Arrangements for the GP Contract in 2024/25

A Summary and Commentary

Mike Pyrah
Director - Howbeck Healthcare
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Introduction

The purpose of this short document is to summarise what we know so far about the GP Contract for 24 / 25. We have also added a commentary to support some sections – the commentary (in red italics) represents our views of the issues that we believe Practices and PCNs need to be aware of.

Understanding the process for changing the GP Contract

For the last 5 years practices have been contracted through a 5-year agreement (valid until the end of this month). This five year 'deal' has been subject to annual revisions to the contract, and the various DES schemes (including the PCN DES). The funding for the contract has been set with annual revisions solely based on pay cost of living assessments.

As the 5-year deal has now ended, NHS England has proposed a new one-year contract for 24 / 25 pending the development of a new multi-year settlement. NHS England and the body negotiating on behalf of practices have failed to agree the proposed new contract therefore this is now being imposed on practices.

There are a number of stages in the process of formally launching a new contract these are:

- **The issuing of a contract letter highlighting the planned contract.** This was done on the 28th February and this forms the basis of this briefing.
- **The issuing of the detailed contractual changes and the contract specifications for the key DES schemes, including the PCN DES**. These should be published before the start of the new year.
- **The issuing of a revised Primary Care Access Delivery Plan**. This will be a key document as the contents will set out the requirements in the Capacity and Access Support Payment (CASP).
- **The issuing of the Contract Variation notices to be signed off by practices**. The variation orders have to be produced by the NHSE legal advisors and therefore this usually lags behind the issuing of the contract specifications. The variation orders apply to the GMS contract and not the PCN DES, as the DES is a standalone scheme.

It is absolutely reasonable for practices and PCNs to plan on the basis of the letter received on the 28th February, however it is really important to recognise that the 'devil is in the detail' and therefore understanding the detailed documents is vital, for example last year some of the requirements set out in the letter did not in the end appear as contractual requirements in the contract variations.

The key changes to be included in the new contract:

GP Contract Finance

The document sets out four elements that make up the funding increases for practices:

- An assumption of 2% pay growth for practice staff.
- An assumption of 2% pay growth for ARRS staff.
- 1.68% inflation growth.
- 0.38% ONS Population growth.

These four figures are then used to calculate the increase in investment of £259m and the widely published % increase figures.

The way the imposed contract figures are presented is misleading as they include the funding required to pay the same 'unit' price per patient for the increased population growth. This clearly is not a real term increase for practices. The pay elements are subject to change following the publication of the Pay Review Body recommendations. The pay elements therefore are notional as these will change and the Governments response to the Pay Review Body will be backdated therefore the 2% will be subsumed in the final figure.

The key issue for practices is that the inflation figure (1.68%) is significantly below the actual inflation rate, as practices are reporting double digit cost rises for many services (cleaning contracts etc).

The pay increase (Pay Review Recommendation) should cover the PCN ARRS increases but this will be significantly below pay inflation for practices as this does not take account of the increases in the National Minimum Wage and the impact of this on the differential pay in practices.

In short, the funding 'increase' is a significant real term cut (assuming actual practice inflation rises and the impact of the minimum wage increases) which will therefore effect practice profits.

GMS Contract Changes

1) QOF

32 indicators are in effect 'retired' with the current income protected. Updated QOF guidance will be published setting out the detail of the suspension and income protection arrangements. QOF aspiration payments will be increased from 70% to 80% in 2024/25 to support practice cash flow.

2) Digital Telephony Data Requirements

The last contract changes included a requirement to procure Cloud Based Telephony systems through a national Framework (when existing contracts run out*). **Each practice will have individual timescales for the changes.***

The new contract will include a requirement for practices to provide data (through a national data extraction system) for use by ICBs and NHSE the data covering:

a. call volumes
b. calls abandoned
c. call times to answer
d. missed call volumes
e. wait time before call abandoned
f. call backs requested
g. call backs made
h. average call length time

This requirement doesn't commence until October – the reason given is to allow practices and PCNs time to look at the data, but I think it is more likely that it will take time to set up the data extraction system.

This is a critical change for practices as it seems inevitable to us that this data will be used to performance manage practices and to be part of the Capacity and Access Payment scheme in future years. NHSE are saying that the use of the data will be developmental but are not defining what this means.

3) Performers List

The changes introduced during the pandemic are to 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.*"

Supporting guidance will be published shortly.

4) Registering with a GP.

Practices (from October) are required to adopt a new digital and paper registration system.

There are a number of tools available to support practices with this requirement.

5) Recognising the importance of continuity of care.

The letter flags up that the GMS contract "will be amended to explicitly require continuity of care to be considered when determining the appropriate response when a patient contacts their practice".

This feels like a reaction to the recently published research highlighting the importance of continuity of care which challenges some of the access initiatives.

6) Vaccinations and Immunisations.

