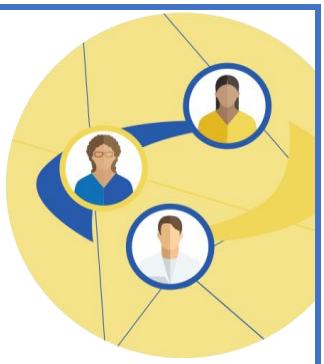
Bedfordshire & Hertfordshire Local Medical Committee Ltd

Working in partnership for excellence in General Practice



GP contract changes in 2024/25

More detailed guidance and information will come from NHSE over the coming weeks/in the publication of the Regulations, but it's worth noting that the changes to the GMS/APMS core contract do not come into effect on 01st April, but once the GMS/APMS Regulations are published (normally published to take effect **from 01st October**).

The elements outside the GMS/APMS contract do come into effect **from 01st April** – these include QOF, PCN DES, IIF and Weight Management Enhanced Services.

The Government has also noted that it plans for an update to the Delivery Plan for Recovering Access to Primary Care 'including the key milestones for 2024/25' to be published shortly.

Global Sum

The letter states:

> *'Now we are outside of the five-year framework, we will return to the pay review body process (Doctors and Dentists Review Body, DDRB) as the established process for determining pay uplifts for public sector workers, when workforces are not in multi-year deals. As the DDRB has not yet made recommendations to Government, we have included a planning assumption of 2% for pay growth in the GP contract. A further uplift **may** be made following the Government's response to the DDRB for 2024/25.'*
>
> *'Numbers:*
>
> *There will be an overall increase in investment of £259m taking overall contract investment to £11,864m in 2024/25. This includes:*
>
> i *a planning assumption of 2% pay growth for contractor GPs, salaried GPs, and other practice staff.*
>
> ii *a planning assumption of 2% pay growth uplift to the overall Additional Roles Reimbursement Scheme (ARRS).*
>
> iii *1.68% inflation, in line with the Government's November 2023 GDP deflator.*
>
> iv *0.38% ONS population growth.'*

We think this means:

The GP contract is notionally divided into three elements: GP Contractor Income, Other Staff Expenses, and Other Expenses.

The details of exact calculations are still unknown but the increase to the Global Sum payment per practice is likely to work out as a 2% pay uplift for GPs (salaried and contractor) plus other practice staff through the two 'salary' components of the Global Sum (i.e. GP Contractor Income and Other Staff Expenses). We assume the third section of the Global Sum payment (i.e. Other Expenses), reflecting costs and rates etc., will increase by 1.68% - giving an average 1.9% uplift in the total Global Sum payment. The Global Sum payments and any increases impact practices in different ways according to each practice's actual balance of salaried staff costs, partner takings, and general costs in relation to the Global Sum percentage breakdown.

Now that GP contractors are outside the 5-year contract, they are able to (not guaranteed to) join salaried GPs within the remit of the DDRB's recommendations due to be released around June 2024. Last year's DDRB recommendation was 6% (so the additional 3.9% uplift in August was to make the original 2.1% up to the 6%) and was applied to the 44% of the Global Sum figure allocated to staffing expenses. This raises the likelihood of a mid-year uplift, like last year and backdated to April, to the two pay sections of the Global Sum – so this year applying to all salaried GPs plus GP contractors.

Interestingly, this could fall in the middle of any IA period.

Each practice will have to balance ongoing fiscal stability with passing on these uplifts to partners, GPs and all practice staff (bearing in mind the National Living Wage increase from April 2024).

We understand that the England registered population is roughly 61,000,000. We have used this number to calculate pounds per patient figures where the NHSE letter only gives a total England figure.

QOF

The letter states:

- '*Help practices with cash flow and increase financial flexibilities by raising the QOF aspiration payment threshold from 70% to 80% in 2024/25.*'
- '*There will be a net reduction in the conditionality attached to QOF … through suspending and income protecting 32 indicators (out of 76 QOF indicators) … 42% of QOF indicators. These indicators account for 212 of the 635 points that can be earned through the QOF scheme.*'

- *'For the income protected indicators, this will mean that practices will be awarded QOF points based on their performance in previous years, while points for the remaining live indicators continue to be conditional on their performance in the year at hand.'*
- *'The 32 indicators which will be income protected (listed in the table below) include the 19 register indicators protected in 2023/24.'*

Clinical/Policy Area	**ID**	**QOF points**
Mental Health	MH021	6
Depression	DEP004	10
Asthma	AST008	6
Register Indicators x 19 covering a range of clinical areas	CAN001, CKD005, CHD001, HF001, HYP001, PAD001,	81
	STIA001, DEM001, DM017, EP001, LD004, MH001, OB003, OST004, PC001, AF001, AST005, COPD015, RA001.	
QI indicators x 6	All	74
COPD	COPD014	2
Smoking	SMOK005	25
Cancer	CAN004	6
Cancer	CAN005	2

'(Indicator CHOL002 will be updated so that it is aligned with the new NICE NM252 indicator definition from 01st

April 2024, ensuring that QOF maintains its strong link to the latest evidence-based guidance.)'

