2014/15 GMS CONTRACT NEGOTIATIONS

Quarry House
Quarry Hill
Leeds
LS2 7UE
0113 525 0000

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To: Area Team Directors

Cc: Regional Directors

Dear Colleague

This letter is to inform you of the outcome of the contract negotiations between the BMA's General Practitioners Committee (GPC) and NHS Employers (on behalf of NHS England) on amendments that will apply to GMS contractual arrangements in England from April 2014.

An agreement has been reached with GPC on changes to the GMS contract for 2014/15 which will support our 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.

We and NHS Employers will issue more detailed guidance on all of the changes in due course. Changes to Regulations and Directions and amendments to the Statement of Financial Entitlements (SFE) will mostly come into force from April 2014.

The purpose of this letter is to set out the key changes that will be made. We suggest that you work with clinical commissioning groups (CCGs) to identify how these changes can support you in developing and implementing local strategic plans for strengthening the quality of general practice services and making more effective use of NHS resources.

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

Named, accountable GP for people aged 75 and over. As part of a commitment to more personalised care for patients with long-term conditions, 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. There 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 scheme 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 to support decisions relating to hospital transfers or admissions;
- carry out regular risk profiling, with a view to identifying at least two per cent 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;
- work with hospitals to review and improve discharge processes;
- 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 Quality and Outcomes Framework (QOF). We will be retiring a number of clinical indicators worth 185 points, public health indicators worth 33 points and the patient experience indicator worth 33 points. For the most part, the released funding will be reinvested into weighted capitation ('global sum') payments. Senior NHS England clinicians have reviewed and agreed the proposed changes, taking into account advice from NICE and Public Health England.

We anticipate that GP practices will to a large extent continue to provide the relevant interventions, where clinically appropriate, but they will have greater scope, working with patients and carers, to flex care to meet the needs of individual patients. We intend to continue to collect and publish data, as far as possible, on the relevant interventions and outcomes in order to support practices in promoting ongoing quality improvement.;

Full details of the changes to the QOF can be found in **Appendix A**.

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 stronger focus on implementing the new arrangements for more proactive care management.

Remote care monitoring. This enhanced service will cease from 31 March 2014 and the associated funding recycled into global sum payments. We will continue

to promote remote care monitoring in other ways. For example; 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. This will give members of the public greater freedom to choose the GP practice that best meets their needs. 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 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.

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.

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. We are working with GPC and NHS Employers to identify whether it is possible to update the existing deprivation factors in the Carr-Hill formula from April 2014 to ensure that the formula reflects the most up to date information on deprivation. We are also working with the GPC to develop changes to the formula to be implemented from April 2015 to give greater weight to 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. We and the GPC will monitor the funding released during 2014/15 and, in light of this, will agree how to reduce funding by 15 per cent a year.

MPIG. As part of last year's GP contract settlement, the Department of Health decided to phase out 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. We will be writing to you separately setting out arrangements for reviewing outlier practices.

Other improvements to quality of patient care

Diagnosis and care for people with dementia. There will be changes to this enhanced service to promote more personalised care planning and allow greater professional judgement in which patients should be offered assessment to detect possible dementia.

Annual health checks for people with learning disabilities. There will be changes to this enhanced service to extend its scope to young people aged 14-17 to support transition to adulthood and to introduce health action planning.

Alcohol abuse. There will be changes to this enhanced service to incorporate additional assessment for depression and anxiety.

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.
- use the '**GP2GP**' facility to transfer patient records between practices, or have a published plan in place to achieve this by March 2015

We 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.

PMS contracts

Although the agreement does not apply formally to Personal Medical Services (PMS) agreements, we will wish to ensure that we follow an equitable approach in relation to PMS. You will therefore need to reflect the changes, as appropriate, in local PMS agreements once underpinning changes to legislation and guidance have been developed over the next few months.

Annual contract uplift

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

Queries

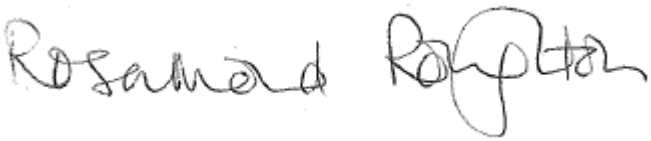
The NHS Employers website www.nhsemployers.org/gms provides details of the agreement documents and will in due course contain implementation guidance.

The Department of Health is preparing the necessary amendments to legislation and, when finalised, these will be published on the NHS England website. The changes will be made in time to ensure that these new arrangements come into effect from April 2014.

Regional and Area Teams are asked to ensure that this letter is distributed to all relevant people within their teams.

This has been the first year for NHS England in these contract negotiations. We will now be taking stock of the process, but I would like in future years to make more use of the considerable expertise in all our area teams in contract development, and will get in touch separately on this.

Yours faithfully



Rosamond Roughton
National Director, Commissioning Development

CHANGES TO QUALITY AND OUTCOMES FRAMEWORK FOR 2014/15

SUMMARY

Proposed retirements	
Clinical domain (table 1) - inc 3 points from LD002 to ES	185
Public health domain (table 2)	33
Patient experience (table 3)	33
Quality and productivity (to ES)	100
SUB Total points released	351
Less points added to amended HYP002 (table 4)	10
TOTAL	**341**

- Total transferring to global sum 238
- Total transferring to enhanced services 103

RETIRED INDICATORS

It is not intended that the retirement of indicators will reduce appropriate clinical workload. GPs will use professional judgement to treat their patients according to best practice guidelines. The removal of the indicators will however, reduce bureaucracy, unnecessary patient testing and unnecessary frequency of patient recall and recording.

