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PSNC Briefing 107/13: Changes to the GMS contract in 2014/15

This briefing summarises changes being introduced to the GMS contract in 2014/15 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 (on behalf of NHS England), an agreement has been reached on changes to the GMS contract for 2014/15 which will support NHS England's emerging strategic objectives for primary care, including providing more proactive care for people with more complex health needs, empowering patients and the public, giving parity of esteem to physical and mental health, promoting more consistently high standards of quality, and reducing inequalities.

NHS England's Commissioning Development Directorate has suggested that Area Teams (ATs) should work with their clinical commissioning groups (CCGs) to identify how the changes to the GMS contract can support them in developing and implementing local strategic plans for strengthening the quality of general practice services.

More personal care for older people and those with complex health needs

The first area of development in the contract reflects the Secretary of State for Health's focus on improving the care of 'vulnerable older people'.

Named, accountable GP for people aged 75 and over - all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.

Out-of-hours services - there will be a new contractual duty to monitor and report on the quality of out-of-hours services and support more integrated care, e.g. through record sharing.

Reducing unplanned admissions - **t**here will be a new Enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current Enhanced service for risk profiling and care management and will be funded from the resources released from these two current schemes.

The key features of the service will be for GP practices to:

- improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission;
- ensure that other clinicians and providers (e.g. A&E clinicians, ambulance services) can easily contact the GP practice by telephone, via an ex-directory number or bypass number, to support decisions relating to hospital transfers or admissions;
- carry out regular risk profiling, with a view to identifying at least 2% of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management;
- provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator;

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- work with hospitals to review and improve discharge processes; and
- undertake internal reviews of unplanned admissions/readmissions.

QOF reform - to promote a stronger focus on addressing the holistic needs of people with multiple health and care needs, there will be a further reduction in the size of the QOF. A number of clinical indicators worth 185 points, public health indicators worth 33 points and the patient experience indicator worth 33 points will be removed.

For the most part, the released funding will be reinvested into weighted capitation ('global sum') payments. NHS England state that they anticipate that GP practices will to a large extent continue to provide the relevant interventions included in the QOF indicators being removed, where clinically appropriate, but they will have greater scope to flex care to meet the needs of individual patients. NHS England intends to continue to collect and publish data on the relevant interventions and outcomes in order to support practices in promoting ongoing quality improvement.

QOF thresholds - the QOF threshold increases that were previously due to be implemented from April 2014 will be deferred for one year to allow a focus on implementing the new arrangements for more proactive care management.

Remote care monitoring - this Enhanced service, introduced in 2013, will cease from 31 March 2014 and the associated funding will be recycled into global sum payments. NHS England will continue to promote remote care monitoring in other ways, e.g. remote care monitoring forms a core component of integrated care for the 3millionlives programme.

Empowering patients and the public

Choice of GP practice - from October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits. Area Teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.

Friends and Family Test - there will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the Friends and Family Test and to publish the results.

Patient online services - GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online. The current Enhanced service for patient online services will cease and the associated funding will transfer into global sum payments.

Extended opening hours - the extended hours Enhanced service will be adapted to promote greater innovation in how practices offer extended access to their patients.

Patient participation - the patient participation Enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.

CQC inspections – when the CQC's new inspection arrangements are introduced, practices will be required to display the inspection outcome in their waiting room(s) and on the practice website.

Transparency of GP earnings - the GPC will join a working group with NHS England and NHS Employers to develop proposals on how to publish, from 2015/16 onwards, information on GPs' net earnings relating to the GP contract (i.e. with the first published data based on 2014/15 earnings). Publication of this information will be a future contractual requirement.

Fairer funding

Giving greater weight to deprivation factors - the parties to the negotiations are seeking to identify whether it is possible to update the existing deprivation factors in the Carr-Hill formula (which determines capitation payments for practices) from April 2014 to ensure that the formula reflects the most up to date information on deprivation.

Seniority pay - the seniority pay scheme will be closed to new entrants from 1 April 2014 and will be abolished entirely from 1 April 2020. There will be a phased approach to reducing current expenditure on seniority pay and reinvesting these resources into global sum payments.

MPIG - as part of last year's GP contract settlement, the Department of Health decided to phase out Minimum Practice Income Guarantee (MPIG) payments over a seven year period. From April 2014, as planned, MPIG payments will therefore be reduced by one-seventh every year for the next seven years, with funding recycled into global sum payments so that funding more fairly reflects the numbers of patients served by each practice and the health needs of those patients.

Decisions on any annual contract funding uplift will be made following recommendations from the Doctors and Dentists Pay Review Body in February 2014.

Information sharing

From 1 April 2014 GP practices will be contractually required to:

- include the **NHS number** as the primary patient identifier in all clinical correspondence;
- provide an automated upload of their summary information on at least a daily basis to the **Summary Care Record**, or have a published plan in place to achieve this by 31 March 2015; and
- use the **GP2GP** facility to transfer patient records between practices, or have a published plan in place to achieve this by March 2015.

NHS England have also agreed joint work with GPC during 2014/15 to deliver consistent access to the detailed patient record for other care providers, e.g. out-of-hours, A&E and NHS 111.

Implications for community pharmacy

A number of the changes to the GMS contract may have implications for community pharmacy.

The ongoing developments in use of IT and record access being given to patients are likely to be of most interest to community pharmacy over the next few years. The agreement to continue working on full GP records access for other care providers could see community pharmacy access to GP records being granted in due course. The shift of the requirement to allow patients to order their repeat prescriptions online from an optional Enhanced service to a core contractual requirement should see an increase in GP practices making this functionality available to patients. Community pharmacies will want to keep abreast of local developments on this subject.

The focus on care for older people and those with complex health needs may present local opportunities to promote MUR and NMS for this group of patients and to seek GP referrals.

The requirement to work with hospitals to review and improve discharge processes may present an opportunity for LPCs to join these discussions in order to secure better transfer of information to community pharmacy when patients are discharged from hospital. In this way post-discharge MUR and NMS may be more effectively provided by local pharmacies.

If you have any queries on this PSNC Briefing or you require more information, please contact Alastair Buxton, Head of NHS Services.