How the GP contract could change in 2019

By Emma Bower on the 7 January 2019

NHS England has suggested that 2019/20 could see the biggest change to the GP contract since 2004. GPonline looks at what this might mean for GP practices.

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At an NHS England board meeting in July last year, health chiefs discussed a report that set out how 2019 could see 'the most substantial changes to the GP contract since 2004'.

Several workstreams looking at different aspects of the GP contract all come to a head in the coming months and will feed into negotiations between NHS England and the GPC for 2019/20.

Meanwhile, health secretary Matt Hancock has indicated that he wants NHS England to take a multi-year approach to the GP contract going forwards and the government has announced that primary and community care will receive a £4.5bn increase in funding by 2023/24 as part of its long-term plan for the NHS.

Mr Hancock has suggested that extra investment may be available in exchange for 'contract reform', but it remains to be seen whether any of the extra £4.5bn will make its

way into the GP contract or if, like funding for the GP Forward View, it is parcelled out to initiatives and schemes that the DHSC or NHS England wants to develop.

NHS long-term plan

Something that may complicate matters is the news that practices will be expected to sign 'network contracts' under reforms set out in the NHS long-term plan that will tie them into networks covering 30-50,000 patients. The suggestion is that this will sit alongside current contracts and provide pooled resources that could cover enhanced services and other work over and above the GP contract. It may be that extra funding is pushed towards these contracts that promote service integration rather than the GP contract.
GP partners will certainly be looking for a decent cash injection into practice funding this year. Last week *GPonline* reported that 55% of partners believe the financial security of their practice has fallen in the past 12 months, with three quarters saying that their practice has not felt a positive impact from either GP Forward View funding or additional investment through the GP contract over the past two years.

So, what looks set to change?

- Wessex LMC chief executive Dr Nigel Watson's review of the GP partnership model is due to report its final recommendations this month.
- NHS England is currently leading a review of GP premises.
- State-backed indemnity for GPs and practice staff is set to be introduced from April 2019 - however negotiations are still ongoing about exactly how this will be funded.
- There are proposals on the table for major changes to the QOF.
- The Carr-Hill formula, which determines how much funding practices receive, could be overhauled.

GP partnership review

The number of GP partners is in freefall - the number of partners fell by 1,800 in the two years to September 2018, a drop of 8%.

Dr Watson's review of the GP partnership model, which was commissioned by the DHSC, is aiming to put forward recommendations to arrest the decline. The review is due to publish its final recommendations this month but the interim report has suggested that incentives must be developed to make partnership more attractive than locum work.

The interim report also suggests that there may be final recommendations around ways to ease risk for GP partners, potentially through allowing them to hold contracts through limited liability partnerships, employee-owned or social enterprise models.

However it also acknowledged that factors undermining the GP partnership model are largely inseparable from the wider GP crisis and therefore tackling the declining workforce, rising workload and indemnity will be as important as dealing with risks associated with premises and being the 'last partner standing'.

GP premises review

In tandem with the partnership review, NHS England has been running its review of GP premises.

This review is aiming to build a full picture of premises problems and the current general practice estate, and will 'propose recommendations for the ownership and operating models' to 'enable the delivery of premises which are fit for current and future purpose'. A report is due to be published early this year, which will feed into the contract negotiations for 2019/20 and possibly beyond.

The GPC has suggested that the review will need to address three key issues: last partner standing, how to ensure GP premises are fit for purpose and service charges.
Clearly there is a big overlap between this review and Dr Watson's work. Last partner standing issues are a huge barrier to the recruitment of new GP partners, while issues around management and services charges are threatening some practices' financial viability. In a *GPonline* poll of 450 GPs last year, 41% said partnership roles would be more attractive if premises responsibility was taken away.

In the same poll a third of partners said that the premises they are working in are not fit for purpose and had not been updated for over a decade. Funding for premises improvement will also have to be addressed if NHS England is serious about moving more services out of hospitals and into the community and helping primary care teams expand to deal with an ageing population and growing patient demand.

Indemnity

The cost of indemnity has been a major problem in recent years. In 2017, the DHSC committed to introducing a state-backed indemnity scheme as a way to address the spiralling costs that were forcing many GPs to either leave the profession or cut the number of sessions they worked. The scheme is due to be up and running in April.

GPs have welcomed the move, but were less pleased when the DHSC announced in November that the scheme would be paid for from existing GP funding.

GPC chair Dr Richard Vautrey had confirmed prior to this that discussions were ongoing about how the cost of state-backed indemnity would be 'shared' as part of the contract negotiations. An element of funding in the current GP contract is related to indemnity costs that were covered by the pre-2004 Red Book contract, although costs have risen substantially since then. However, it remains unclear whether funding for the scheme will be stripped from global sum payments, which could significantly hit GP partner earnings, or if any of the cost will be met from the extra funding promised for primary care in the NHS long-term plan.

The RCGP has written to the health secretary urging him to review the decision to pay for the scheme from existing funding, saying that GPs need assurances that they will see a substantial net reduction in indemnity costs.

Changes to QOF (Quality Outcomes Framework)

A review of the QOF, which was conducted by an advisory group involving NHS England, the BMA, the RCGP, NICE, Public Health England, NHS Employers, the CQC and others, has suggested five main changes to the framework in England.

- Around half of QOF indicators could be updated to 'improve efficacy and impact', potentially through 'a more targeted approach to population segments'. The first suggestion of how this could work were new QOF targets for diabetes recommended by NICE for inclusion in the framework this year, which use stratification based around whether or not a patient has moderate or severe frailty to set treatment targets and reduce cardiovascular risk.
- The exception reporting process should be 'updated and rebranded' as the 'personalised care adjustment' for indicators. NHS England says 'this would operate at the individual indicator level rather than the domain level, which would bring it into closer alignment with the way in which clinical decisions are taken and patient choice is expressed'.
- Up to a quarter of current indicators could be dropped from the QOF.
- A new domain would be added to promote 'quality improvement'. This would enforce quality improvement cycles to address around three priority areas each year, and would absorb points from scrapped indicators. Practices may be able to select which quality improvement activities they undertake from a national or local list.
- A 'network-level QOF' could be developed over time, with a trial version to be piloted at 'a select number of sites'.

NHS England says the changes could take 'a number of years to phase in', and any change would be subject contract negotiations with the GPC. However, this week's NHS long-term plan backed the review's recommendations and, as the advisory group included representatives from the GPC and RCGP, it seems likely that this document represents how the QOF will look in future.

Carr-Hill formula

The Carr-Hill funding formula was developed as part of the 2004 GP contract and determines how much funding practices receive as their global sum. The global sum is based on a practice's registered list size, adjusted through the Carr-Hill formula to reflect differences in the age and sex composition of the practice, additional needs of patients, list turnover, variation in staff costs, morbidity and an assessment of the rurality of the practice.

Some GPs have argued that the formula fails to properly fund the additional workload associated with deprivation and other atypical practices, and that it creates too much funding variation.

As part of the contract negotiations for 2015/16 it was agreed to re-examine the formula with the aim of adapting it to better reflect deprivation. This work has been ongoing since 2015. It was initially thought that changes would be introduced in 2017/18, then

2018/19, so it seems that any changes, if agreed, could now take effect in April 2019 - but it would not be a surprise to see this aspect of negotiations slip further.

There are, however, plans to change how 'digital-first' providers (such as the controversial GP at Hand service) are funded. NHS England has proposed that payments per patient reduced by 20% for these providers, which could come into effect in April 2019.