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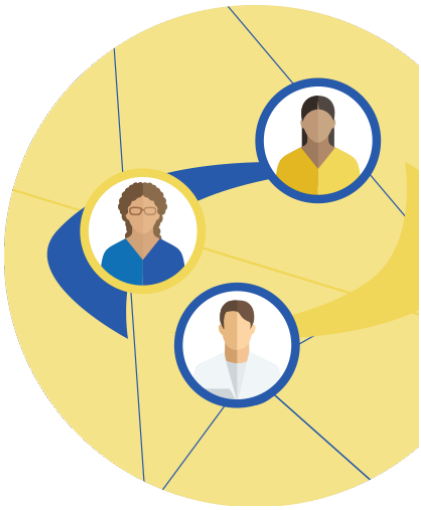

BEDFORDSHIRE & HERTFORDSHIRE
LMC Ltd

2023/24 Contract Changes

17th April 2023

What is included in this review?

Registered as a Company limited by Guarantee
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Introduction (please read)

While the NHS England documents talk about the contract changes for 2023/24, there are in fact two distinct sets of changes that practices need to be aware of:

1. The changes to the GMS/APMS contract.

Changes to your core contract **do not come into effect on 1st April**. These changes can only come into effect once:

- the changes to the GMS/APMS Regulations are published, and
- the contract has been issued and signed by practices (or 14 days after the date of issue if not signed).

The revised regulations are normally published to take effect from 1st October. Until the regulatory changes are published, the full details of the changes to the contract will not be known. What we have included in this update is taken from the information included in the Amanda Doyle letter published last month (link).

2. The changes to elements outside the GMS/APMS contract.

Changes outside the GMS/APMS contract **will come into effect on 1st April** (or whenever the relevant contract is signed) and cover QOF, PCN DES, IIF and Weight Management Enhanced Services.

The Government has also said they will publish a "Delivery Plan for Recovering Access to Primary Care" which was first promised for "early 2023". Amanda Doyle's letter of 6th March said that it would be "published shortly". It has not been published to date (17th April). This document may well give further hints as to the specific changes within the GMS/APMS contract.

Primary Care Network (PCN) DES

1. PCN ARRS Entitlements

The PCN's Additional Roles Reimbursement Sum equates to £22.671 multiplied by the PCN Contractor Weighted Population as of 1st January 2023 for 2023/24. This is an increase from £16.696 for 2022/23.

There is an increase in national population to 62,284,036 up from 61,499,657 for 2022/23.

LMC Comment: *The increase in the ARRS funding represents the expected increase for the final year of the five-year funding.*

The national population against which most PCN pence-per-patient (PPP) payments are calculated has been increased by 1.275%. If a PCN's population has increased by more than this amount for this year over last year, then the PCN is likely to be getting more funding on some of the PPP payments. However, you will be delivering services to more patients; there may be more risk of patient complaints or other issues because of increased patient numbers; uplifts have not been applied to PPP payments to account for increased running costs for all businesses.

2. PCN ARRS Roles

Advanced nurse practitioners and apprentice physician associates have been added to the list of reimbursable roles, note there were no established baselines for these roles previously.

3. PCN Clinical Director Funding

The PCN Clinical Director funding for 2023/24 has been slightly reduced from £0.736 per registered patient 2022/23 to £0.72963 for 2023/24.

LMC Comment: *The drop in funding on this payment (0.865%) is less than the increase (1.275%) in the national population on which the PPP payment is based so PCNs might still see themselves getting more CD funding in absolute terms if their PCN population has increased. However, it is recognised that funding does not equate to the level of work undertaken by CDs which seems to be ever increasing and for most/all CDs exceeds the hours for which the PCN DES funds them.*

4. Enhanced Access Payment

The Enhanced Access payment for the period 1st April 2023 to 31st March 2024 is calculated as £7.578 multiplied by the PCN's Adjusted Population.

There are no service requirement changes.

LMC Comment: *The single payment is an amalgamation of the previous Extended Hours & Enhanced Access schemes and is unchanged in amount.*

5. PCN Leadership and Management Payment

The PCN Leadership and Management Payment for the period 1st April 2023 to 31st March 2024 is calculated as £0.684 multiplied by the PCN Adjusted Population. This is a reduction from the £0.699 payment for 2022/23.

