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Dear Richard

General Medical Services – Contractual Changes 2013/14

I am writing to set out the response of the BMA's General Practitioners Committee (GPC) and the response of GPs nationwide, to the Government's proposed imposition of changes to the General Medical Services (GMS) contract from 2013/14.

During the course of this consultation, the GPC has organised GP road shows across the country to hear the views of over two thousand of our colleagues. We have also surveyed all GPs in England about your proposals and engaged with key patient groups. A summary of the survey results can be found at Appendix I. Although the consultation is focused on GMS contracts, many of the proposals will affect both GMS and PMS practices. The GPC represents all general practitioners and our response therefore covers the views of GMS and PMS practices, GP contractors, salaried and locum GPs.

The implications of your proposals for delivery of patient care

The GPC shares the Government's aim of promoting the very best quality of care for patients. We recognise that some of the proposals seek to achieve improvements in care for certain patient groups and we are happy to discuss options for new services. This package of changes fails to consider the cumulative impact of these proposals and includes suggestions that are simply not feasible in practice or would lead to unintended consequences. The changes would make it difficult for practices to maintain the level of care they currently offer while introducing an even greater focus on targets and box ticking at the expense of holistic, patient-centred primary care. This is of particular concern given the recent conclusions of the Francis report.

An overwhelming 88% of GPs responding to our survey with some awareness of the proposed contract imposition agreed with the statement that they personally will be less able to offer good quality care to their patients as a result of this imposition. Of the 58% of GPs who said they were prepared to take action and who expected to make changes as a result of the imposition:

- 54% said they expected their practice to have to reduce access to patients.
 - 91% of these said that GPs would not be able to see patients for routine appointments as quickly as they currently do
 - 72% thought they would have to reduce the number of consultations offered to free up time for the new workload
 - 75% expected to reduce the range of services offered to patients.
- 82% expected to have to make changes to staff working hours or employment
- 52% expected to reduce their use of locums

How the proposals will affect funding of primary medical services

We all recognise the demographic and financial pressures that the NHS is currently facing. It is widely acknowledged that the best chance of meeting these challenges is to move care closer to the patient (sometimes referred to as 'shift left'). We know that many GPs are willing to rise to this challenge, both as providers and as commissioners but the only feasible way of developing this policy successfully is for resources to be made available to meet this new demand. GPs are struggling to reconcile the government's intention to create this new work and these new priorities with the significant constriction of resources and capacity heralded by the current contract proposals.

We know that many practices are already experiencing financial strain caused by consecutive freezes and overall restrictions in contract funding and unmet increases in practice expenses alongside the increased demand for services driven by demographic and medical challenges of an aging population. Practice expenses have increased as a proportion of practice income from 55% in

2005/06 to 61% in 2010/11. The 1.5% investment in general practice which you initially suggested alongside the proposed changes would not have been realised in practice as GPs will find it much harder to access continuing contractual funding as a result of the planned changes – particularly the threshold changes in QOF and removal of the organisational domain, which we predict could see the average practice with £31,100 less funding in 2014/15. Many practices will also lose core finances as a result of the 'equitable funding' process. We believe that on average GP funding and particularly the funding available for patient services will fall as a result of these changes. We therefore consider your reference to additional or maintained levels of investment to be misleading. It will certainly be detrimental to patients to destabilise practices to this extent.

We were willing, during negotiations, to look at developing and modelling methods to reduce the variability in practice funding. Our full response to your proposals on this matter is included in the annex to this letter. I must, however, emphasise that these changes will have far reaching consequences for some practices and for their patients. The lack of commitment to modelling and consultation, the omission of a clear commitment to dealing with significant outliers and, above all, the ambiguity in the proposed approach to PMS funding, has left practices with considerable financial uncertainty. PMS funding taken from practices over the next few years must be ring-fenced and reinvested in general practice through the global sum, to ensure that practices do not lose out and that the aim of fairer funding is not undermined.

During our road shows, the GPC negotiators spoke to well over two thousand GPs and were told about very real concerns from many about the viability of their practices in the short to medium term. We have heard from GPs who, faced with changes of this magnitude, lack the confidence to take on much needed new staff or enter into new service commitments. The lack of certainty will also make it even more difficult for practices and GPs to raise bank loans, limiting the possibility of new partnerships and service development. **In many cases practices will have to make major changes to their services to patients to work within available resources over the next few years.**

Our survey results indicate that the impact on funding could have serious implications for clinical and administrative staff and staffing in general practice. Fifty-one per cent of GPs said their practices would reduce the use of locums. In addition, of those that indicated that they would make staffing changes:

- 22% expected to make clinical staff redundant, 35 % of GPs surveyed expected to make administrative staff redundant
- 48% thought they would not replace clinical staff who leave, 66% thought they would not replace administrative staff who leave
- 53% said they would not recruit any new clinical staff and 63% said they would not recruit any new administrative staff.

The most effective way for the Department to mitigate the likely damage to patient services from this imposition would be to reduce the financial instability for practices by following the example of Scotland and moving funding from the organisational domain in QOF into practices' global sum equivalent (GSE) or baseline funding.

Concerns about sustainability of GP workload

The GPC made it clear at the beginning of last year's negotiations that practices are under huge pressure at the moment and are unable to cope with unfunded additional work without more resources. Practices are already struggling under the weight of a wholesale NHS reorganisation, especially the implementation of CCGs, and CQC registration. They have been pushed to deliver year on year improvements in QOF, while having to meet rising demand for health services increasing the length and number of consultations.

We believe that the proposals simply ask too much of an already stretched service. GPs are going to be forced to look carefully at their work and to prioritise their commitments and services. In particular the increasing pressure on GPs within their practices will leave less time for development of fledgling CCGs. Of those who expected their practice to make changes as a result of the imposition, nearly half expected to reduce their involvement with their CCG. As advocates of clinically led commissioning, we are very concerned about this, and disappointed that the changes to the contract will reduce the chance of adequate engagement and input from general practice.

Possible consequences of the proposals for the primary care workforce

The proposals indicate that the government does not recognise the pressure that practices are already facing. If implemented as planned, these changes will significantly increase practice workload placing an enormous strain on GPs and staff. Half of the GPs who expected to do something differently as a result of these proposals expected to have to increase their hours of work. For existing general practitioners and their staff, the changes will cause increased stress and lower morale. Of those surveyed who had some awareness of the proposed contractual changes:

- 91% said they felt they would be less able to manage their workload
- 97% said they believed that general practice would become more stressful for them
- 92% said they felt they would be less able to achieve a satisfactory work-life balance

We expect decreasing morale, increasing stress and falling practice funding, to have a real impact on both recruitment and retention in general practice. Our survey results demonstrate this problem. Of respondents with some awareness of the contract changes:

- 89% said that these proposals made them less enthusiastic about general practice as a career
- 87% said they were less likely to recommend general practice as a career for new doctors.

The process

Before setting out our detailed response to each of the proposed contractual changes, **I must state again our great disappointment about the way negotiations and these proposals have been handled.** The GPC spent five months of last year negotiating with NHS Employers in good faith. We felt that negotiations were constructive and that we had reached a point where both parties could agree a way forward that would accommodate the government's priorities while recognising practice workload. We made it clear that GPs have already more than delivered efficiency savings for the NHS. Nevertheless, the GPC offer included:

- the introduction of some major new clinical indicators recommended by NICE
- appropriate QOF indicator retirements and amendments
- a new risk profiling scheme to be included in QOF
- a considerable reduction in the size of the organisational domain to fund the new clinical work
- an agreement in principle to reduce variability in practice funding in England
- an increase of 5% across nine QOF indicator thresholds

The proposed imposition, which goes far beyond much of the substance of our negotiations with NHS Employers, disregards this negotiating process and undermines the trust between Government and general practice. A negotiated settlement would have been so much better for patients, practices and in our view for the government.