We think this means:

QOF monthly aspiration payments will increase to reflect 80% of the projected income.

32 of the 76 QOF indicators will be suspended, with these protected points awarded based on performance in 'previous years'. The determining year/s are yet to be clarified, but for Herts practices, this places greater pressure on the ICB to provide a true assessment of the 2022/23 15-month-adjusted QOF figures, which are likely to form at least part of the relevant time period. BLMK practices do not have the additional complication of Herts ICB's previous adjustment to QOF.

The change to align QOF CHOL002 indicator to NICE NM252, essentially loosens the control slightly from:

LDL <1.8, to LDL<2 and non-HDL <2.5 to non-HDL <2.6

IIF

The letter states:

- *'The Investment and Impact Fund (IIF) indicators will be reduced from five to two meaning that the Capacity and Access Payment (CAP) Funding from the three retired indicators, relating to flu and access, will be redirected into the Capacity and Access Payment (CAP) which will increase by £46m [to £292m].'*
- *'The two retained indicators will be health checks for people with a learning disability and the use of FIT testing in cancer referral pathways, worth £13m.'*
- *'As in 2023/24, 70% of the funding will be paid to PCNs without any conditions via the Capacity and Access Support Payment (CASP) proportionate to their Adjusted Population, in 12 equal payments.'*
- *'The remaining 30% of the Capacity and Access Payment (CAP) will be available to PCNs via the Capacity and Access Improvement Payment (CAIP). The Capacity and Access Improvement Payment (CAIP) will now start to be paid at any point in the year, once PCNs confirm they meet the simple criteria for payment … (once the PCN Clinical Director (CD) confirms to their ICB that all practices within a PCN have put in place one or more of the three individual components of the Modern General Practice Access model, which each attract 1/3 of the overall CAIP funding', as shown in the table below. 'Each PCN Clinical Director will need to provide assurance of this to their ICB. These conditions can be met at any point during the year and PCNs will receive payment in year once they are met':*

MGPA priority domain	All PCN practices to have following components in place and these continue to remain in place
1) Better digital telephony	• Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England. • Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.
2) Simpler online requests	• Online consultation (OC) is available for patients to make administrative and clinical requests at least for the duration of core hours. • Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.
3) Faster care navigation, assessment, and response	• Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests. • Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.

We think this means:

A figure of £292m for England for CAP equates to about £4.79pp. 70% of this equates to about £3.35pp and 30% equates to about £1.44pp.

The CAIP funding is based on 'assurance' from the PCN CD, and in the NHSE webinar on 29th February, Amanda Doyle suggested this will be a simple self-declaration that criteria are being met (without necessitating the submission of any material to the ICB), which can be made at any point during the year – so could theoretically be made on 01st April with the additional 30% then spread over all monthly payments. Please note that the full 30% is available whenever a PCN meets the relevant criteria. If a PCN meets the criteria before 01st April 2024 then the PCN would get the 30% in 12 monthly payments from April 2024. If a PCN meets the criteria in March 2025, then it would get a lump sum of the 30% for 2024/25 in the financial year 2025/26. The sooner a PCN can report it has met the criteria, the sooner it will receive – or start to receive – this 30%.

The letter states that *'PCNs have the discretion to use the funding according to local needs – for example, the supervision of ARRS staff or to increase the care home premium within the PCN'*. In reality, local needs may be more Practice based to ensure efficient GMS delivery to underpin PCN delivered services but 70% of the CAP is "without any conditions" so each PCN can use that money for whatever it/its practices decide.