LMC Comment: *This is a reduction of 2.15%. If a PCN's population has increased by 2.15% or more then the PCN should not have lost anything in arithmetical terms, but the failure to provide any uplift in this payment disregards the increases in staff pay and running costs that all businesses face.*

6. PCN Service Specifications

i. CVD

There are some additional recommendations noted for Heart Failure coding.
Those who have confirmed heart failure should be additionally coded according to accepted classification (following the results of an echocardiogram).

ii. Personalised Care

This was introduced last year. Proactive social prescribing remains without any significant changes. Implementation of improvements highlighted by the audit set out in 22/23 must continue.

iii. Cancer Care

The only change is around direct access for patients who fall outside of local 2WW templates. The wording is vague:

> *"It is strongly recommended that PCNs make use of available IT solutions in place to enable referrals and results to be communicated through a digitally integrated workflow system to support use of direct access to diagnostic tests for patients with symptoms which could be caused by cancer, but who do not meet the threshold for urgent suspected cancer referrals as set out in NG12."*

Funding is being allocated to a digital clinical support tool called iRefer-CDS:

> *"To ensure the use of iRefer-CDS by GP practices, we strongly encourage PCNs to require all GP practices to have digital order comms systems. NHS England is working with GP system providers to ensure that all primary care digital order comms systems are compatible with iRefer-CDS."*

iv. Tackling Neighbourhood Inequalities

The specification has remained largely the same, but additional clarity has been provided to the responsibilities of the PCN Health Inequalities lead.

Investment & Impact Fund (IIF)

This year the IIF funding will be broken down into three distinct elements:

1. **IIF Indicators** (worth £59m or £0.947 per patient). The number of IIF indicators will be reduced from 36 to five focusing on four specific areas: vaccinations & immunisations (two indicators), tackling health inequalities (LD health checks), early cancer diagnosis, and access.
2. **Capacity and Access Support Payment** (worth £172.2m or £2.765 per patient). This will be provided as a monthly payment to PCNs.
3. **Access Improvement Plan** (worth £73.8m or £1.185 per patient). This will be available to PCNs after delivery against an access improvement plan. The access improvement plan is to be drawn up in Q1 of 2023/24, and payment will be assessed by ICBs after March 2024.

1. IIF Indicators

There are 262 IIF points available. The value of a point will be £198 (adjusted for list size and prevalence).

Vaccinations & Immunisations (seasonal influenza vaccination) **EXISTING INDICATOR**

Indicators VI-02 and VI-03 remain. The lower threshold for VI-02 has risen from 57% to 72%. The lower threshold for VI-03 has risen from 45% to 64%. The upper thresholds for both indicators have remained the same. The points for VI-02 have risen from 88 to 113. The points for VI-03 have risen from 14 to 20.

Tackling Health Inequalities (learning disability health checks) **EXISTING INDICATOR**

Indicator (HI-01) has been amended by adding a requirement to record the ethnicity of people with learning disabilities. There are no changes to the thresholds (60% - LT; 80% - UT) or to the points (36).

Cancer (early cancer diagnosis) **EXISTING INDICATOR**

A Personal Care Adjustment (PCA) has been added to the indicator on FIT testing (CAN-02) so that PCNs are not incentivised to refer for FIT testing when there is rectal bleeding. There will be additional support provided where practices are struggling to access testing, via a national 'supply chain' escalation system. The lower threshold has increased from 40% to 65%. The upper threshold (80%) and the points (22) are unchanged.

Access **NEW INDICATOR**

ACC-08 – Percentage of appointments where time from booking to appointment was two weeks or less. This measures the number of appointments delivered by the practice under 8 national appointment categories (General Consultation Acute; General Consultation Routine; Unplanned Clinical Activity; Clinical Triage; Walk-in; Home Visit; Care Home Visit; Care Related Encounter but does not fit any other category).

It does **NOT** measure any other of the national appointment categories, e.g. Planned Clinics; Planned Clinical Procedure; Social Prescribing Services; Structured Medical Review etc. None of these are in the denominator for this indicator, only the 8 specified categories.

Lower Threshold 85%, Upper Threshold 90%. These thresholds look high, but the guidance says that 85% corresponds to the 20th percentile of current national performance, while the upper threshold of 90% corresponds to the 50th percentile (i.e. median performance).