The timescale for implementing these changes is now extremely tight. At this point, GPs still lack clarity about what will be expected of their practices in just over five weeks time. **We would urge you, for this reason alone, to postpone some of these changes,** particularly changes to locum superannuation contributions, to give the GPC and NHS Employers time to develop guidance for GPs to help them adjust to the new arrangements. The timescale also poses challenges from an IT point of view. In previous years this has meant that practice IT systems, which are crucial in supporting QOF, were not modified until well into the year. If this is the case this year, it will make the impact of the change from 15 to 12 months on QOF indicators even harder for practices to achieve.

The devolved governments in Scotland and Wales have worked very constructively with the BMA GP committees in those nations to create genuine alternatives to the terms proposed for English GPs. This has resulted in successful agreements in these nations and a much better starting point for the introduction of contractual changes next year. It is clear from our road show interactions that GPs in England feel very strongly that the failure to seek a negotiated agreement leaves them and their patients much worse off. We believe patients in the UK are best served by a UK wide GP contract. The position of the Department of Health in England is needlessly undermining this. Although the

proposed date for implementation of the planned changes is fast approaching, **we remain willing to work with you to explore alternative, more realistic arrangements.**

Comments on the draft SFE and DES directions

Alongside this response to the main consultation proposals, we are submitting detailed comments on the draft Statement of Financial Entitlements (SFE) and directions. We have not covered overarching matters of principle in these documents but you should take our detailed comments in light of our broader position, as there are elements of the new SFE, designed to implement your imposed contract changes, which we oppose in principle. As usual, we would expect to set up a lawyer to lawyer meeting as soon as possible to go through our detailed comments on the draft SFE.

Yours sincerely

Laurence Buckman
Chairman, General Practitioners Committee

Cc Rt Hon Jeremy Hunt MP
Dame Barbara Hakin
David Nicholson
Ben Dyson

General Medical Services – Contractual Changes 2013/14: BMA GPC response

Securing 'equitable funding' in contractual arrangements 2014/15 and beyond

1. We appreciate that currently practices receive widely differing core funding per weighted patient for historical reasons. Those with higher levels of funding generally receive either large correction factor payments or above average PMS funding. The profession is in favour of reducing this variability of funding over time but it also acknowledges that the reasons for historically higher funding can be complex and are often reflected in additional patient services, higher staffing levels, unusual practice structures or unique patient populations in better funded practices. For this reason it has always been accepted that a move towards more equal funding must be done gradually and in a planned way that does not radically destabilise patient services.
2. During negotiations, the GPC and NHS Employers discussed possible changes to practice payment streams in England only which would, over time, reduce variability in practice funding. Our willingness to consider redistribution of funding between practices reflected considerable movement on our part and was contingent on the following:
 - that the proposals would not reduce existing investment overall for primary medical services
 - that the arrangements would cover GMS and PMS practices equally and that, in this way, redistribution would secure PMS funding, which is rapidly being eroded on a local basis, for general practice. Local reviews of PMS funding would be halted until the new arrangements had been agreed. PMS practices would retain their right to revert to GMS contracts
 - that the proposals would be fully modelled, down to individual practice level, to ensure we understood the likely impact for all practices and could identify and help financial outliers. This modelling requires accurate information on nationwide PMS funding streams.
 - that the proposals would not be agreed until all the data had been analysed, shared with the profession and approved by GPs through an opinion survey or special conference.
 - that as part of this process Area Teams would have conversations with higher funded practices to establish if extra services were being offered or if there were particular reasons for the higher funding. In this way, and through local recommissioning of specific services, we sought to protect practices and patients from destabilising change. We agreed with NHS Employers that there may be a few GP practices for which different arrangements might need to be agreed. This might include practices serving very small or specific populations.
3. The current proposals do not, as is suggested, implement the GPC's suggested approach. The proposals focus on 'securing equitable funding in GMS contractual payments' by phasing out and redistributing correction factor payments. PMS practices are to be considered 'separate to these provisions'. The proposals appear to be motivated more by a wish to end MPIG funding than by a real commitment to secure fairer access to services for patients. Most notably there is no commitment to preserve PMS funding for primary medical services. If this is in fact the intention, it is essential that we know as soon as possible how much PMS funding is involved so all practices can begin to understand what is likely to happen to their funding over the next eight years and how they might need to change their work in accordance with changes to their resources.
4. The draft Statement of Financial Entitlements (SFE) sets out a methodology for removing correction factor payments at odds with that developed during negotiations. Removing one seventh of the year-one correction factor payment each year for seven years does not allow for the increases in global sum resulting from recycling of the correction factor money, annual uplifts to global sum and redistributed PMS funding. Erosion of MPIG was only part of the proposals drawn up between NHSE and GPC for reducing variability in practice funding. In the absence of proper redistribution of PMS funding, correction factor recycling and annual uplifts, there will really be no equalisation of resources across practices. This exercise, as proposed, will generate a huge amount of bad feeling amongst affected practices, especially as MPIG was promised in perpetuity, and will destabilise many.
5. The proposals as they stand will have a huge impact on many practices, yet there is no reassurance that the effects will be modelled first or that professional opinion will be sought before implementation. Our opinion survey of GPs (conducted in January 2013) indicates that 85% of GPs expected the

phasing out of correction factor payments to have a negative impact on staffing, services and income and 68% expected the same from reducing PMS funding.

6. There is no clear commitment to give special consideration to 'outlier' practices which may, for legitimate reasons, receive and require greater per capita funding than global sum payments can deliver. The GPC wants to see a commitment to giving outliers proper consideration and to excluding from the process those who need higher funding for legitimate reasons.
7. We urge the Department of Health to go back to the draft proposals developed between NHS Employers and the GPC. Implementing these plans before full modelling has been done may lead to serious unintended consequences for patient services.

We urge the Department of Health to go back to the draft proposals developed between NHS Employers and the GPC for reducing variability in practice funding

Correction factor money and PMS funding removed from practices over the next few years must be ring-fenced and reinvested in general practice through the global sum.

The equitable funding proposals must be fully modelled prior to implementation

We want to see a commitment to giving outliers proper consideration and to excluding from the process those who need higher funding for legitimate reasons

Changes to the Quality and Outcomes Framework

8. The GPC has already submitted detailed comments on the proposals for the Quality and Outcomes Framework in our letter of 31 January 2013. This set out our very significant concerns about the likely effect of the proposals on patient care, GP workload and funding (see the following link for ease of reference <http://bma.org.uk/working-for-change/negotiating-for-the-profession/gp-contract>)
9. Since submitting our interim response on the QOF proposals, we have received the results of our GP opinion survey.
 - 87% of respondents said that implementing all the changes to QOF recommended by NICE would have a major negative impact on staffing, patient services and income
 - 77% thought increasing upper thresholds for QOF indicators would have a major negative impact on staffing, patient services and income.
 - 64% thought reducing the time period for most QOF indicators from 15 to 12 months would have a major negative impact on staffing, patient services and income.
10. Also since submitting our interim response on the QOF proposals, the Francis Report has been published. We believe that the QOF proposals work against the thrust of the Francis Report findings and recommendations by introducing increasingly challenging targets for GPs that will divert even greater time and resources towards box ticking rather than core holistic patient care. This is a concern which has been reflected repeatedly by GPs at our road shows (held in January/February 2013 and covering well over two thousand GPs).