NHS England will use data extracted from GP practice systems and reported through CQRS to ensure continued transparency about quality and outcomes in relation to the areas in which indicators are retired. This will enable NHS England's commissioning teams, clinical commissioning groups (CCGs) and the Care Quality Commission (CQC) to take this information into account in reaching more rounded judgements about the quality of care provided by general practice and in supporting transparency for patients and the public. It will also help evaluate the impact of retiring these indicators and help inform future decisions about the development of the QOF.

Table 1: Clinical domain

QOF ID	Points Value	Indicator wording
AF002	10	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 12 months (excluding those whose previous $CHADS_2$ score is greater than 1)
CHD003	17	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
HYP003	50	The percentage of patients aged 79 or under with hypertension in whom the last recorded blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less
HYP004	5	The percentage of patients with hypertension aged 16 or over and who have not yet attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months
HYP005	6	The percentage of patients with hypertension aged 16 or over and who have not yet attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12 months
PAD003	3	The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
STIA004	2	The percentage of patients with stroke or transient ischaemic attack (TIA) who have a record of total cholesterol in the preceding 12 months
STIA005	5	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of DM whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less

QOF ID	Points Value	Indicator wording
DM005	3	The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months
DM011	5	The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months
DM013	3	The percentage of patients with diabetes, on the register, who have a record of a dietary review by a suitably competent professional in the preceding 12 months
DM015	4	The percentage of male patients with diabetes, on the register, with a record of being asked about erectile dysfunction in the preceding 12 months
DM016	6	The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months
THY001	1	The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine
THY002	6	The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months
DEP001	21	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded
MH004	5	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months

QOF ID	Points Value	Indicator wording
MH005	5	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months
MH006	4	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months
EP002	6	The percentage of patients aged 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months
EP003	3	The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counseling about contraception, conception and pregnancy in the preceding 12 months
LD002	3	The percentage of patients on the learning disability register with Down's Syndrome aged 18 or over who have a record of blood TSH in the preceding 12 months (excluding those who are on the thyroid disease register).
RA003	7	The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months
RA004	5	The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 24 months
	185	**Total points retired (3 points transferred to Learning Disabilities Enhanced Services)**

Table 2: Public health domain

QOF ID	Points Value	Indicator wording
CVD-PP002	5	The percentage of patients diagnosed with hypertension (diagnosed after on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet
SMOK001	11	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months
CHS001	6	Child development checks are offered at intervals that are consistent with national guidelines and policy agreed with NHS England
CS003	2	The contractor ensures there is a system for informing all women of the results of cervical screening tests
MAT001	6	Antenatal care and screening are offered according to current local guidelines agreed with NHS England
CON002	3	The percentage of women, on the register, prescribed an oral or patch contraceptive method in the preceding 12 months who have also received information from the contractor about long acting reversible methods of contraception in the preceding 12 months
	33	**Total points retired**

Table 3 Patient Experience Domain

QOF ID	Points	Indicator wording

QOF ID	Points	Indicator wording
PE001	**33 (retired)**	Length of consultation. The contractor ensures that the length of routine booked appointments with doctors in the surgery is not less than 10 minutes. If the contractor routinely admits extra patients during booked surgeries, then the average booked consultation length should allow for the average number of extra patients seen in a surgery session such that the length of booked appointments is not less than 10 minutes. If the extra patients are seen at the end of the surgery, then it is not necessary to make this adjustment. For contractors with only an open surgery system, the average face-to-face time spent by the GP with the patient is not less than 8 minutes. Contractors that routinely operate a mixed economy of booked and open surgeries should ensure that the length of booked appointments is not less than 10 minutes and the length of open surgery appointments is not less than 8 minutes.

Quality and Productivity Domain

All indicators (100 points) retired and funding transferred to a new enhanced service to help reduce emergency admissions

FURTHER AGREED AMENDMENTS

Table 4: Clinical Domain

QOF ID	13/14 Points	Points added	New value	Indicator wording
HYP002	10	+10	20	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding ~~9~~12 months) is 150/90 mmHg or less. GPC and NHS England agree that the threshold should revert to 45-80 per cent. The indicator timeframe will also be changed from 9 months to 12 months.

BP001: The age range for this indicator has been changed to say age 45, which means the indicator, will pick up patients from the age of 40.

Seasonal flu: The timeframe for the for the seasonal flu indicators has changed from 1 September to 31 March each year, to allow practices to begin vaccinating from 1 August each year to commence the programme earlier in line with the enhanced service. This change would apply to CHD004, COPD006, DM010 and STIA006. No change to points.

Cancer review (CAN002, 6 points): The timeframe for this indicator has changed from three months to six months (where clinically appropriate the review will be delivered within three months). No point changes.

Depression review (DEP002, 10 points): The timeframe has changed from 10 – 35 days to 2 – 8 weeks. No points change.

AF003: The wording for AF003 and AF004 are inconsistent, therefore the wording for AF003 has been amended to remove the reference to 'latest in preceding 12 months'. No points change.

Referral after a stroke or TIA (STIA002, 2 points): It is not clinically necessary to refer a patient after each TIA; as such the indicator wording has been amended to require a referral after each stroke and only after the first TIA. The indicator would also be reset from 1 April 2014. No points change.

NICE RECOMMENDATIONS

The indicators recommended this year were not believed to add significant clinical value to the QOF for 2014/15. In line with the general approach this year to streamline QOF, it was agreed not to introduce new indicators at a time when we are seeking to reduce the size of QOF by a third. Negotiators did however agree to replace LD001 with NICE recommended replacement NM73 respectively. The register will now apply to all patients with learning disabilities.