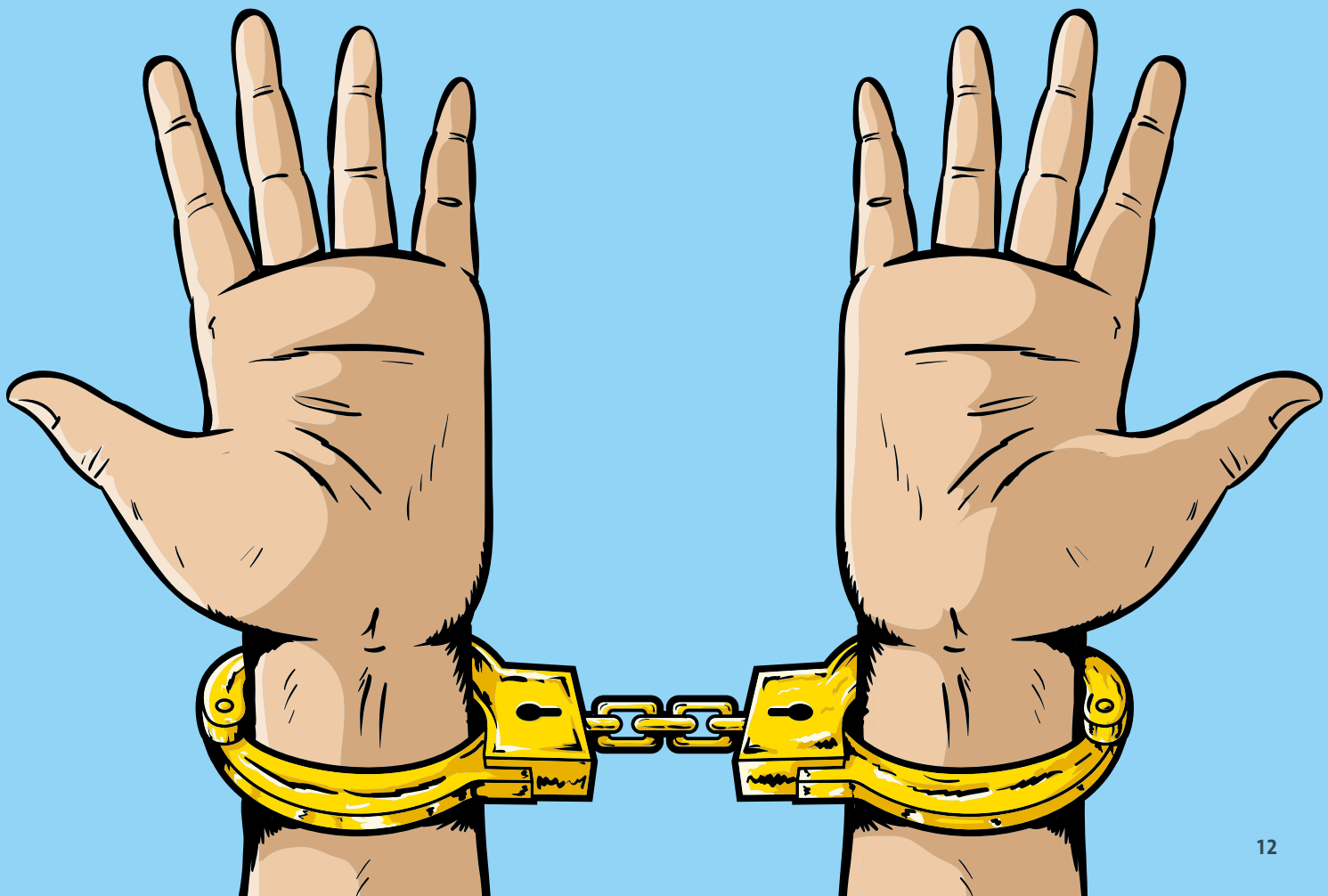
The fund will support initial set-up and implementation costs only in the expectation that initiatives will be designed to be self-sustaining where ongoing support is required. Direct GP employment costs will continue to be borne by the practice.