PCN changes

The letter states:

PCN leadership:

- *'We are simplifying the PCN Clinical Director role specification by articulating the following key responsibilities: co-ordination of service delivery, allocation of resources, supporting transformation towards Modern General Practice and supporting the PCN role in developing Integrated Neighbourhood Teams.'*

ARRS roles

- *'Enhanced practice nurses will be included in the roles eligible for reimbursement. This will allow nurses working at an enhanced level of practice and holding a (level seven or above) postgraduate certification or diploma in one or more specialist areas of care to be recruited via ARRS. As a new role, this will initially be capped at one per PCN (two where the list size is 100,000 or over).'*
- *'PCNs will be able to recruit other direct patient care non-nurse and non-doctor MDT roles, if agreed with their ICB.'*
- *'Where PCNs already have one mental health practitioner (MHP) in place, 50:50 funded by the PCN and the mental health provider, funding arrangements for subsequent MHP roles will be for agreement between the PCN and the mental health provider, subject to ICB approval. This could include additional MHPs being up to 100% funded through ARRS. All mental health practitioners will continue to be employed or engaged by the mental health provider.'*
- *'Caps on all other direct patient care roles will be removed.'*

Financial changes

- *'We will roll the PCN Clinical Director and PCN Leadership and Management Payment (£89m combined) into core PCN funding to give £183m in total. This is intended to provide PCNs with greater autonomy and to allow PCN Clinical Directors to lead their PCN in the way that best suits local arrangements.'*
- *'PCNs will be able to claim reimbursement for the time personalised care roles spend out of practice undertaking training or apprenticeships to obtain a level three occupational standard.'*
- *'In 2024/25 the mechanism which allows commissioners to redistribute unclaimed funding from the Additional Roles Reimbursement Sum between PCNs will be*

removed from the Network Contract DES. We continue to encourage PCNs to recruit up to their individual entitlements.'

We think this means:

This removal of restrictions around payments gives the PCN the freedom to make decision to suit all practices – whether paying GPs for the time spent supervising ARRS staff or simply distributing all money to practices once the CD/PCN admin staff have been paid.

The ringfencing of the CD and Leadership and Management Payment is removed. This means greater flexibility to reflect the variations and sizes of the administrative mechanisms of PCNs across the country, and to fully reimburse the CD role. With that comes the freedom to put more funding into PCN control/leadership or into practice funds.

We believe that the above financial alterations to the allocation of IIF and PCN leadership funds is, in effect, creating a PCN 'global sum'. £183m is equivalent to around £3.00 per patient.

There has been no flexibility given for the employment of GPs or of 'generalist' Practice Nurses with ARRS funds.

We are waiting to see if there is more detail about the definitions and qualification of "enhanced practice nurses" but, on the information available so far, we cannot see any reason why a specialist mental health nurse, for instance, could not be employed using this funding.

Other doctors/Performers List

The letter states:

- *'During the COVID-19 pandemic there was an amendment to the Performers List Regulations that intended to allow doctors other than GPs to deliver primary care services without being on the Medical Performers List (MPL) if they had a prescribed connection to a designated body in the Medical Profession (Responsible Officers) Regulations 2010; or were granted permission to practise as medical practitioners in hospitals owned or managed by such bodies.'*
- *'Flexibilities similar to the COVID-19 amendment will be made permanent. Doctors that are employed or registered with bodies designated by the Medical Profession (Responsible Officers) Regulations 2010 (Schedule, Part 1 only) will be able to deliver primary care services without being on the MPL. There will be a corresponding change to the GP contract regulations.'*
- *'These changes will permit GP practices and PCNs to employ doctors who are already employed, for example, by an NHS trust, NHS foundation trust or health board without the requirement for the doctor to also be registered on the MPL.'*

- *'Supporting guidance will also be issued to clarify that non-GP doctors should not see undifferentiated patients, and that they continue to be required to operate within their sphere of competence.'*

We think this means:

More detail is needed around the meaning of these changes, but this effectively opens the gate for funding to be paid to, for example, a paediatrician, even if practices are struggling to afford to employ more GPs. It also raises issues around governance/clinical responsibility for those employees not on the Performers List, who by nature are unable to see undifferentiated patients. There is also the risk that this leads to an increased push of secondary care work into the community.

The Network Contract DES service requirements

The letter states:

- *There are currently nine service requirements which are detailed in the Network Contract DES. A number of these are supported by non-contractually binding guidance documents.*
- *Eight of the current PCN service specifications will be replaced by one simple overarching specification with a greater outcomes-focus. The new overarching specification will focus on supporting resilience and care delivery, improving health outcomes, reducing health inequalities and targeting resource to deliver proactive care.*
- *The Enhanced Access specification will remain as a separate specification with the arrangements unchanged in 2024/25.*

We think this means:

We await more detail to understand what this might mean.