Discontinuation of the organisational domain

11. Our interim QOF response did not address your proposal to discontinue the organisational domain in QOF. We strongly object to the wholesale removal of organisational indicators, as this will have major implications for practice finances (and for practice workload where practices try to engage with the new DESs and QOF indicators) and therefore for patient services and quality of care. We calculate that removing all organisational indicators will amount to £167 million or 15% of total QOF funding, with £120 million being removed from QOF entirely, potentially removing £19,800 from the average practice. This funding stream is an important source of funding for practice running costs. Your insistence that practices will be able to earn this resource back through engaging in new work is immaterial as practice capacity is severely restricted and a great deal of the organisational work will have to continue in England after the domain is abolished as a result of CQC registration. NHS Commissioning Board contract management is also likely to make compulsory many areas currently funded by the QOF organisational domain. In the future, GPs will have to meet these standards for CQC and the Board without associated resources. Of GPs surveyed, 85% said that ending most of the QOF organisational indicators and requiring GPs to take on new additional work to retain this funding would have a major negative impact on their staffing, patient services and income.
12. Recognising the Department of Health's wish to remove the organisational domain from QOF, we were willing during negotiations to retire some organisational points (Records 15, 18, 19 and 20) and use others to fund practicable and clinically appropriate work recommended by NICE (Medicines 6, 10, 11, 12, Education 7, 10 and 11). This would have accommodated your desire to redirect some of the organisational funding while ensuring that practices were not destabilised by the change.
13. During negotiations we were also willing to consider alternative ways for practices to access the funding currently in the organisational domain, including increasing the value of other QOF points or adding the resource to global sum equivalent (GSE). Where funding is moved from the organisational domain into clinical indicators it will become subject to prevalence calculations. Practices with low prevalence, such as university practices or those with special populations, are likely to lose more of this funding than other practices as a result. This is one reason why we favoured the GSE approach. QOF is not simply an incentive scheme. It was created by moving money from GP basic pay and returning it to those practices that delivered better outcomes. It also paid for the expenses that were incurred in delivery. We believe that moving funding from the organisational domain to GSE would have been the best approach given that this element of QOF was always intended to fund the infrastructure and running costs of practices to deliver these higher organisational standards.
14. Much of the work associated with the organisational indicators contributes to the quality of patient care offered by the practice. Some will need to continue and will be monitored in England from April 2013 by the CQC. However, this is not a valid reason to cease funding this important work. Other indicators in the organisational domain do not relate so immediately to CQC standards and, as a result, will no longer be funded. This includes Education 6 - review of complaints, Management 1 - child protection information, Management 9 – identification of carers and Management 10 - staff equal opportunities, Education 5 – staff training for basic life support skills. Practices will be under increased work pressure as a result of this imposition, and may no longer have as many staff resources as previously to deal with these important initiatives. . The Carers Trust has already contacted the GPC with concerns about the removal of Management 9.
15. Scotland and Wales have both offered GPs alternative credible proposals for the existing organisational points. In Wales, 31 points will be used to fund new NICE recommendations and QP indicators but 59 organisational points which have a clinical and patient safety focus will be retained. In Scotland, though the organisational domain will cease, funding from 77 of the organisational points will be transferred into Global Sum Equivalent to reflect historic practice achievement and relative unweighted practice list size, with no deductions for opt-out or correction factor receipt. Monitoring of the associated work will be consistent with existing post-payment verification for the core elements of the contract. Twenty-three points from the organisational domain in Scotland are likely to be used to create a new Medicines Management domain. These alternative approaches recognise the value of work undertaken within the organisational domain and the importance of this funding to practice stability. We urge that consideration be given to these alternative approaches.

Raising upper thresholds for existing indicators

16. As we said in our interim QOF response, the GPC rejects the proposal for a blanket increase in thresholds, as this would disadvantage practices financially, could put patient care at risk and could

reduce patient choice because it will promote a focus on achieving targets, rather than providing individual holistic care. We also reject the suggestion that practitioners stop treating patients once the practice has reached a particular threshold level. We do not believe there is any evidence to support this and that it could have serious implications for patient care.

17. For a practice to meet an upper threshold above 90%, they would need to aim higher than the upper thresholds to ensure that they reach the threshold by year end. This could lead to reduced patient autonomy because the GP may be focusing on the achievement of these thresholds as opposed to responding to patient need. It would also impact disproportionately on access for non-QOF consultations, as priority may understandably be given to those most likely to allow the practice to achieve these targets..
18. Our analysis shows that if practice achievement stays at current levels, unless there is additional investment in the contract, the average practice will lose about £3,700 from their QOF income in 2013-2014, rising to £11,300 in 2014-2015, from the threshold changes alone..
19. The GPC therefore rejects the increase in thresholds as proposed. However, as we proposed in the negotiations, we are willing to increase by 5% the upper thresholds of nine indicators where we believe the impact to practices would be minimal and the gain to patients the greatest This would be in areas such as coronary heart disease, stroke, or COPD (see our full interim response to the QOF changes at <http://bma.org.uk/working-for-change/negotiating-for-the-profession/gp-contract>)
20. The GPC and, we understand, the Department of Health expects exception reporting to have to rise as a consequence of the threshold changes in QOF. The way the media, PCTs and politicians have handled exception reporting in the past has been profoundly unhelpful and the GPC does not want to see practices forced to justify exception reporting rates inflated as a result of these changes. We suggest that, if these changes go ahead, the joint NHSE and GPC guidance on exception reporting should be revised and reissued to reflect the impact on clinical practice of the new thresholds.

Removing the overlap of QOF years

21. We believe that the implication of reducing the time-periods from 15 to 12 months or from 27 to 24 months is considerable. If reviews have to be done within the year, flexibility for GPs will be reduced, compressing appointment opportunities and QOF workload into a shorter timeframe.
22. It is possible that a small number of patients may indeed have missed a review because of the current rule (although ONLY if the GP practice had no other recall than QOF software - like medication reviews for instance), but practices need some flexibility to accommodate their patients' needs. In practice GPs would have to schedule all QOF reviews between April and mid-February to take account of the need for flexibility for patients and any late appointments. Appointments scheduled later, which are missed and run over to the next year, would otherwise lead to that year's funding being lost.
23. The proposed change would have significant workload and access implications for practices and patients, as well as leading to some lost funding for practices and reduced patient satisfaction due to the reduced flexibility of the system for patients. The GPC therefore rejects the reduction of time-periods in indicators from 15 to 12 months and from 27 to 24 months.

Reforming the contractor population index (CPI)

The proposed changes to CPI were not discussed in this year's negotiations and we have not seen any modelling. If this change is to be made, we would like an assurance that overall population increases will be reflected in future years in the value of QOF points, as failure to do so could lead to an additional year on year loss of resource to all practices.

Presentational amendments to QOF

There are proposals to change the SFE so it no longer includes clinical QOF rationale and guidance on verification of achievement. Under the proposals, this will now be published separately in guidance. If this is to happen, this new guidance must be absolutely transparent and make entitlement clear and unequivocal. It should be explicitly stated that the guidance is intended to operate against the section of the SFE to which it applies.

It is proposed to streamline the QP indicators so that the administrative requirements on practices and the NHSCB are reduced. We would like some further clarification on this matter.

We want to see an end to the encroachment of QOF targets on holistic patient centred care by the implementation of the following:

- The financial instability for practices should be reduced by following the example of Scotland and moving funding from the organisational domain in QOF into practice's global sum equivalent (GSE) or baseline funding.
- We reject the proposals for a blanket increase in QOF thresholds and want public recognition that exception reporting will increase as thresholds rise and that this is an appropriate clinical response to individual patient needs.
- We oppose changes to timescales for some indicators (from 15-12 months) in QOF. If changes are to be imposed, we ask that they are postponed to allow for changes to IT systems and the development of guidance for GPs if changes are made to CPI we want an assurance that overall population increases will be reflected in future years in the value of QOF points

New Directed Enhanced Services (DESS)

It is proposed that £120 million of QOF funding is used to support new Directed Enhanced Services in England. We have already explained our objection to removing the organisational domain from QOF and stripping this money out of practices unless they undertake this very significant new work. We have a fundamental objection to all the new DESs in principle because they are being introduced without any new funding. In our GP survey, 79% of GPs felt that introducing significant new work through the four new DESs would have a major negative impact on their patient services, staffing and income.

The draft DESs do include certain suggestions that could be built on to provide valuable services to patients. It is unfortunate that these service proposals are not supported by new funding and therefore probably limited in their potential. As unfunded work, any improvement in services brought about by the new DESs, such as improvements for patients with dementia, are likely to come at the cost of services or access for other patient groups.

The rush to establish these new services in a very short timeframe, with little consultation and no negotiation, runs the risk that practices will be ill-equipped to participate and may end up losing out on the funding altogether. They cannot afford to lose this at a time when demands on general practice are increasing. All of these new schemes will have associated costs for practices, so even those who try to maintain their current levels of funding by participating in the new work are unlikely to be able to recoup the loss to the practice of the removal of the organisational domain.