Exceptions – Where a patient explicitly requests an appointment beyond two weeks or where there is a clinically defined interval between encounters, e.g. the GP may say "come back and see me in four weeks" – in both the above cases the appointment would be omitted from the indicator.

LMC Comment: *Currently, half of the appointments offered are within two weeks 90% of the time, and four-fifths of the appointments offered are within two weeks 85% of the time. However, one-third of patients (in the national survey) were unsatisfied with the appointment times offered to them.*

The fault is that the Government does not do enough to promote how hard general practices are working, that numbers of appointments are actually up, and that practices are working in new ways. This contributes to patients having little appreciation for what practices are actually doing and to patients having unrealistic expectations about what they should get from their practices. An element of this is the failure of Government to be clear that the NHS pays GPs to provide patients' services that they clinically NEED not the services that a patient may WANT.

2. Capacity and Access Support Payment

This payment should be made directly to PCNs on a monthly basis and is worth £2.765 per patient per annum. There is no requirement for PCNs to make "claims" or submit supporting evidence.

LMC Comment: *The Capacity and Access Payment (CAP) guidance makes it clear that this payment is unconditional, i.e. it is not dependent on what is in the access improvement plan or on any work in relation to the access improvement plan. It is entirely down to each PCN whether it chooses to divide up this money between itself and its member practices, and what it chooses to spend the money on.*

3. Access Improvement Plan

The access and improvement plan money will be available to PCNs after delivery against an access improvement plan. The access improvement plan is to be drawn up in Q1 of 2023/24, and payment will be assessed by ICBs after March 2024.

To be eligible for the Capacity and Access Improvement Payment, practices within the PCN must comply with the existing contractual requirement to report results of completed Friends and Family Tests to NHS England and publish the results locally.

LMC Comment: *It is reasonable for access improvement plans to include support needed from ICBs and the guidance says ICBS should provide that support where it is required. This could be in the form of practical support needed when practices reach capacity and report Opel Red/Black, or equivalent, to commissioners.*

If a PCN is hoping to receive any element of the Access Improvement Plan Payment, make sure that all constituent PCN members are meeting their contractual requirements re the Friends and Family Tests, if this is to be a qualifying criterion for any other Improvement Payments.

A template is provided for the access improvement plan and should be submitted to the ICB by Friday 12th May 2023. The plan should cover three areas:

i. patient experience of contact
ii. ease of access and demand management
iii. accuracy of recording in appointment books

The guidance says that the available funding should be set "equally" across all three key areas such that 100% of funding can only be received if improvements are achieved across all three areas.

LMC Comment: *It is not clear if "equally" means that each of the three areas should receive 33.3% of the funding or if it only means that there must be some improvements set for all of the three areas. We are seeking clarification on this.*

Patient experience of contact

The national patient survey may be used to set the context for this assessment, but the ICB will have to assess improvement on this area before the 2024 data is published, so metrics from the national patient survey are not appropriate in this area.

PCNs **may** choose to include improvements in Friends and Family Tests but may also choose to run local surveys on patient experience or to be measured by process improvements on how the PCN analyses and acts on feedback.

Ease of Access and Demand Management

This area includes cloud-based telephony (CBT) and online consultation. Possible criteria for improvement include cloud-based telephony is in place with call-back function activated and the practice/PCN uses CBT data to drive improvement; increased online consultation usage.

LMC Comment: *We would expect practices/PCNs where CBT is already in place and providing data to be able to positively assess in this area by maintaining such processes.*

We would not expect practices which cannot move to CBT this year because of their existing contracts to be penalised in this area because of the inflexibility of their existing contracts.
We would expect the ICB to listen to representations from practices/PCNs where a significant proportion of their patients is digitally excluded either by age and/or through not having English as a first language etc.

The LMC will make the above points to the ICBs in advance of the 12th May deadline for submission of the access improvement plans.

Accuracy of recording in appointment books

The assessment of this area is based on self-certification by the PCN that all practices in the PCN are accurately recording all appointments and complying with categorisation guidance on the recording of appointments. The ICB is required to triangulate the PCN self-certification with the PCN's appointment recording seen via the ICB GPAD dashboard.

