

Gateway Ref: 06446

To: Directors of Commissioning,  
Regional Heads of Primary Care  
Heads of Primary Care  
CCG Clinical Leads and Accountable Officers

Medical Directorate  
NHS England  
Quarry House  
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7 February 2017

Dear Colleague

## **OUTCOME OF 2017/18 GMS CONTRACT NEGOTIATIONS**

This letter confirms the outcome of the contract negotiations between NHS Employers (on behalf of NHS England) and the BMA's General Practitioners Committee (GPC) on amendments that will apply to GMS contractual arrangements in England from 1 April 2017.

An agreement has been reached with GPC on changes to the GMS contract for 2017/18 which seeks to address concerns of the profession in relation to workload and increasing expenses and other agreed changes. The agreement also reflects commitments made as part of the General Practice Forward View (GPFV) and continues to make significant investment in primary care. The agreement has been approved across Government.

We suggest regional teams discuss with clinical commissioning groups (CCGs) how these changes can support local strategic plans for strengthening the quality of general practice services and making more effective use of NHS resources and how the changes might need to be reflected in co-commissioning plans.


As last year, we will now work with NHS Employers and GPC to develop more detailed guidance where appropriate, on all of the agreed changes which are provided in the attached annex.

The NHS Employers contract website [www.nhsemployers.org/gms](http://www.nhsemployers.org/gms) provides details of the agreement [www.nhsemployers.org/gms201718](http://www.nhsemployers.org/gms201718) and we will be updating this and NHS England's dedicated GP contracts page <https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/> with details of the implementation guidance, links to supporting legislation and standard contract documentation in time for these new arrangements to take effect from 1 April 2017. Given the timing of this announcement we will be implementing the changes to the Regulations from July 2017 at the earliest.

OFFICIAL

Please ensure that this letter is distributed to all relevant people within your teams.

Yours faithfully

A handwritten signature in black ink, reading 'Rosamond Roughton'. The signature is written in a cursive style with a large, looped 'R' at the end.

Rosamond Roughton  
Director of NHS Commissioning

## **Key Changes to GMS Contract for 2017/18**

### **Contract Uplift and Expenses**

We have agreed an investment of £238.7 million in the contract for 2017/18. This investment is to uplift the contract and to take into account increasing expenses, covering:

- A pay uplift on pay of 1% (based on DDRB formula) and an uplift on expenses of 1.4% (using latest OBR inflation forecast for CPI)
- Payments for indemnity costs that will be made based on registered patients at 51.6p per patient
- An increase in the value of a QOF (Quality and Outcomes Framework) point
- The payment fee for the Learning Disabilities Health Check Scheme will increase from £116 to £140 per health check

### **Carr-Hill formula**

Negotiations on changes to the Carr-Hill formula will begin shortly. Full implementation of any agreed changes will be effective from 1 April 2018 at the earliest.

### **QOF**

We have agreed that for 2017/18 there will be no change to the number of QOF points available, the clinical or public health domains and no changes to QOF thresholds. However, the CPI will be adjusted to reflect the changes in list size and growth in the overall registered population for one year from 1 January 2016 to 1 January 2017.

We have also agreed that a working group will be set up immediately following these negotiations to discuss the future of QOF after April 2017.

### **Directed Enhanced services (DESS)**

The payment for the Learning Disabilities Health Check Scheme will increase from £116 to £140 per health check. A new learning disabilities health check template has been developed by NHS England for practices to use if they so choose. All other requirements of the enhanced service will remain unchanged.

The Extended Hours Access DES will continue unchanged until 30 September 2017 (see below – core opening hours and extended hours access DES).

The Avoiding Unplanned Admissions DES will cease at 31 March 2017. Funding of £156.7 million will be transferred into global sum, weighted and without the out-of-hours deduction applied, and used to support the new contractual requirement on Identification and Management of Patients with Frailty (see below).

### **Identification and management of patients with frailty**

We have agreed a new contractual requirement to be introduced from 1 July 2017.

Practices will use an appropriate tool, e.g. Electronic Frailty Index (eFI) to identify patients aged 65 and over who are living with moderate and severe frailty. For those patients identified as living with severe frailty, the practice will deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions. In addition, where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this by seeking informed patient consent to activate the enriched SCR.