Using funding from the QOF organisational domain for new enhanced services puts GPs into a position of having to take on new and unresourced work. Generally, moving money out of the QOF is worrying as it moves from a largely evidence based vehicle to channel it into schemes which are under-developed and un-negotiated.. An umbrella scheme has been referred to for these four services as well as local flexibility. It is therefore unclear exactly what status these new services will have.

Aside from our general opposition to this new approach, there are specific elements of the proposed DESs which we believe are ill-advised for ethical or practical reasons. These are outlined below from paragraph 33 onwards.

If the NHSCB wants to see any improvement in specific services as a result of these DESs, the funding removed from the organisational domain in QOF will have to be concentrated on a more limited range of new services. Spreading this resource across four DESs is likely to result in low uptake in England's overstretched GP practices. We have already indicated that we are willing to work with the Department of Health and the NHSCB to improve the outline specifications set out in the consultation. Engaging with us would avoid a situation where the services fail as a result of the specifications being unworkable in practice.

Risk profiling and care management

The GPC does not dispute the potential clinical advantages of taking a multi-disciplinary approach to monitoring the health of those who are most at risk of unscheduled hospital admissions. Ensuring patients receive appropriate preventative treatment and care before conditions can deteriorate is of primary concern to all GPs. We believe increasing the time spent on this activity for specific patients does have the potential to reduce pressure on local care systems. In order for the anticipated benefits to be realised, however, practices must have the resources required to undertake this work. As we have repeatedly made clear, practices do not have much flexibility within their current funding and staffing arrangements to undertake risk profiling as an additional component of the services they already deliver.

We are sorry that the Department has chosen not to accept the proposals for the risk profiling scheme developed between GPC and NHSE in negotiation (plenary negotiating meeting NHS Employers/GPC, 22 October 2012). We believe that we had accommodated the mandate NHSE had been given while devising a scheme that was not only beneficial for patients but manageable for practices to deliver without compromising the quality of care for other patients.

We suggested in negotiations, and still maintain, that the risk profiling work should replace specific sections of the existing QP domain (QP004, QP005, QP006). This makes sense as we know that some practices already engage in this work as part of the QOF QP work. Introducing the proposed scheme into the QP domain would mean that the objectives of improving care for vulnerable patients and reducing unscheduled hospital admissions can be tackled together, without increasing pressure on overstretched practice staff. Both Scotland and Wales are introducing risk profiling and care management as part of the QP domain, in both cases replacing A&E indicators, with Scotland also using points from the emergency admissions indicators.

The proposed terms of the specification, as detailed in part three, Appendix 5 of the Department's consultation letter of 6 December 2012, are currently not specific enough to ensure that the workload generated from this scheme will be manageable for practices. The position the negotiating parties reached in October is a more practical alternative to the Department's proposal given the economic constraints practices are facing. The knock-on effect of your proposals will be a reduction in access for other patients as, whilst GPs are in multi disciplinary meetings, the number of available routine patient appointments will decline.

Rather than requiring practices to agree a percentage of patients to be identified for care management with the NHS Commissioning Board, it would be more practical to specify a percentage cap on the numbers of patients that receive case management. This would help ensure practices are not completely over burdened by this increased workload and control the number of routine GP appointments that will have to be replaced by this work. The fewer the patients chosen for case management, the more thorough the reviews that will be done. Implementing this scheme for a smaller cohort will therefore reap greater benefits both in terms of the quality of care for the patients and potential savings for the NHS.

The draft proposals specify that the contractor participates in regular multidisciplinary integrated care team meetings to achieve a shared multidisciplinary approach to case management. We accept that this would be the ideal situation but must acknowledge the reality that multidisciplinary working has become fragmented in many areas of the country. Our proposals with NHSE stated that the meetings would be open to multidisciplinary professionals. This would make the DES more achievable.

The GPC is concerned that some practices will be expected to compile the list of at risk patients without having access to a risk profiling tool. This would be laborious and time consuming. All

commissioners should give practices the option to use software specifically procured for this scheme. Any software tool supplied to practices, without cost, is likely to represent less work than manually generating the lists.

Whilst the GPC does not believe the arrangements for the schemes in Scotland and Wales are entirely ideal, there are elements that would be beneficial if implemented in England. Replacing the A&E QP indicators with risk profiling indicators would reduce some of the likely burden on practices resulting from the increased workload. Likewise, setting a cap on the percentage of patients that are identified for case management would ensure that identified patients receive the best care possible. Overstretching practices in order to reach an unrealistic target will simply mean that patients do not receive the expected benefits of this extra care. Since practices in England will be asked to undertake this additional work merely to try to maintain current levels of funding, the bigger the patient cohort for case management, the greater the reduction in access for other patients. A consequence of reduced availability of GP appointments could be an increase in attendances at A&E and unscheduled hospital admissions, which is presumably the opposite of what the Department hopes to achieve.

Case finding for patients with dementia

The GPC recognises the challenges posed by dementia in the UK. We are very willing to discuss how services could be improved for this very important group of patients but regrets that, if the Department's proposals are implemented as planned, an important opportunity will have been missed. Here we set out our main concerns with the DES as currently drafted.

Our main concerns with the dementia DES proposals are as follows:

- The intention to screen at risk groups for dementia is not supported by the evidence and directly contradicts policy from the National Screening Committee and NICE
- If screening were to be undertaken, we would have serious concerns about consent and ethical issues. A large number of 'false-positives' could be identified, causing unnecessary anxiety and other adverse consequences for patients and their families
- This DES fails to focus on the changes that would generate the greatest benefits for patients and their carers
- The DES proposals have major workload implications which will affect access and services for other patients

Problems with case finding or screening

The GPC understands the desire to put in place a proactive approach to the assessment of patients who may be showing the early signs of dementia. However, this assessment should only happen where a patient or their family has approached the practice with concerns about memory loss or where the practitioner themselves suspects a patient has dementia. Dementia does not meet widely accepted criteria for screening programmes¹. Indeed, the 2006 NICE clinical guidelines on supporting people with dementia clearly states that 'general population screening for dementia should not be undertaken'². The National Screening Committee has also specifically recommended against screening for Alzheimers³. We understand that definitions of screening differ but we strongly believe that the current DES proposals amount to population screening of at risk groups.

Consent and ethical issues

We believe there is potential for great harm if attempts at dementia diagnosis are opportunistic. Knowledge of this approach may dissuade anxious patients from seeking other necessary care. There would also be little or no opportunity to counsel the public on the risks and benefits of screening before presentation. Although there are advantages of receiving a formal diagnosis of dementia before the disease becomes acute, patients may have a great deal to lose as they have to come to terms with a diagnosis at a point where they may still be functioning quite well. In any case, treatment options for dementia are limited and low or patchy provision of memory services will make accessing support difficult. There is no indication that additional resources will be made available for a national

¹ Wilson JMG, Jungner G. *Principles and practice of screening for disease* Geneva: WHO; 1968

² [NICE clinical guideline 42 – Supporting people with dementia and their carers in health and social care](#)

³ [National Screening Committee](#) www.screening.nhs.uk/alzheimers

care pathway. As with any screening programme, the current proposals also introduce the possibility of uncertainty and false positives and the serious consequences this could have for patients and their families. This is particularly likely as memory clinics can be reluctant to diagnose dementia at the early stages of memory loss.

Lack of focus on the real needs of patients and their family

44. The GPC supports initiatives to raise awareness of dementia in the general population and to encourage patients who are experiencing memory problems to present at their practice to discuss their concerns. As there are benefits of treating symptomatic memory problems, a public campaign to make people aware of the prevalence of dementia and the services available would seem sensible.
45. The emphasis on case finding or population screening in the current proposals seems to overshadow any concern for patient and carer services after a positive diagnosis of dementia. We have recently heard of patients who have faced six month waits for an appointment at a memory clinic. The commissioning of services for patients diagnosed with dementia must be improved and better resourced if we are to rise to the challenge posed by this increasing disease burden. Carers also need increased help, respite care and signposting to necessary information and support. Our own proposals place greater emphasis on these important factors. It would make eminent sense to improve these services and reduce the waiting time before increasing the number of people who are referred to them.

