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PSNC Briefing 047/14: Changes to the GMS contract in 2013/14

This briefing summarises changes being introduced to the GMS contract in 2013/14 and highlights those aspects of the changes that may have an impact on community pharmacies.

Introduction

Following negotiations between the GP Committee (GPC) of the BMA and NHS Employers, the Department of Health (DH) consulted on proposals to change the primary medical care contractual arrangements in December 2012. DH said the proposed changes were intended to maintain current levels of investment in general practice, whilst promoting continuous improvement in the quality of GP services.

The GPC and other medical stakeholders raised a wide range of objections to the changes proposed by DH, but in March this year DH determined that the changes would be implemented by NHS England, with a number of amendments being made following feedback from the GPC and others. The main changes to the service elements are amendments to QOF and the introduction of new Enhanced services.

New Enhanced services

Four new Enhanced services are being introduced into the contract, funded by the retirement of the QOF organisational measures. The new services are:

1. The identification and case management of patients identified as seriously ill or at risk of emergency hospital admission. This will be undertaken by risk profiling and stratification of their registered patients on at least a quarterly basis. For patients identified by this process the practice should coordinate the care management of those patients who would benefit from more active case management. It is likely that the CCG will have a significant interest in this service and may coordinate the work across its practices.

2. Undertaking a proactive approach to the timely assessment of patients who may be at risk of dementia. This will be based on an opportunistic offer of assessment to at-risk patients who are aged 60 and over with CVD, stroke, peripheral vascular disease or diabetes; patients aged 40 and over with Down's syndrome and other patients aged 50 and over with learning disabilities; and patients with long term neurological conditions which have a known neurodegenerative element, for example, Parkinson's disease.

3. Undertaking preparatory work in 2013/14 to support the subsequent introduction in 2014/15 of remote care monitoring arrangements for patients with long term but relatively stable conditions. This will involve agreement with the CCG which long term condition is to be the local priority for remote care monitoring in 2014/15. The appropriate test or bodily measurements required to support the stable management of the chosen condition will be agreed alongside how the tests and measurements will be accessed or fed in by patients. The options by which patients will receive results of the tests or measurements, other than by face to face consultations, will be identified, e.g. video call, telephone, text, email or letter. Practices will then discuss the opportunity to use this service in the following year with appropriate patients.

4. Enabling patients to use electronic communications for booking of appointments and requesting repeat prescriptions. NHS England intends to develop the service in 2014/15 to take into account the Government's

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commitment for implementing secure online communication and viewing medical records (including test results and letters).

The latter service is of most immediate interest to LPCs and community pharmacy, as contractors will want to understand the local process to be used for the ordering of repeat prescriptions and the ramifications this may have for current pharmacy practice and the potential for this development to prompt changes in GP practice procedures or behaviour related to collection of repeat prescriptions. LPCs may wish to highlight this development to their contractors, so contractors can ascertain whether local GP practices plan to implement the service.

The other services are not likely to have such an immediate impact on community pharmacy, but the widespread adoption of risk profiling and stratification of patients, especially if this is conducted at a CCG level, may provide opportunities for promotion of community pharmacy medicines optimisation services such as MUR and NMS and their more effective integration into local care pathways (e.g. using risk stratification data to prompt GP referrals to the MUR service for certain patients). LPCs may want to keep an eye on such developments in order that they can highlight to CCGs the support community pharmacy can provide to high risk patients.

The dementia service will sit alongside other local initiatives to support the early identification and management of people with dementia, such as the introduction of a dementia element to the NHS Health Check service, which local pharmacies may be providing. There has been comment in the medical press that suggests that this service is less favoured by some GPs, due to the potential workload it may impose on practices.

The introduction of remote care monitoring arrangements will be phased over two years, so there may be minimal immediate implications for community pharmacy, but LPCs and contractors will be able to see the potential for community pharmacy to be involved in supporting the provision of such monitoring. This was also noted by Deborah Jaines, Head of Outcomes and Primary Care in NHS England's commissioning development directorate, when she commented at the recent PSNC Community Pharmacy Conference that she was keen to explore the opportunities for extension of remote care monitoring into community pharmacy.

Quality and Outcomes Framework (QOF)

DH proposed a number of changes to the Quality and Outcomes Framework (QOF) in order to secure further health improvements for patients. These included implementing all the NICE recommendations for changes to QOF (NICE became responsible for managing an independent and transparent approach to developing the QOF clinical and health improvement indicators from April 2001); raising thresholds for existing indicators in line with the 75th centile of achievement to ensure more patients receive evidence-based care; setting up a Public Health Domain in the QOF, as originally proposed in the 2010 Public Health White Paper; and removing the remaining organisational indicators that represent basic standards that all practices will be expected to meet as part of CQC registration.

A summary of the QOF, including the new and amended indicators is available on the NHS Employers website. The new indicators relate to management of heart failure, hypertension, diabetes, COPD and rheumatoid arthritis.

For more information please contact Alastair Buxton, Head of NHS Services.

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