North Midlands
Primary Care Team
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May 2018

Sent by email to:
All GP practices
Derbyshire and Nottinghamshire

Dear Colleagues

Re: 2018/19 national GMS contract and Directed Enhanced Services changes

We are writing on behalf of Derbyshire and Nottinghamshire Clinical Commissioning Groups (CCGs) who took on delegated responsibility for commissioning primary medical services on 1st April 2015 and continue to be supported by the NHS England primary care team.

The purpose of this letter is to:

- Outline local implementation of the national GMS contract and Directed Enhanced Services changes for 2018/19 agreed by NHS Employers and the General Practitioners Committee (GPC)
- Offer participation in the Directed Enhanced Services which will be issued to all practices
- Outline new core contract requirements and a reminder of some previously implemented

A summary of the main changes is as follows:

Contract uplift and expenses

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.

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.

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

Locum reimbursement
There will be an uplift to the maximum figure practices can be reimbursed for locum costs by 1%, The 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

Vaccinations and immunisations (V&I)
An uplift to the IoS fee for the following programmes has been agreed, 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, the following V&I programme changes from April 2018 have been agreed:

• 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. The eligibility is now 1 April 2012.

• Meningococcal B – programme moved in to the 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.

Directed Enhanced services (DESs)
The learning disabilities health check scheme will continue unchanged with the exception of a minor change to the clinical codes that make up the register. All other DESs are unchanged.

Contractual changes (to come into force 1 October 2018)

Electronic prescription service
Regulations will be amended to implement electronic prescription service (EPS) Phase 4, allowing an initial phase of implementation to support a planned roll-out during 2018/19 (changes to Regulations are expected in October 2018). 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 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.

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.

Please ensure the practice has made reference to the following 2018/19 GMS Contract guidance documents:

- **GMS Contract 2018/19 Guidance** - **GMS contract changes 201819 - NHS Employers**
- **Summary of 2018/19 GMS contract negotiations – see link from above**
- **Technical Requirements for 2018/19 GMS Contract Changes – not yet available, will be circulated when available.**
- **Vaccination & Immunisation Programmes 2018/19 Guidance and Audit Requirements -** *201819 Vaccination and immunisations - NHS Employers*
- **2018/19 GMS Contract Quality And Outcomes Framework (QOF) Guidance** - *Changes to QOF 201819 - NHS Employers*

Yours sincerely

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NHS North Midlands (Derbyshire and Nottinghamshire)

Enc: Participation Agreement form
Cc:

- Derbyshire and Nottinghamshire Clinical Commissioning Groups
- Derbyshire and Nottinghamshire Local Medical Committees