Workload implications of proactive case finding

46. We believe a reasonable assessment of a patient in an at risk group would take at least 30 minutes, and quite possibly longer, for patients with learning disabilities. Without additional resources, these assessments would have a serious impact on the time available for the care of other patients.

Remote care monitoring

47. The GPC has considered the Government's plans to encourage practices to establish remote care monitoring arrangements for patients with long-term but relatively stable conditions, with the intention of reducing unnecessary patient attendances at the practice. The Department has recognised the need to introduce arrangements in a manageable way and has suggested that a single national disease area such as hypothyroidism is addressed in the first year of the scheme, while planning for a further locally agreed priority area to be established for the second year.
48. The GPC shares the Government's wish to reduce unnecessary patient attendance at practices, recognising the benefits this could bring to both practices and patients. However, we do not agree that these proposals will necessarily achieve this aim and there are a number of concerns we would like to highlight.
49. Remote care monitoring arrangements will involve test results, and the monitoring and discussion of the results, to be carried out in a manner agreed with the patient other than by face-to-face consultation i.e. telephone, text, email or letter. Practices would record in the patient record whether the offer of remote care monitoring arrangements was accepted using a Read Code and would update the record as appropriate to their ongoing management under those arrangements. The practice will also need to make patients aware of the service and support them in its use by providing appropriate information. This will introduce a potentially significant new workload for practices in setting up the required systems.
50. The workload will be further increased with the addition of a second condition in 2013/14. Depending on the condition, this could create significant additional work, service redesign and disruption, particularly if the condition required the use of telehealth devices. Further funding, resources and modelling of the transfer of care from secondary to primary care would be needed. The letter states that the additional condition will be agreed locally, but the draft DES Directions state '*long term conditions as may be specified by the Board*'. We would like clarity on this and feel it is essential that conditions within this scheme are decided locally, to take priority areas and the circumstances of each practice into account.
51. Providing remote care monitoring will place practices under pressure and yet evidence of any benefit is limited. Patients will continue to book face-to-face appointments to discuss their condition despite the availability of remote monitoring; the evidence that the number of face-to-face appointments decreases with the availability of remote care monitoring is very limited. In addition, patients do not necessarily compartmentalise their conditions, and often wish to discuss their hypothyroidism, for

example, during an appointment for an unrelated condition. We therefore do not agree that remote care monitoring will necessarily reduce workload for practices.

52. In terms of the evidence, the conclusion from studies (including one of the largest telehealth and telecare studies ever conducted; the UK Whole System Demonstrator trial⁴) is that the evidence does not warrant full scale roll-out, but more careful exploration. There are uncertainties about the cost, quality and safety of telehealth interventions, their effects on patient-clinician relationships, and their scalability and sustainability.⁵
53. Additionally, some patients may not be happy with 'remote care' because they find it intrusive. This can increase anxiety about their condition which will increase their use of health services not decrease it; there needs to be flexibility to allow for this. In fact, many of the early telehealth projects failed because extensive anecdotal evidence from patients to their doctor made it clear that they preferred 'personal' care from a human.
54. We would also like further clarity around the provision of test results under this scheme. It is essential that practices are not expected actively to inform patients of the result of every routine test. Under this scheme, test results should instead be made available by the practice for patients to view in the manner agreed, as is the case now where the onus is sometimes on patients to contact the practice for routine test results.
55. In light of the risks outlined here, we would urge the Government to consider very carefully the implementation of remote care monitoring. The benefits of this scheme, including the anticipated reduction in routine attendances, should not be overestimated. Exploratory work in this area would be better incorporated into a broader IT DES than made subject of a whole new DES.

Improving online patient access

56. The GPC has considered the Government's plans to reward practices that improve online access to services for their registered patients. The specific aim is to encourage practices to enable current IT functionality of systems that support online patient booking of appointments, online ordering of repeat prescriptions (including, eventually, the Electronic Prescription Service), and online access for patients to test results and medical records, and who promote greater usage of these services by their patients.
57. While we are supportive of many of the aims of this initiative, we do have a number of concerns. We appreciate recognition of the need for a phased approach, with a focus on certain services in the first year of the DES, and further services in the second year, in order to moderate workload and because some GP systems do not yet have the necessary functionality.
58. It is proposed that the NHS Commissioning Board will continue to work collaboratively with the RCGP to identify how best to implement these services. We would also urge you to ensure that the NHS CB works directly with the GPC, as the only body representing the collective interests of all GPs in England, to identify how best to implement these services and realise the potential benefits.
59. It is also proposed that the benefits 'in future years' to improving online access will include reduced administrative workload for GP practices and reduced administrative costs for the wider NHS. The evidence does not support this claim⁶. The impact on workload in introducing this DES in the early years will be significant, particularly so for practices that are less developed in their IT systems. We have outlined our specific concerns with each element of the proposals.
60. We believe increasing online access to services will have an impact on health inequalities. Patients who do not speak English as their first language, those who have literacy problems or those without access to computers or the technical knowhow will be less able to access online services. Patients who can easily access these services will have an advantage and are likely book more appointments

⁴ Steventon A, Bardsley M, Billings J, Dixon J, Doll H, Hirani S, et al. Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial. [BMJ2012;344:e3874](#).

⁵ Car J, Huckvale K, Hermens H. Telehealth for long term conditions. [BMJ2012;344:e4201](#)

⁶ Journal of the American Medical Association. 2012;308(19):2012-2019

online, or book appointments to seek further information about an entry in their online record, for example, which could further reduce access for others and increase health inequalities.

Online appointment booking

61. We recognise the aim here is to reduce the administration associated with appointment booking and to increase patient convenience and satisfaction. However, online appointment booking is currently only offered by a minority of practices, and introduction will represent new organisational work for the majority in setting up the system and process.
62. If this were to be implemented, the proportion of appointments offered for online booking should be the individual practice's decision based on its appointment system and circumstances.
63. We would need reassurance that measures could be taken to prevent misuse of online appointment booking for instance through patients block-booking appointments or making appointments 'just in case'. This could reduce access to appointments by other patients, including those without access to the internet.

Online ordering of repeat prescriptions

64. Again, the stated aim here is to reduce administration and increase convenience. We completely support this aim but do have concerns that this will in fact be a considerable amount of new organisational work for the majority of practices in setting up systems to register patients and deliver the necessary functionality. Once implemented, requests for repeat prescriptions will still need to be processed in the same way, regardless of whether the request comes via paper or email, so there is no time saved or work reduced for practices.
65. Another concern is that the facility to request repeat prescriptions online will become a conduit for other requests or questions that patients may not have otherwise asked, and are not appropriate to ask by this means. This is a completely new route for patients to access their practice, and while we support the principle of such access it is important to ensure that it is not open to exploitation when workload is already so high.
66. The draft DES included in Appendix 5 to the contract imposition letter includes provision for the Electronic Prescription Service (EPS) to be utilised by offering patients making such requests the opportunity for their prescription to be issued electronically direct to a pharmacy of their choice. We disagree that the EPS should be included within the DES because it is not yet available to all practices and is also not available for dispensing GPs. The EPS does not actually allow patients to request prescriptions online and so should be separate to the DES for improving online access.