Regional teams may also direct use of the fund to support:

- Additional local team capacity and capabilities to administer support directly.
- Contracted third party supplier(s) to work with Sustainability and Transformation Plans (STPs), CCGs, GP Federations or other at scale providers. Suppliers may provide specialist aspects of the menu of possible support.
- Backfill - or other costs - for individual GPs and other practice team members, for example to provide peer support to other GPs or to free up time for GPs to contribute and design new initiatives.

Regional and local teams may wish to use funding to offer a range of incentives to attract suitable GPs to join proposed initiatives. These may include reimbursement for indemnity, support for CPD, mentoring, facilitated peer support, and support with appraisal/revalidation.

Newly qualified GPs should ideally be appointed a mentor to support transition into the workforce, provide clinical support and discuss future career options.



GP superannuation - and other changes

Tiered rate contribution levels have been set for the four years to 31 March 2019 and remain as follows, with the employer rate remaining at 14.3%:

GP (and non-GP provider) tiered contribution rate table from 1 April 2015 to 31 March 2019

	Total pensionable income	Contribution rate
1	Up to £15,431.99	5%
2	£15,432.00 to £21,477.99	5.6%
3	£21,478.00 to £26,823.99	7.1%
4	£26,824.00 to £47,845.99	9.3%
5	£47,846.00 to £70,630.99	12.5%
6	£70,631.00 to £111,376.99	13.5%
7	£111,377.00 and over	14.5%

- **MPIG will continue to be reduced by a further 1/7th and is recycled back into the global sum.**
- **The out of hours deduction has changed from 4.92% to 4.87%.**

Please note that all of the information on pages 1 to 13 relates to contracts in England only.

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GP pay and contract changes in Scotland, Wales and Northern Ireland

Scotland

New contract arrangements in Scotland are the subject of significant changes and are not covered by this article. Additional information can be obtained from your local AISMA accountant.

Wales

Details of the annual GP contract changes for 2018-19 in Wales, which will provide financial stability for practices and reduce workload and bureaucracy, have been agreed to include:

- An uplift to the General Medical Services (GMS) contract for 2018-2019 of £11.67m.
- An uplift of 1% for pay and a 1.4% increase for general expenses (whilst awaiting delayed DDRB determination).
- An uplift of £2.7m towards the rising costs of professional indemnity for GMS GPs and the wider practice clinical teams.
- Reduced Quality and Outcomes Framework (QOF) to disease registers (other than flu indicators which will be retained) to alleviate workload pressures.
- Cluster network domain reduced to engagement in five meetings over the year.
- Improved mentoring and coaching arrangements including access to the Academi Wales coaching collaborative.
- A commitment to explore access to health board employment benefits to improve the recruitment offering available to GPs.
- Improved recording of Welsh language provision at practice and cluster level.
- A commitment to explore and address barriers currently faced by those who have recently left the GP workforce.
- An extension of the enhanced service for influenza outbreak prescribing for 2018-2019.
- Support for IT migrations to commence in January 2019.

No announcement following the pay award in England at the end of July had been made in Wales as we went to press.

Northern Ireland

The Health Department in Northern Ireland announced in June an investment of £8.8m in general practice.

Half of this sum is for a practice-based pharmacist scheme, £1m to cover increased indemnity costs, £1.5m for premises upgrades and £1.8m for demographic pressures.

£12.78m has also been invested in 2018-19 from a transformation fund to assist GPs to find new ways of working with multi-disciplinary teams.

No announcement following the pay award in England at the end of July has been made yet in Northern Ireland.

Key action points

As ever, practices must be fully aware of these many changes and the impact they might have on practice funding and workload.

It follows that practices need to take a careful look at future strategy and work on finding the best and most profitable way of using time and resources.