Practices will code clinical interventions for this group appropriately. Data will be collected on the number of patients recorded with a diagnosis of moderate frailty, the number of patients with severe frailty, the number of patients with severe frailty with an annual medication review, the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months and the number of severely frail patients who provided explicit consent to activate their enriched SCR. NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This data will not be used for performance management purposes or benchmarking purposes.

### **National diabetes audit (NDA)**

Practices will be contractually required to allow collection of data relating to the NDA from July 2017 at the earliest.

### **NHS Digital Workforce Census**

Practices will be contractually required to allow collection of data relating to the NHS Digital Workforce Census from July 2017 at the earliest. Recurrent funding of £1.5 million has been agreed to support this requirement and will be added to global sum allocations without the out of hours deduction applied.

### **Data collection**

We will introduce a contractual requirement, from July 2017 at the earliest, for practices to allow data collections for a selection of agreed retired QOF indicators (INLIQ) and retired DESs .

### **Registration of prisoners**

We will introduce a contractual change from July 2017 at the earliest, to allow prisoners to register with a practice before they leave prison. This agreement will include the timely transfer of clinical information, with an emphasis on medication history and substance misuse management plans, to the practice from the prison to enable better care when a new patient first presents at the practice.

### **Access to healthcare**

We have agreed contractual changes that help to identify patients with a non-UK issued EHIC or S1 form or who may be subject to the NHS (Charges to Overseas Visitors) Regulations 2015.

Practices will be required to provide all new patients with a revised GMS1 form, which includes supplementary questions to determine a patient's eligibility to healthcare. For those patients who self-declare that they hold either a non-UK issued EHIC or a S1 form, the practice will be required to manually record that the patient holds either a non-UK issued EHIC or a S1 form in the patient's medical record and then send the form and supplementary questions to NHS Digital (for non-UK issued EHIC cards) or the Overseas Healthcare Team (for S1 forms) via email or post. The Department of Health has agreed to provide practices with hard copy patient leaflets which will explain the rules and entitlements overseas patients accessing the NHS in England.

We have also agreed that NHS England and GPC will work with GP system suppliers to put in place an automated process, as soon as possible, to replace the manual process. This will include discussions on development of systems to support collection of GP appointment data for these patients.

Once the technical solution to automatically collect this data is in place, we have agreed that further discussions on implementing the system to support collection of the data will take place.

New recurrent investment of £5 million will be added to global sum allocation, without the out of hours deduction applied, to support this requirement.

### **GP retention scheme**

We have agreed a new scheme to replace the existing one, with the key changes being as follows:

- Tighter criteria for those who are joining the new scheme. The scheme is aimed at those GPs who are seriously considering leaving or have left general practice due to personal reasons, approaching retirement, or require greater flexibility.
- In 2016, under an interim scheme, the practice payment rose from £59.18 to £76.92 per session, an increase of approximately 30 per cent. NHS England will fund the 2017 scheme wholly from within the primary care allocation budget and the practice payment and bursary professional expenses salary supplement will remain the same as the 2016 scheme. The payment is to be used by the practice as an incentive to provide flexibility for the retained GP and should be used towards the retained GP's salary, to cover human resources administration costs and to provide funding to cover any educational support required from the practice, including course fees where relevant.

- A professional expenses salary supplement will be payable to the GP via the practice (on a sliding scale, net of any applicable deductions payable by the doctor in respect of income tax, national insurance and superannuation contributions) and is to go towards the costs of the GP's indemnity cover, professional expenses and Continuing Professional Development (CPD) needs.
- A strong element of the new scheme is around education and CPD. The retained GP will be entitled to the pro rata full time equivalent of CPD as set out within the salaried model contract. The CPD aspects will be based on the needs of the individual, as established at their appraisal and in discussion with the educational supervisor.
- GPs can be on the scheme for a period of up to five years. In exceptional circumstances an extension can be made for up to a further 24 months.

Any retainers on the 2016 Retained Doctors Scheme will continue under these arrangements until 30 June 2019 after which time they will default to the new scheme.

Retainees who have been accepted on to the Retained Doctor Scheme 2016 (where the application form has been approved by the NHS England DCO) but who are not in post before 31 March 2017, will be accepted onto the GP Retention scheme without the need to re-apply.

