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To: All GPs in England

Chairman of the General Practitioners Committee

Our Ref: FN/kd

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Dear Colleague

You will be aware that the government has written to me threatening to impose very significant changes to practice contracts from next year. We are stunned that the government is disregarding five months of detailed negotiations between GPC and NHS Employers to push through these proposals. I am writing to you now to explain the context of this, to detail the proposed changes and outline the likely implications for practices.

Context

In June, GPC entered negotiations with NHS Employers on the 2013/14 GMS contract. We were presented with a challenging mandate from the four UK health departments and spent almost five months working together to translate the governments' priorities into something workable for practices. We made it very clear from the outset that practices are under huge pressure and can not cope with unfunded additional work.

Two weeks ago it seemed that we were close to reaching a negotiated agreement. We felt we had found a way to accommodate many of the government's requests while protecting practices from the most unworkable and damaging of their demands. We are therefore greatly angered that the government has disregarded our progress and threatened to force through changes that neither we, nor practices, could ever have accepted through negotiation.

The government has chosen to ignore our warnings that practices are already stretched to breaking point. **We believe that the terms of the proposed imposition are bad for doctors, bad for patients and bad for general practice.**

The government has asked us to enter new talks to refine the terms of their proposals and has suggested that, if we do so, it would include a 1.5% contractual uplift. However, any such uplift would be dwarfed by the negative impact of other elements of the proposal. We have no intention of legitimising something so fundamentally damaging to the profession by returning to the table, especially as government has made it clear that it is not willing to make significant changes to its plans.

After months of detailed negotiations, the government knows our position and has demonstrated contempt for the profession and the negotiating process by ignoring both our legitimate concerns and our negotiated position. The approach they are taking now, ignoring our advice and introducing elements to the proposals which have not even been discussed during negotiations, makes a mockery of the proper process and shows the government to have acted disingenuously.

The government's implication that doctors do not already seek to maximise the benefits to patients of the QOF is disgraceful.

We have already submitted evidence to the Doctors and Dentists Review Body for an independent recommendation on any contractual uplift for next year. We will keep the Review Body informed of the developments as they unfold.

We are aware that there will be different arrangements made in the devolved nations.

The proposed imposition
The contractual changes that the government intends to impose on the profession include:

- Reducing variability in GMS and PMS practice funding over a seven year period
- Implementing all the changes to QOF recommended by NICE, including those judged unworkable by GPC negotiators
- Increasing thresholds in QOF to the upper quartile of current achievement
- Removing organisational indicators from QOF and using some of the money to fund what we consider to be politically motivated rather than evidence based enhanced services
- Making changes to reduce time limits on some QOF indicators from 15 to 12 months and changing the way QOF payments are calculated for practices
- Making changes to the Carr-Hill formula

Governments' intention to implement the 2013/14 contract differently across the four UK nations moves the GP contract ever further away from a national model.

Implications for practices
If the government's proposals are implemented as planned, practices will face very significant increases in their workload. This will place an enormous strain on GPs and their staff at a time when many are struggling under the weight of a wholesale NHS reorganisation, especially the implementation of CCGs, as well as pension changes and the introduction of revalidation and CQC registration.

Despite public declarations that changes are being made for the benefit of patients, the governments' proposals are driven by an obsession with further so called 'efficiency savings'. In fact, general practice has more than delivered its fair share of efficiencies in recent years. We have seen consecutive freezes to contract funding, unmet increases in practice expenses, continual year on year improvements in QOF and an increase in the number and length of GP consultations. The principal GMS income streams have failed to keep pace with population growth, let alone the additional workload imposed by an ageing population. GPs have already seen decreases in real net incomes in excess of 20 per cent since 2004. We believe there is simply no further scope for making savings in the system without damaging patient care.

At the end of this letter you will find an initial analysis of each of the components of the proposed imposition. Further details will follow as soon as the government has elaborated on its intentions.

By squeezing practices even harder, these changes are certain to lead to the biggest pay cut yet for GPs in a year other doctors expect to receive a 1 per cent pay rise. This is bad news for recruitment and retention in general practice, particularly with so many GPs nearing retirement age.

All practices are going to need to look carefully at the way they work and prioritise their commitments to protect core patient care. I am sure you will share our dismay that the government has failed to recognise the difficulty GPs will have engaging fully in new CCG work whilst managing these huge contractual changes.

I will write to you again shortly as matters develop.

Yours sincerely

Laurence Buckman

Reducing variability in practice funding
The government is determined to reduce variability in funding between practices. Their initial proposals involved very rapid equalisation which would have radically destabilised some practices. During our negotiations, the GPC worked with NHS Employers to consider changes to contract funding that would reduce the currently large differences in core funding between practices over a more realistic timeframe. This objective is in line with LMC Conference policy.

As part of a negotiated settlement, GPC agreed it would be willing to start modelling a seven year programme of funding changes which would redistribute PMS and GMS funding across practices in line with a new weighted capitation target. We were clear that no changes would be agreed until we had approved the modelling and consulted the profession on the implications of these changes. We are no longer clear if the government will honour this understanding.

The government now seems intent on pushing through these changes starting in 2014. We will notify practices of the details of these proposals as soon as we know more.