Online access to test results

67. The draft DES includes '*identifying and making available selected test results to patients online*' within the first year and '*further test results*' within the second year. We have serious concerns with this proposal as we believe it would be better to work to identify what results would be available during the first year, and not actually implement this until the second year. This would be in line with the RCGP's working groups' conclusions, and we would urge you to work further with the GPC and the RCGP to develop proposals.
68. We would like more clarity about the definition of 'selected' and 'further' test results. We believe that the GP should decide which test results are appropriate for a patient to view online and this should only occur after the GP has viewed the result and added appropriate comments. Some test results may never be appropriate for a patient to view online (eg a diagnosis of cancer) – a face to face conversation will always be needed. There is an area of concern where test results show small abnormalities that a doctor will be able to identify as insignificant, where a patient may be extremely worried by them. This in turn may lead to more work as patients query their results, see next paragraph.
69. Including online patient access to clinical information in the first year of the DES will increase workload because of the likely increase in appointments when, for example, patients view a result they do not understand and seek further information from their GP. GPs will also have to change the way they record test results so that their interpretation is more patient-facing and avoids unnecessary concern. It could be argued that this is a good thing, but it does potentially change the nature and value of the clinical record. There are additional potential risks around the uncertainty of knowing whether a patient has viewed their test result or not. It is recognised that the outcome of simple tests (eg cervical

smears) is currently communicated by post, but generally here we are talking about the more complex and less straightforward results.

70. The implications for security and confidentiality are also of major concern. Identity verification would need to be secure and, having gained access, there would need to be technical measures in place to ensure that only the person logged in can see the data. We recognise that this has been possible in online banking, but would argue that medical records are more personal to the individual. Coercion is another risk, whereby patients, e.g. children or adults in an abusive relationship or employees with a bullying employer are put under pressure to reveal clinical information to others.
71. Providing patients with online access to their test results will require robust systems based upon clear agreed principles and safeguards. There is a great potential for unintended negative consequences if these proposals are not implemented in a measured and careful way.

Secure electronic communication with the practice

72. It is difficult to comment on this without clarity around what is meant by electronic communication and the purpose of the communication. Electronic communication with a practice could be acceptable if this was for the purpose of requesting repeat prescriptions, booking appointments or to amend basic demographic patient data held by the practice, such as telephone numbers.
73. If secure electronic communication refers to email consulting with patients, then we would have major concerns. A consultation is a dynamic human-to-human synchronous exchange with multi-faceted interactions. Asynchronous exchange of snippets of text cannot replace this. Healthcare is not a simple transaction and even when a physical examination is not required, there are often follow-up questions which draw out the consultation.
74. It takes a significantly longer time to communicate in writing than orally, and evidence from the study published in the Journal of the American Medical Association (see previous references) shows that email consultations are often used as additional contact with a GP rather than replacing face-to-face contact, and can increase patient dependence on their GP. The workload implications are therefore significant.

Online access to medical records

75. The GPC has in the past debated patient access to GP records and has been willing to consider the principle of patients having appropriate access to some aspects of their records, beyond what would be required by current legislation. The BMA has encouraged doctors to give patients informal access to their records. Potential benefits include improved accuracy of records and greater patient understanding about their care.
76. However, we have major concerns about the inclusion of access to records within the proposed DES. There are a number of issues still to address and possible consequences to consider before any widespread rollout.
77. Even if strict safeguards are included, there is a risk that third parties such as insurance companies and employers will take advantage of online access by requesting copies of medical records directly from patients and that some, particularly vulnerable people, will feel pressured into complying with such requests.
78. There will be a risk of coercion where patients in abusive relationships are put under pressure to reveal information from their GP record to others. Simply stating that the patient could decide not to enable on-line access would not protect such patients if online access is being promoted by the Department of Health as vulnerable patients could be bullied in to enabling access. We are concerned that this might deter some patients from consulting their GP.
79. The impact on the quality of records is another risk. Where patients can view their records online, there may be an increase in inappropriate requests for information in the record to be deleted or altered. It is also likely that clinicians will change the way they record information in the record. .. For example, GPs may be less likely to record any concerns that could inform another colleague reviewing the patient. This will mean that the records may be less useful in future. Medical records also act as aide memoires for clinicians as well as records of fact, and often include relevant third party information and again, this may not be possible if patients are viewing their records online.

80. The potential workload for practices in implementing online record access is enormous. Practices will inevitably have to deal with questions from patients once they have viewed their record and will need to support patients in understanding the record. A health record will contain clinical terms, abbreviations and possibly technical information that a patient may not understand. Historically, GPs have not recorded data for the purposes of patient access and hence information will not be in a lay friendly format. Research has indicated a significant increase in encounters with patients as a result of an online record access system⁷. Thirty-three percent of patients surveyed in a study⁸ into patient access reported difficulty in understanding their medical record: for instance abbreviations, terminology and test results. Even recognising that the majority did not report such problems, it seems likely that, as before, those who do will be among the most vulnerable patients. Some information in a medical record may distress patients if they were to access this information without any explanation.
81. If online records access were to be implemented, access would need to be prospective and not retrospective. The work involved in reviewing historical records and preparing them for access, e.g. removing third party information, would be very substantial and so online access should only be granted to information from a particular date onwards. We believe that it would be more sensible to give patients access to a more limited set of data in the form of the summary care record, rather than all coded data and free text. This could mitigate some of the risks and concerns highlighted here.

General comments

82. In summary, we recognise the potential benefits of online access and remote care monitoring to patient care and convenience. However, there are numerous factors to consider in how, and whether, each element is implemented, and we would urge that consideration is given to the points raised in our response, as well as the IM&T proposals we have already shared with you. We would like to work with you to develop proposals to ensure they are safe and manageable.
83. An additional point to make here is that demand for online records access is actually very low and this has been demonstrated by the uptake of similar initiatives in the past e.g. Healthspace and GoogleHealth. Given that records access has financial implications both in terms of developing systems to enable access, and funding the additional workload, there should be a thorough evaluation of the cost/benefits; roll out should only proceed if there is clear evidence of demand and benefits to patients.
84. We therefore do not believe that online access to medical records should be included within the DES, either in the first year or second year.
85. Another point to make in responding to these proposals is that training will be required for practice staff in respect of each element of the proposed DES. This is yet another workload implication that will put pressure on practices.
86. Draft proposals we discussed with the Department that we included the use of GP2GP for the electronic transfer of patient records. We feel that this is an important addition to the DES given the great deal of effort that has been invested over many years to enable GP2GP record transfer. GP2GP is a fundamental building block to true universal interoperability in the NHS. For practices that have it available, it has rapidly become business as normal with benefits for patients, practices and the NHS as a whole. We would like to see the DES encourage further take up. We are confident that this will be a one off stimulus because of the benefits once implemented. We would be very happy to discuss this, and any other part of our response, with you.

The GPC is fundamentally opposed to the introduction of new DESs without new funding

If the NHSCB wants to see any improvement in specific services as a result of the new DESs, the funding removed from the organisational domain in QOF will have to be concentrated on a more

⁷ Journal of the American Medical Association. 2012;308(19):2012-2019

⁸ Fisher B, Bhavnani V, Winfield M. How patients use access to their full health records: a quantitative study of patients in general practice. JR Soc Med 2009; 102: 539-44

limited range of new services.

We urge a return to the proposals for risk profiling developed between the GPC and NHS Employers during negotiations. The risk profiling work should replace parts of the existing QP domain.

Screening should not form any part of the new DES for dementia. Instead it should focus on the needs of patients and carers after diagnosis. The Department should consider the national availability of care for dementia patients before implementing this DES.

The implementation of remote care monitoring should be reconsidered. Exploratory work in this area would be better incorporated into a broader IT DES than made subject of a whole new DES.

The work outlined in the draft proposals improving online patient access must be phased in to be manageable for practices and safe for patients. It is clear there are numerous factors to consider in how, and whether, each element is implemented, and we would urge the Department to consider the points raised in our response, as well as the IM&T proposals we have already shared

We remain willing to work with the Department of Health and the NHSCB to make the DES specifications more workable.

Existing Directed Enhanced Services

87. We await further details of the revised Patient Participation Scheme and notice that the draft SFE states that the payment mechanism is under review.
88. We have no objection to the removal of register agreement payments from the Learning Disability DES.
89. We are happy for payment for the clinical DESs to be managed through the Calculating Quality Reporting System from April.

Amendment to Item of Service Payments

90. The item of service fees proposed for rotavirus and shingles date from 2004. We believe these fees are too low and should be revised to take account of increased expenses eg postage costs. Given the capacity problems in general practice, we believe some practices will struggle to deliver these services for the proposed item of service fee. We would also like to know what plans there are for shingles catch up for over 70s who have not yet been vaccinated.