### **Payments for sickness leave cover**

We have agreed changes to the arrangements for making sickness leave payments, as follows:

- To allow for cover to be provided by external locums or existing GPs already working in the practice but who do not work full time.
- An amendment to the qualifying criteria for reimbursement to begin when the absence is two or more weeks (as opposed to current arrangements which is linked to patient numbers and the period of absence).
- An increase in the maximum amount payable to £1,734.18 per week. Payments will no longer be discretionary and will be payable where the absence is two or more weeks.
- Sickness leave payments will not be made on a pro-rata basis and will be the lower of actual or invoiced costs up to the maximum amounts as set out in the Statement of Financial Entitlements (SFE).

These changes will be applicable as from 1 April 2017 and all other requirements will remain unchanged.

### **Parental leave payments**

We have agreed that parental leave payments will not be made on a pro-rata basis and will be the lower of actual or invoiced costs up to the maximum amounts as set out in the SFE. All other requirements will remain unchanged.

### **Business Improvement District (BID) levies**

Agreement has been reached for eligible practices to be reimbursed for costs relating to BID levies. The reimbursement is to be made via the Premises Costs Directions on submission of a paid invoice. Payment of the BID levies will not be a discretionary payment.

### **Care Quality Commission (CQC) Fees**

CQC Fees will be reimbursed directly. Practices will present their CQC invoices to the CCG (where delegated powers exist) or the NHS England regional team and they will be reimbursed as part of the practice's next regular payment.

### **Vaccinations and immunisations (V&I)**

We have agreed to the following V&I programme changes from April 2017:

- Childhood seasonal influenza – the removal of four year olds from enhanced service patient cohort (transferring to schools programme) and the removal of the requirement to use Child Health Information Systems (CHIS).
- MenACWY programmes – a reduction in the upper age limit from 'up to 26th birthday' to 'up to 25th birthday' (in line with the Green Book).
- Seasonal influenza – the inclusion of morbidly obese patients as an at-risk cohort in the DES and a reminder for practices that it is a contractual requirement to record all influenza vaccinations on ImmForm. Funding to cover this new cohort will be from Section 7A.
- Pertussis or pregnant women – a reduction in the eligibility of patients for vaccination from 20 weeks to 16 weeks.
- Singles (routine) – a change in patient eligibility to the date the patient turns 70 rather than on 1 September.
- Shingles (catch-up) – a change in patient eligibility to the date the patient turns 78 rather than on 1 September.

The following programmes will roll-over unchanged:

- hepatitis B (newborn babies)
- HPV for adolescent girls

- measles mumps and rubella (aged 16 and over)
- meningococcal B
- pneumococcal polysaccharide
- rotavirus.

### **Core opening hours and extended hours access DES**

In relation to the extended hours access DES new conditions will be introduced from October 2017 which will mean that practices who regularly close for a half day, on a weekly basis, will not ordinarily qualify for the DES. GPC have agreed that Local Medical Committees should be integral partners in working with local commissioners in ensuring practices are fulfilling their contractual requirements.

### **GMS digital**

We have agreed to build on the work of recent years to develop high quality secure electronic systems and pro-actively encourage patients and practices to use them. The changes that we have agreed for 2017/18 will be taken forward through non-contractual working arrangements which we will jointly promote in guidance.

Recognising the importance of cyber security, practices will want to ensure that they have strong underpinning information governance which supports their and patients' use of all electronic systems.

We have further agreed non-contractual changes to joint guidance that will promote:

- practice compliance with the ten new data security standards in the National Data Guardian Security Review,
- practice completion of the NHS Digital Information Governance toolkit including attainment of level 2 accreditation, and familiarisation with the July 2016 Information Governance Alliance guidance
- an increased uptake of electronic repeat prescriptions to 25 per cent with reference to co-ordination with community pharmacy,
- an increased uptake of electronic referrals to 90 per cent where this is enabled by secondary care,
- continued uptake of electronic repeat dispensing with reference to CCG use of medicines management and co-ordination with community pharmacy
- uptake of patient use of one or more online service to 20 per cent including, where possible, apps to access those services and increased access to clinical correspondence online,
- better sharing of data and patient records at local level, between practices and between primary and secondary care.

### **Indemnity Inflation**

When the GP Indemnity Review was published (available at: <https://www.england.nhs.uk/wp-content/uploads/2016/07/gp-indemnity-rev-summary.pdf>), NHS England agreed to make payments to practices to cover indemnity inflation experienced in 2016/17 and 2017/18.



### **Further work**

NHS England and GPC have committed to take forward discussions in the coming months on a national programme of self-care and appropriate use of GP general practice services and information sharing between practices.