As part of these changes, the government intends to make adjustments to the Carr Hill Formula to give greater weight to deprivation factors. Previously, when our analysts explored this issue with the Department of Health, they encountered a paucity of relevant research and data to inform any such change. The GPC believes that there are better ways to improve the health of patients in deprived areas than changing the funding formula, especially as there is little published evidence to suggest a link between population deprivation and practice workload. We sincerely hope that the government will think very carefully about what it is doing to avoid un-evidenced, unnecessary and destabilising changes to practice funding.

Clinical changes in QOF
GPC is always open to examining clinical evidence for changes in QOF. During negotiations this year we gave very thorough consideration to the changes proposed this year by NICE. We were willing and able to accommodate many of the suggested amendments, as well as introducing some new indicators with a sound evidence base.

Careful consideration of each NICE recommendation before implementation is always vital to ensure that clinically indicated proposals are workable in practice. During our negotiations, several of the changes proposed by NICE were rejected as impractical in practice - for example proposals that require the referral of patients to certain rehabilitation services or education programmes which are not universally available. The GPC also rejected certain NICE proposals (such as assessing physical activity in hypertension patients each year) which would have had such far reaching workload implications that health care would have been disproportionately skewed to a certain section of the patient population at the expense of other patients. The proposal to impose clinical changes in QOF, without reference to our negotiations, means that these important practical considerations may not be taken on board. This will cause problems for both practices and patients.

Increasing thresholds in QOF
During negotiations, though we opposed wholesale changes in thresholds, we were willing to work with NHS Employers to look at areas where thresholds could be raised in a sensible way without significant detriment to patient care and practices. We offered to raise the thresholds of nine QOF indicators based along those lines.

The government now intends to disregard our offer and raise QOF thresholds across the board in line with upper quartile achievement. Some will rise to 95%. This intention is based on a simplistic assumption that GPs will only treat more patients if they are incentivised to do so and that more treatment will always be a good thing. This demonstrates a real lack of understanding about clinical practice. We know that practices do not stop treating patients appropriately when they reach a certain target. Those that fail to achieve all of the QOF points in a certain domain usually do so because, despite their best efforts, it is not possible, perhaps because their patient population faces more challenging circumstances than others.

Increasing thresholds in this indiscriminate way shows little regard for the overriding responsibility of GPs to treat patients as individuals. We would expect the rise in thresholds to be accompanied by an increase in exception reporting as practices translate treatments based on population studies into appropriate care for individuals, many of whom will already be struggling with the demands of polypharmacy.

There is no evidence for raising all thresholds. Research quoted by the government suggesting a case for raising some thresholds actually shows some of the greatest potential gains to come from increasing thresholds for indicators which have been discredited since the paper's publication. We all know that chasing the last few patients for any domain takes a disproportionately long time, particularly in more challenging areas. There is therefore no guarantee that there will be much to gain from increasing thresholds but every reason to fear that it will distract doctors from doing other work of greater benefit to patients. We fear the practices most likely to lose funding through these proposals could be those in the most disadvantaged areas. The total cost to practices of these threshold changes could amount to £126 million, about 11% of total QOF funding or 1.7% of overall practice funding.

Removing organisational points from QOF

Recognising the health departments' determination to remove the organisational domain from QOF, we were willing during negotiation to use some of the current organisational indicators to fund practicable and clinically appropriate work recommended by NICE. We were also willing to consider alternative ways for practices to access this funding, including increasing the value of other QOF points. This would have been appropriate as much of the work associated with the organisational indicators is vital, will need to continue and will be monitored in England by the CQC and the Commissioning Board.

The government now intends to remove all organisational indicator funding from QOF (around £167 million or 15% of QOF) and put it into new enhanced services (examples given include dementia, care for frail or seriously ill patients, enabling patients to have on-line access to services and helping people with long term conditions monitor their health). This not only forces GPs to take on swathes of un-resourced new work, but also worryingly moves money from an evidence based vehicle to channel it into schemes which are undeveloped, un-negotiated politically driven government whims. We are concerned that some of the enhanced services proposed may prove to be a suboptimal use of NHS resources. They may for example end up reducing acute access for patients who do not fall into targeted categories or advantage the most technically savvy patients at the expense of the deprived, widening health inequalities.

Other changes to QOF

Changes to QOF being proposed include a reduction in the time available to GPs to meet targets for certain QOF indicators. For all indicators where practices currently have 15 months they will now have 12. This issue was discussed during negotiations but was not progressed because there was no evidence on the impact that changes to QOF rules would have on practices. GPC feels that these changes will make QOF achievement unnecessarily awkward for practices for no additional benefit to patients. Inclusion of this change in the imposed package is another example of unevidenced and poorly considered policy change.

The Contractor Population Index, which is used to help determine QOF payments based on the size of practices, will be changed under the government's proposal to reflect the average practice list size in any given year rather than the average list size as it was at the time of contract implementation in 2004. The value of each QOF point will be increased to take account of this change so for most practices the effect will be broadly neutral. Those whose lists have grown faster than those of the average practice in 2004 will gain slightly more than those with less growth over this period. This proposal was not discussed during negotiations and has not been modelled by the BMA.