Digital Telephony/Access

The letter states:

- *'The amendments to the 2023/24 GP Contract require that when practices enter into any new digital telephone contract, it must be procured through the national framework.'*

- *'In 2024/25 the GP Contract will be amended to require practices to provide data on eight metrics through a national data extraction, for use by PCN Clinical*

Directors, ICBs and NHS England. The requirement will come into force from October 2024 to allow practices time to review and understand their own data before it is shared as outlined. The eight metrics are:

i *call volumes*
ii *calls abandoned*
iii *call times to answer*
iv *missed call volumes*
v *wait time before call abandoned*
vi *call backs requested*
vii *call backs made*
viii *average call length time'*

We think this means:

There is no guidance on those practices currently financially tied to non-framework contracts. The requirement for call data metrics around calls comes into effect on 01st October, when NHSE will pull the data automatically. Practices/PCNs are expected to 'review and understand' their data ahead of October. This will only become a GMS contractual requirement after the updated GMS contract has been produced and sent to individual practices. This will not happen on 01st April and usually does not happen until the Autumn.

Enhanced Services

The letter states:

- *'The Weight Management Enhanced Service will continue in 2024/25. Practices will receive £11.50 per referral with total funding of £7.2m for the Enhanced Service.'*

We think this means:

There is no change on last year.

Registering with a GP

The letter states:

- *'NHS England has co-developed a new registration solution with patients and practices to make registering with a GP easier, simpler and standardised. Over 2000 practices have already adopted the solution which consists of an online registration service and a new paper form. Practices will be contractually required to adopt and offer both formats. There will be a mobilisation period with both formats to be in place from October 2024.'*

We think this means:

Both formats for registration will need to be in place by October, if the GMS contract has been duly updated and sent to practices in advance of 01st October. However, there is no suggestion of volume of usage for each.

Continuity of care

The letter states:

- *'In order to highlight the importance of continuity of care, whilst ensuring practices have flexibility to deliver services to best meet the needs of their patient population, the provisions in the GP Contract Regulations will be amended to explicitly require continuity of care to be considered when determining the appropriate response when a patient contacts their practice.'*

We think this means:

The ongoing conversation around the importance of continuity of care means this comes into the contract but is likely to be just a tick-box requirement with no activity attached.

Vaccinations and Immunisations data

The letter states:

'The GP Contract will be changed in 2024/25 so that practices are required to:

- *share vaccination status (both vaccinated and unvaccinated) with the local Child Health Information Services (CHIS), and any other system nationally required, and support CHIS data cleansing.*
- *improve data recording of vaccination status for all patients, including where they have arrived from overseas and where there is an unknown or incomplete history to offer vaccinations in line with the UK Schedule and Green Book.*
- *improve data quality for vaccination events, with this being supported through a rationalisation of SNOMED codes used for vaccination event recording. following an impact assessment by NHS England, with practices ensuring they are using the relevant codes within their clinical system templates; and*
- *maintain accurate and up-to-date patient vaccination records, including correcting vaccination records as and when they are made aware of any errors.'*

We think this means:

The sharing of data with CHIS and supporting their data cleansing is essentially an unpaid workload shift to general practice. The elements with respect to data recording could be seen as good practice and minimise safeguarding risk.

Workforce data collection

The letter states:

- *'Practices and PCNs will be required to submit workforce information on a quarterly basis to the National Workforce Reporting Service (NWRS) via changes to the GP contract and the Network Contract DES.'*

We think this means:

We await more detail on what this might mean. The language of the letter says that practices will be required to submit quarterly. The current GP contract requires practice to make sure the data is "available for collection on a timetable that NHSE can set. We will need to see the details of the contract wording to understand what this change will mean.

Catchment area data

The letter states:

- *'The GP Contract Regulations will be amended to require GP practices to use digital tools provided by NHS England to reproduce a digital copy of their practice boundary (including any branch site areas, whether coterminous or not). Practices will also be required to review and where necessary update GP practice boundaries where data quality is insufficient for the intended purpose.'*
- *'Practices will also be required to produce a digital copy of a practice's agreed practice boundary where a new practice is established or merged or a catchment area change is agreed, either as part of a new contract or variation procedures.'*

We think this means:

This is likely to be dependent on availability of digit tools.

Armed Forces Veterans

The letter states:

- *'The GP Contract will be updated so that practices must have due regard for the requirements, needs and circumstances of Armed Forces Veterans when offering services and making onward referrals.'*

We think this means:

This is likely to be another tick boxing exercise: it is not clear what having "due regard" will mean in reality.