A range of requirements designed to improve data collection and the sharing of vaccination status (through a new national system).

It is likely that this will be part of the NHS App and one of the consequences may be an increase in queries direct to practices.

7) Changes to workforce data collection.

Contractional requirement for practices to submit workforce information quarterly via the national system.

This will enable NHSE to have baseline staffing figures for any future 'additionality' schemes (such as ARRS).

8) Digital Tools for Catchment areas.

Practices required to use a digital tool to define the practice catchment area.

9) Armed Forces Veterans.

Contract amended to include a requirement to have "*due regard for the requirements, needs and circumstances of Armed Forces Veterans when offering services and making onward referrals".*

The Network Contract DES

1) ARRS

Changes to the ARRS roles to include Enhanced Practice Nurses. Caps on other Advanced Practitioners to be removed. Changes to the rules for Mental Health Practitioners.

PCNs able to claim reimbursement for the 'time' personalised care staff spend obtaining a formal level three occupational standard.

The mechanism to allow PCNs to redistribute unused funding (in other PCNs) will be scrapped.

These changes are marginal – it is worth noting that the nursing roles must be 'Advanced' nurses- however the increased flexibility may allow some PCNs to revisit their plans. The key to remember in respect of ARRS is that the base funding will not be increased, we can assume that the pay awards (Pay Review Body) will be incorporated into the funding. PCNs will need to be innovative to ensure they use the full amount of funding (i.e. have a plan for managing a vacancy factor) in order to use the full allocation.

2) The Capacity and Access Payment (CAP).

Overall fund increasing significantly, 70% paid monthly without reporting requirements. 30% paid once practices have demonstrated they have met the following 3 key requirements**.**

Please note that the wording indicates that the 30% is not backdated and therefore the sooner the PCN meets the 3 requirements the more £ is released.

- Digital Telephony. ***Clearly an incentive to change as soon as possible.***
- Simpler Online Requests. 2 elements, having a system in place, and signing the Data Provision Notice so that the system provider can send the data on online consultations through to NHSE. ***This may require some work and changes to work processes for some practices.***

- Care Navigation. “Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access”.

PCN CD responsible for signing this off!

It is worth noting that the telephone data to be collected from October does not feature in this year’s CAP, but I think it is inevitable that it will next year.

3) IIF

Indicators reduced from 5 to 2. (LD Health Checks and FIT testing)

We had previously thought that the plan was to increase the IIF and reduce QOF, it now seems that the plan is to reduce the IIF and QOF and increase the CAP – this inevitably means that NHSE believe that the key focus of PCN leadership should be on access, this could (we would say will) cause some conflict between practices and the PCN (i.e. other practices in the PCN) as the PCN is being set up to performance manage practices in respect of access.

4) PCN Clinical Director requirements and funding.

PCN CD role to be simplified to focus on:

- co-ordination of service delivery,
- allocation of resources,
- supporting transformation towards Modern General Practice
- supporting the PCN role in Integrated Neighbourhood Teams.

This supports our earlier views on the performance management of practices in respect of access and the ‘Modern General Practice’ model. The PCN role in respect of Integrated Neighbourhood Teams is interesting as there isn’t a definition of the INT but this does seem to require PCN CDs to take a wider role (we need to study the devil in the detail on this).

PCN CD funding now rolled into a total funding pool including the Leadership funding and Core funding.

The total figure is quoted but we need to do some further work looking at the uplift on this to see if it just covers the ONS increases or if there are any other changes. The interesting thing is that the letter only quotes the total and not the unit figures.

5) Network DES service requirements.

The nine current service specifications are to be replaced by one overarching specification *“with a greater outcome-focus”.*

It is really important to study and understand this new specification when it is released – the current 9 specifications are supported by non-contractual guidance documents and the fact that the letter refers to this may indicate that the new specification will include some new contractual requirements – it’s worth noting that this includes the Care Home Scheme.

6) Enhanced Access.

Arrangements unchanged**.**

It is important to note that the activity will increase based on the ONS figures and that the funding should also. The complexity is that the required activity is based on practice list size and therefore a PCN activity requirement change may need to be disproportionately applied to practices (for example if one practice list size has dropped and another has increased).

7) Weight Management Referral Service.

This will continue. Practices will receive £11.50 per referral with total funding of £7.2m for the Enhanced Service.

We will check whether this is the same as this year.

Our normal 'Health' Warnings:

- This document seeks to summarise the information in the initial contract letter, and therefore this may not reflect the actual specifications and contractual requirements (when published).
- The paragraphs in red italics reflect our views and therefore these are our opinions of the impact and what practices and PCNs need to consider. These views are deliberately focussed on the impact on practices and PCNs and we have no doubt our ICB and system colleagues will present alternative perspectives which may be helpful.
- We will inevitably have missed some of the implications and therefore we would welcome your thoughts and views – we will update this paper once the detailed documents are published.

Mike Pyrah
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