British Medical Association
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General Practitioners Committee

2 November 2011

Dear Colleague,

2012/13 contract agreement

We are writing to inform you that, following negotiations between the General Practitioners Committee (GPC) and NHS Employers, on behalf of the four health departments, we have reached agreement with the English, Scottish, Welsh and Northern Irish health departments on changes to the contract for April 2012/13. The agreement relates to the following areas of the contract:

- Practice Expenses
- Certain QOF points, indicators and thresholds
- New Quality and Productivity Indicators in the QOF
- Choice of GP Practice (England only)
- Clinical and Extended Hours Directed Enhanced Services (DESs)
- Carr-Hill formula
- CCG membership (England only)

2011 has been another challenging year for GPs, given the general economic outlook and the need to make further significant savings across the NHS. 2012 will be no different for practices and their staff, but we have worked hard in our negotiations to limit the degree of change to the contract whilst ensuring that any changes agreed were consistent with good clinical practice. We have also sought to reach an agreement that retains the current resource within the contract and ensures all practices receive some compensation for increased expenses.

In recognition of the general state of public finances and the efficiency contribution expected of general practice, NHS Employers and GPC negotiators have agreed that, in line with Government policy, there will be no uplift to GP net pay in 2012/13, which is the same as other doctors.

Practice Expenses
For 2012/13, in order to reduce the risks of a further net pay cut for GPs, we have agreed to an increase to the overall value of GMS contract payments by 0.5 per cent, to support practices in meeting the costs of increased expenses, including the pay award for employed staff with a full time equivalent salary of less than £21,000. This increase will be delivered through an increase in the value of a QOF point. This increase in the value of a QOF point is intended to deliver the full 0.5 per cent expenses increase agreed with NHS Employers. This will therefore also apply to PMS practices.

In June 2010, the Chancellor of the Exchequer announced that staff on Agenda for Change terms and conditions with a full-time equivalent salary of less than £21,000 will receive a flat pay rise worth £250 in

2011/12 and 2012/13. We would expect GMS practices to use this expenses rise to mirror the award for Agenda for Change staff for practice staff earning under £21,000, where applicable.

Quality and Outcomes Framework (QOF): NICE Recommendations
Two indicators (17 points) have been retired following recommendations from the National Institute of Health and Clinical Excellence (NICE) and a further 26 points in total have been removed from other indicators (BP4, BP5, CKD2, DM2, DM22, Smoking 3 and Smoking 4).

We have agreed to a number of changes to some of the current indicators and most significantly introduced two new disease areas, osteoporosis and peripheral arterial disease.

The full details of the changes to QOF for 2012/13 are detailed on the BMA website..

QOF: Changes to Thresholds

There will be a number of changes to QOF thresholds from 2012/13 as follows:

- raising the lower thresholds for indicators currently 40-90% to 50-90%
- raising all lower thresholds for indicators currently with an upper threshold between 70-85% to 45%
- a number of upper threshold changes for indicators CHD6, CHD10, PP1, PP2, HF4, STROKE6, STROKE8, DM17, DM31, COPD10
- lower and upper threshold changes to BP5

QOF: Quality & Productivity (QP) Indicators
We have agreed to replace the QOF-QP prescribing indicators with new indicators which aim to reduce avoidable Accident and Emergency (A&E) attendances. The new A&E indicators will be worth 31 points (28 points from prescribing and three points from other QOF changes). These indicators are for one year from 1 April 2012 until 31 March 2013.

The guidance for these indicators will be available shortly on the BMA website.

The QP indicators covering emergency admissions and outpatient referrals will continue for a further year until 31 March 2013.

In order to ensure that prescribing improvements continue, we have agreed to the following joint statement with NHS Employers:

"Although the prescribing element of the quality and productivity scheme will be replaced with A&E attendances in 2012/13, we agree that all practices in the UK should continue to ensure cost effective prescribing when compared to peers, building on the progress achieved in 2011/12. Those practices who remain significant outliers would also be expected to continue to participate in external peer review during 2012/13."

Choice of GP Practice (England only)
All three main political parties in England are committed to policies that extend choice of practice for patients in England. In the GPC's response to the previous government's consultation, during 2009, and restated since to the current coalition government, during October 2010, we opposed the complete removal of practice boundaries and instead proposed greater local flexibility to allow patients to remain registered with a practice when they have only moved a short distance outside the practice area, and a modified temporary resident scheme to allow practices to provide primary medical services to commuters.

We have agreed that practices will agree with their PCT an outer boundary where they will retain, where clinically appropriate, existing patients who have moved into the outer boundary area and want to stay with the practice. There will also be a pilot to test two different models enabling commuters to receive primary medical services when away from home. It will allow patients in two or three cities (or part of cities) to visit

a practice, either as a non registered out of area patient, or as a registered out of area patient in a number of voluntary practices in those areas. The funding to pay for patients who use surgeries on a non-registered basis will be capped at £2m which will therefore limit the size of the pilot. The pilot will be subjected to an independent evaluation. The Department of Health has agreed that the results of that evaluation will be published and results considered before any further implementation.

Detailed guidance on both the establishment of outer boundaries and the operation of the choice pilot will be developed and published shortly.

Clinical DESs

The osteoporosis DES in England, Scotland and Northern Ireland will no longer be available from 1 April 2012. In England, the GMS element of the funding for the osteoporosis DES (based on the last available audited accounts, 2010/11) will be reinvested in the global sum with no corresponding increase to correction factor payments. Any money released through reductions in correction factor payments are to be reinvested back into the global sum.

Scotland and Northern Ireland have both agreed to reinvest the funding for the osteoporosis DES into the GMS contract but the exact mechanism for doing so will be agreed with the respective GPC.

In England the following existing directed enhanced services are to be re-commissioned by PCTs for the twelve-month period ending on 31st March 2013:

- the alcohol reduction scheme
- the learning and disabilities health check scheme.

The requirements of these two clinical DESs remain the same and the payment scheme will mirror the payment scheme at the same rate that applied for the period 1 April 2011 to 31 March 2012.

Any other changes to Direct Enhanced Services in Scotland, Wales and Northern Ireland will be agreed separately between the Devolved Administrations and their respective GPC.

Extended Hours Access Directed Enhanced Service (England)
The extended hours access directed enhanced service is to be re-commissioned by PCTs for the twelve-month period ending on 31 March 2013. The requirements of this DES remain unchanged.

Carr-Hill formula
We have agreed in principle to explore how the Carr-Hill formula might be adjusted from 2013/14 onwards to give greater weighting to deprivation factors. Such work will refer to the Formula Review Group recommendations from 2007 and Professor Roy Carr-Hill's original work in 2001-03.

Risk profiling and case management

Subject to confirmation of the evidence base, we have agreed to explore how risk profiling and case management of patients might be introduced from April 2013.

Clinical Commissioning Group (CCG) Membership
We have agreed in principle that, subject to the successful passage of the Health and Social Care Bill, all GP practices in England would be contractually required to be a member of a CCG.

Implementation
We believe that the changes described above represent the best possible agreement that your negotiators could reach in these unprecedented and challenging economic times. and are confident that GPs in England, Scotland Wales and Northern Ireland will continue to work within their contract to provide the best possible service to their patients.

Yours sincerely,




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Chairman,
General Practitioners Committee

David Bailey
Chairman,
General Practitioners Committee Wales

Tom Black
Chairman,
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