LMC Comment: *We will be asking the ICBs to verify the accuracy of the data on their GPAD dashboards and to bear in mind the accuracy of such data when assessing this area.*

We will also ask what evidence PCNs could expect to see to be able to certify the performance of all practices in their PCN. Will it be the CD who formally certifies all the PCN's practices? What support will there be for the CD to do this? What would it mean for a PCN (and a CD) if the ICB's triangulation does not support the PCN's self-certification?

The guidance says that where ICBs forecast that not all of the Capacity and Access Improvement Payment IIF monies will be awarded they should seek to invest these in local access improvement to general practice for the population where appropriate with wider ICB plans.

LMC Comment: *If an ICB should make such a forecast the LMC would want the ICB to be very clear on the evidence for such a forecast and to have discussions with the LMC, PCNs and practices about what it wants to invest such monies in.*

Quality Outcomes Framework (QOF)

The main change is the protection of all register indicators. This amounts to 81 points (a reduction of 25%) and equates to a release of £97m in funding. The funding will be paid to practices based on their 22/23 performance.

LMC Comment: *Although the Government have badged this as protected income, maintenance of these registers is still in the Practice's interest. Processes that have been set up could be easily continued and will improve further income related to disease prevalence.*

All QOF indicators sit within the existing three domains:

- Clinical domain (401 points)
- Public health domain (160 points)
- Quality improvement domain (74 points)

Below we have summarised the key changes in each of the three areas.

Clinical Domain

Indicator	Domain Area	Description of change	Change Type
RA002	Rheumatoid Arthritis (RA)	Face-to-face review of patients with Rheumatoid Arthritis removed.	REMOVED
DEM004	Dementia (DEM)	Reduced from 39 to 14 points with the mode of review not being specified.	AMENDED
AF007	Atrial Fibrillation (AF)	AF007 has been removed and replaced with AF008.	REMOVED
AF008	Atrial Fibrillation (AF)	Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2-VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist 12 points and a threshold 70-95%.	NEW
CHOL001	Cholesterol Control and Lipid Management (CHOL)	Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy 70-95%.	NEW
CHOL002	Cholesterol Control and Lipid	Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, or Stroke/TIA Register, who have a recording of non-HDL cholesterol in the	NEW

	Management (CHOL)	preceding 12 months that is lower than 2.5 mmol/L, or where non-HDL cholesterol is not recorded a recording of LDL cholesterol in the preceding 12 months that is lower than 1.8 mmol/L 20-35%.	
MH002 MH003 MH006 MH007 MH011 MH012	Mental Health (MH)	Each MH indictor has been reduced by 1 point to create a new indicator (MH021) worth the re-purposed 6 points.	AMENDED
MH021	Mental Health (MH)	Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who received all six elements of the Physical Health Check for people with Severe Mental Illness 50-80%.	NEW

Public Health Domain

The thresholds have been reduced for three of the childhood immunisations indicators.

Indicator	Domain Area	Description of change	Change Type
VI001	Vaccination and Immunisations (VI)	The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months. Threshold: 89-96% (reduced from 90-95%).	AMENDED
VI002	Vaccination and Immunisations (VI)	The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months Threshold: 86-96% (reduced from 90-95%).	AMENDED
VI003	Vaccination and Immunisations (VI)	The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years Threshold: 81-96% (reduced from 87-95%).	AMENDED

LMC Comment: *There remains no exception clause for vaccine refusers. The clawback of monies on failure to reach the lower target has been removed.*
The letter from Amanda Doyle about the contract says that there will be a Personalised Care Adjustment (PCA) for patients who register too late at the practice, e.g. those who register too late in age because they have come from abroad. However, this change has not been included in the Statement of Financial Entitlements or the QOF guidance. These two documents have more contractual weight than the letter from NHSE so it is not clear practices will be able to use this PCA this year.

Quality Improvement Domain

Indicator	Domain Area	Description of change	Change Type
QI013	Workforce and Wellbeing (37 points)	This is set with the aim of improving wellbeing, resilience, and risk of burnout for the GP workforce and creation a compassionate and inclusive culture in GP.	NEW
QI014			NEW

LMC Comment: *This has always been our focus and we would state that all practices need to be prioritising their wellbeing. We would encourage all practices to review the BMA safe working guidance (available here).*

Indicator	Domain Area	Description of change	Change Type
QI016	Optimisation of demand and capacity in General Practice (37 points)	There has been a change in wording from access to an acknowledgement of capacity pressures. The aim in this area revolves around use of data in relation to demand and capacity to make changes in respond to better meet demand.	NEW
QI017			NEW
QI018			NEW
QI019			NEW