Locum superannuation changes

91. We note the Government's proposal to change the arrangements for locum pensions from April 2013, so that practices in England and Wales will become responsible for the 14% employer's contributions that are currently paid by Primary Care Organisations (PCOs). We understand the intention is to introduce this through amending regulations to NHS Pension Scheme legislation and this is currently being consulted upon separately by the Department of Health. This section of our response should be read in conjunction with the BMA response to the consultation on those Regulations, which was submitted on 8 February 2013 (insert link).
92. We would like to re-state here the serious concerns we hold about this proposal. It will have a significant effect not only on practices, but on individual locum GPs, and we feel an alternative system, whereby the payments are administered centrally, would be far preferable. We are particularly worried that a change with wide reaching consequences has not been fully impact assessed, and would, at very least, urge you to delay implementation by 12 months, to allow this to be carried out.
93. We understand that the current intention is that GMS practices will be reimbursed for the additional costs via Global Sum. This will probably mean that practices in receipt of correction factor payments receive little or nothing. If this is pursued, Global Sum Equivalent should be used, to allow a fairer distribution of funds. However, even this would take no account of the variation of the extent to which practices require locum cover. Smaller practices, especially single handed practices, where it is not possible for colleagues to cover a partner's absence, will be severely disadvantaged. Transferring

employers superannuation costs for locums into global sum is clearly an attempt to cap the Government's contribution forever. This will increase costs to practices over time.

94. We do not currently know the Government's intentions for how the transfer of these costs would be handled in PMS practices. Delaying by 12 months would also allow time to assess current locum use by PMS practices and make appropriate arrangements.
95. There will be an increased administrative burden for practices, which is particularly unwelcome at a time when workload pressures are increasing in other areas. With less than two months until the intended implementation, we are concerned that there is little information about how the payments should be processed. Again, for this reason, we feel that postponing for 12 months would be recommended to allow guidance to be developed for practices on how to process the payments.
96. It will be equally important for locums to be able to check that the payments have been made. We have heard many reports of locum GPs finding it difficult to track payments, and ensure they are allocated to the correct tier. This is the case in the current system and we can only envisage this becoming more complicated when payments are received from a number of different sources, rather than the PCO.
97. The change will have a distorting effect on the locum workforce. It would likely encourage practices to engage locums who are no longer contributing to the pension scheme, disadvantaging younger GPs. At a time when many newly qualified GPs are finding few partnership opportunities available, and many are choosing to start their career as locums, this is very worrying indeed.
98. We suspect that the proposal could for the reasons set out above drive down locum fees and, potentially, make locuming a less desirable option. Locum GPs are a valuable part of the general practice workforce and we would not wish to see any changes to their pension arrangements discouraging them from developing portfolio careers.
99. Furthermore, it is possible that many practices will choose where possible not to hire a locum at all due to the increased costs, but to cover workload from among the partners and salaried GPs. This will mean that existing services are stretched further. In particular, we would highlight the possibility of reducing the availability of GPs for undertaking CCG work.
100. In our survey, we asked those who had indicated that they would reduce their use of locums what they thought the impact would be:
 - 76% said they expected this to reduce patient access
 - 96% thought it would increase work for permanent GPs in the practice
 - 68% thought it would increase work for others in the practice
 - 63% thought it would reduce involvement with CCG work.
101. We are concerned that an unintended consequence of the proposals could be that partners are put under pressure not to take sick leave when they are unwell, due to the practice no longer being able to afford the cost of a locum. The arrangements for locum cover payments for maternity leave, which are covered by the Statement of Financial Entitlements, have long been unsatisfactory, and adding the employer's contributions on top of the current costs will only make this situation worse for practices.
102. We would question the logic transferring locum superannuation payments to practices as practices do not have a contract of employment with locums.
103. Finally, we note that the explanatory notes to the Pension Regulations state that the intention behind the change is to treat locum GPs in the same way as employed GPs who are part of the NHS scheme. We therefore feel that if the proposal is implemented, this equivalence should apply to all aspects of the pension scheme. Currently, locum GPs are only eligible for death in service benefits if they are contracted to provide services at the time of death. We would support eligibility for these payments being extended to cover the full time that a locum is on the Performers List, to bring the

provisions in line with those of Type 2 Practitioners. Equally, it should be possible for locum GPs to pension appraiser work.

The GPC has serious concerns about the proposal to transfer the responsibility for locum's employer superannuation payments to practices. We oppose this change and ask that, at the very least, implementation is delayed by 12 months.

If this is pursued, the funding should be transferred to Global Sum Equivalent rather than to global sum to allow a fairer distribution of funds

Locums must have an easy way of checking that the employers contributions have been made

If the proposals are implemented, equivalence should apply to locums in all aspects of the pension scheme including death in service benefits and the ability to pension appraiser work.

Initial findings from the 2012 GPC Contract Imposition Survey

Background

An electronic survey aimed at gauging opinion on the Governments' general practice contract imposition was sent to all GPs on 11 January 2013. 25,471 invitations were sent, as of 11 February 2013, 7,746 responses had been received. Therefore, the initial response rate for this survey is 30.4 per cent.

Results

Respondents

Figure 1 illustrates that the vast majority of respondents to this survey were GP contractors/ GP Principals (5,869 of 7,746). A further 13 per cent (1,023 of 7,746) of respondents were working as practice-employed salaried GPs.

Half of all respondents were working under a General Medical Services (GMS) contract. One-third of respondents were on a Personal Medical Services (PMS) contract. 59 per cent of (3,462 of 5,869) of contractor GPs were working on a GMS contract, 36 per cent (2,134 of 5,869) were working on a PMS contract and 273 contractor GPs did not indicate their contractual status (figure 2). This broadly reflects the structure of general practice in England.

Analysis of respondents' characteristics; age and sex, revealed that the respondents were broadly representative of the general practice medical workforce in England. However, GPs

1 - Current status

in the 51-60 age group were slightly over represented.

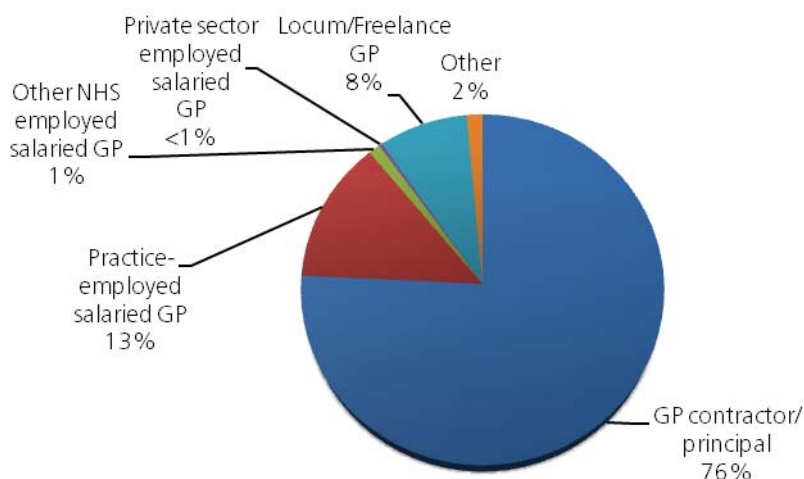
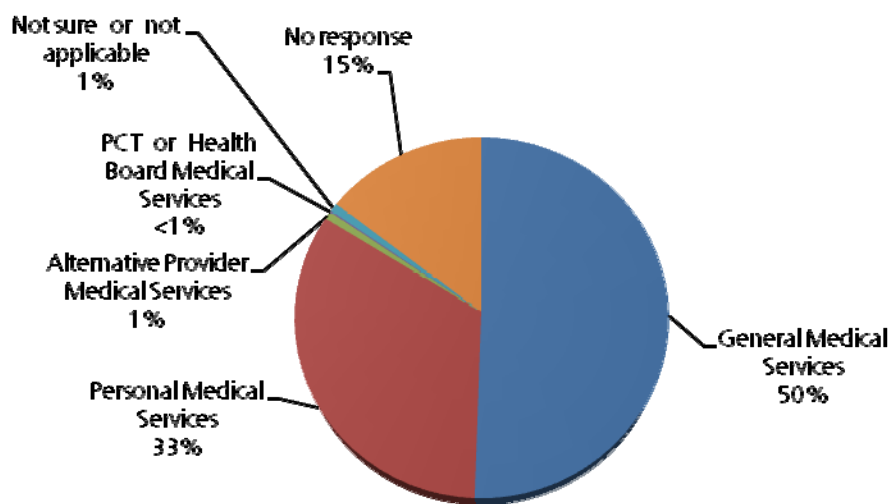