LMC Comment: *Much of what is listed here as NHSE Guidance will be very familiar to practices – some might even say patronising. However, as this indicator is about **PRACTICE** initiatives on access, there might be ways for practices to make the practice improvement plans for QOF coordinate with and support the **PCN** Access Improvement Plan required under the PCN DES – for those practices which sign up to the PCN DES.*

Weight Management Enhanced Services

The funding envelope has reduced from £11.5m to £7.2m. The referral allocation has also reduced from 20% to 12 % of the number of patients on the practice obesity register. The payment per person made under this service remains the same.

GMS/APMS Contract

As mentioned in the introduction, changes to your core contract **do not come into effect on 1st April**. These changes can only come into effect once the changes to the GMS/APMS Regulations are published, and the contract has been issued and signed by practices (or 14 days after the date of issue if not signed). **The revised regulations are normally published to take effect from 1st October**. Until the regulatory changes are published, the full details of the changes to the contract will not be known. However, the following changes have been outlined by NHSE.

Target to improve patient satisfaction with general practice

This was mentioned in the Amanda Doyle letter, however, there are no details as to what such a target might be (and if it is a target whether it is in fact referring to either the QOF or IIF targets).

LMC Comment: *The likelihood of achieving this target – no matter how good the service a practice provides – needs to be set against the dropping patient satisfaction figures across the whole of the NHS.*

Practices and PCNs need to think carefully about how such targets are framed and set, and how much effort is put into achieving them for the achievement rewards promised.

Practice "offer" to patients

The GP contract will be updated to make clear that **patients should be offered an assessment of need, or signposted to an appropriate service, at first contact with the practice**.

LMC Comment: *The contractual requirement for practices is binary – EITHER the offer of an assessment of need OR signposting to an appropriate service. There are no further details from the Government about what form an "assessment of need" should take or what would count as signposting to an appropriate service*.

Prospective (future) record access

This will need to be offered to all patients by 31st October 2023. There will also be amendments to provide clarity on how practices are required to offer, promote and provide online access to patient records.

LMC Comment: *This has been on the Government's wish-list for a number of years. Previous deadlines have been postponed or opt-outs have been available for practices. Less than a quarter of practices are currently offering this and only about a tenth of patients have access to it. However, the Government seems wedded to this proposal, despite concerns from the profession about data breaches or unintended consequences of blanket access.*

The Government will need to get the contract re-write into Regulations and ICBs would need to issue new contracts in advance of 31st October for this contractual requirement to take effect for 31st October.

We do not know what the clarification on how to offer and promote access to patient records will be. It is possible that the Government might require a more proactive approach, i.e., actively

communicating with patients about this, rather than the more passive approach of putting information on the practice website, within surgeries etc.

Subject Access Requests (SARs)

The Government has ended the additional funding in Global Sum (£20 million) which had been included to reflect workload for practices from Subject Access Requests (SARs). The original 5-year deal had assumed that this funding would cease beyond 2021/22 so it was never guaranteed to continue.

LMC Comment: *It is very regrettable that this additional source of funding has ended. The Government has not given a reason for this. Requests for SARs will continue. Prospective online access to records could in due course start to reduce the demand for SARS but it will take years for that to happen. It is clear that the Government is also in favour of retrospective access to records. It may be working on the assumption that the removal of any financial support for SARs will make practices more willing to engage with any plans for retrospective access to records.*

Mandate use of cloud-based telephony (CBT) national framework

Practices will be required to procure their telephony solutions only from the Better Purchasing Framework once current contracts expire. The Delivery Plan for Recovering Access to Primary Care will describe further support available for practice who are interested in making this move in 2023/24.

LMC Comment: *It will be interesting to see if the Delivery Plan includes the option of buying out contracts, as that has been a limiting factor for some in making a move.*

The use of cloud-based telephony is also referred to in the Access Improvement Plan which is part of the Capacity and Access Payment under the PCN DES. It is specifically referred to in the "Ease of Access and Demand Management" area of the Access Improvement Plan.

GP Retention Scheme

The four-session cap within the GP retention scheme was lifted during the pandemic and will now be removed permanently. Sessions worked above the cap will be funded by the employing practice.