Figure 2 - Contractual arrangements



Awareness of the terms of the proposed imposition

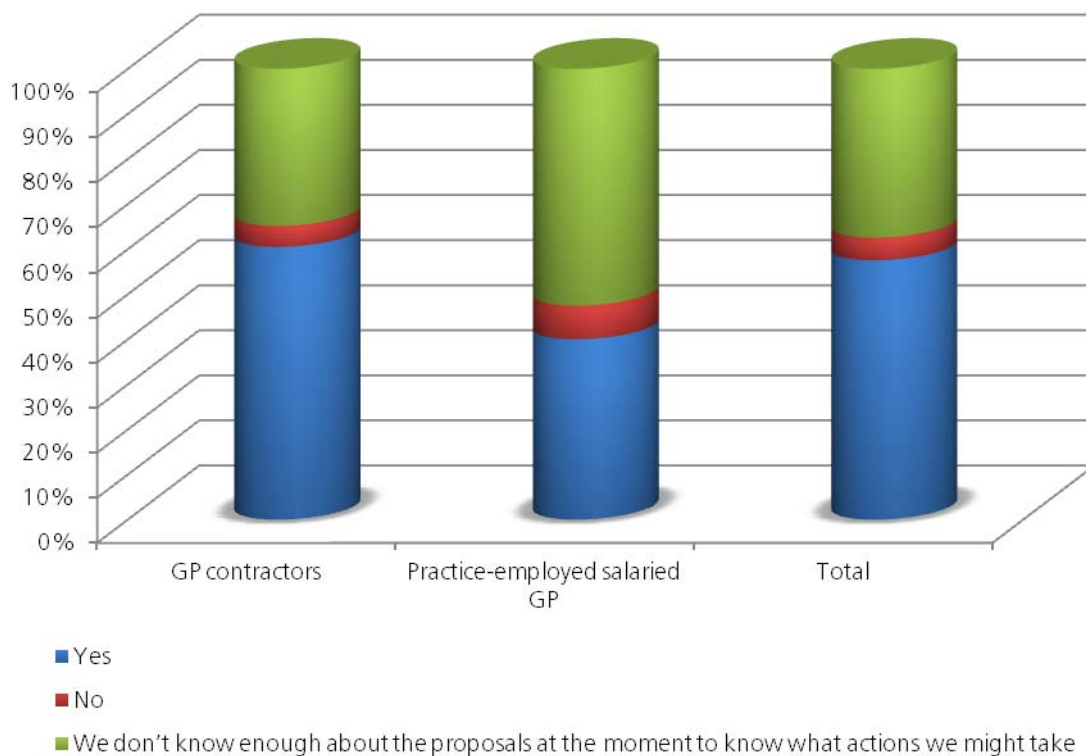
Respondents mostly indicated they had a broad understanding of the terms of the proposed imposition, but that they have not investigated the terms in great detail. Contractor GPs, regardless of contractual arrangements, were more likely to have a detailed understanding of the terms than other GPs.

Implications for GP Practices if the proposed contract is imposed

Respondents working as a contractor GP or as a practice-employed salaried GP were asked a number of questions relating to the implications of the proposed contract impositions for their practice. Six in ten contractor GPs indicated that their practice would do things differently if the proposed contract imposition was implemented in its entirety. Those respondents who were aware of the proposals in detail were even more likely to indicate their GP practice would make changes if the contract were to be imposed (84 per cent).

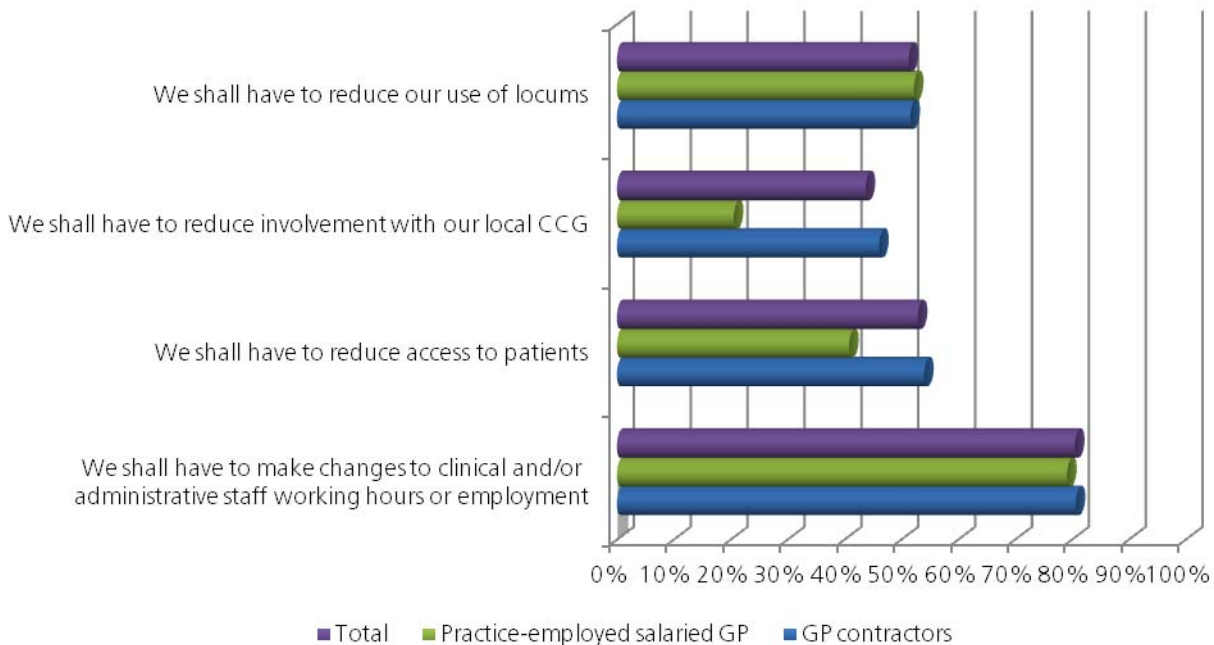
Practice employed salaried GPs were more likely to say that they didn't know enough about the new contract proposals to know what actions their practice might take (figure 3), which probably reflects governance and decision-making processes within their practice.

Figure 3 - If the Government still imposes the proposals in their entirety with no changes, do you expect your practice to do anything differently?



Respondents who indicated that changes would have to be made as a result of the contract imposition, were asked what actions they would expect their practice to take.

Figure 4 - If your practice would do things differently, what actions would you expect your practice to take?



The most likely course of action would be making changes to clinical and/or administrative staff working hours or employment (81 per cent). PMS contractor GPs were slightly more likely to think this change would have to be made (83 per cent) than GMS contractor GPs (79 per cent).

Within this, the most significant potential change relates to administrative staff not being replaced when they leave. 67 per cent of contractor GPs indicated they would not replace administrative staff when they leave if the proposed contract conditions are imposed. PMS contractor GPs were slightly more likely than GMS contractor GPs to take this course of action.

In addition, 48 per cent of contractor GPs said they would not replace clinical staff if they left, in the event that the contract was imposed in its current form. Again, PMS contractor GPs were more likely than GMS contractor GPs to state they would consider this option. Both of these courses of action would restrict the ability of practices to take on additional workload.

The second most likely form of action was not to recruit any new staff. 64 per cent of contractor GPs indicated they would not recruit any new administrative staff. 53 per cent of contractor GPs stated no new clinical staff would be recruited if the proposed contract is imposed.

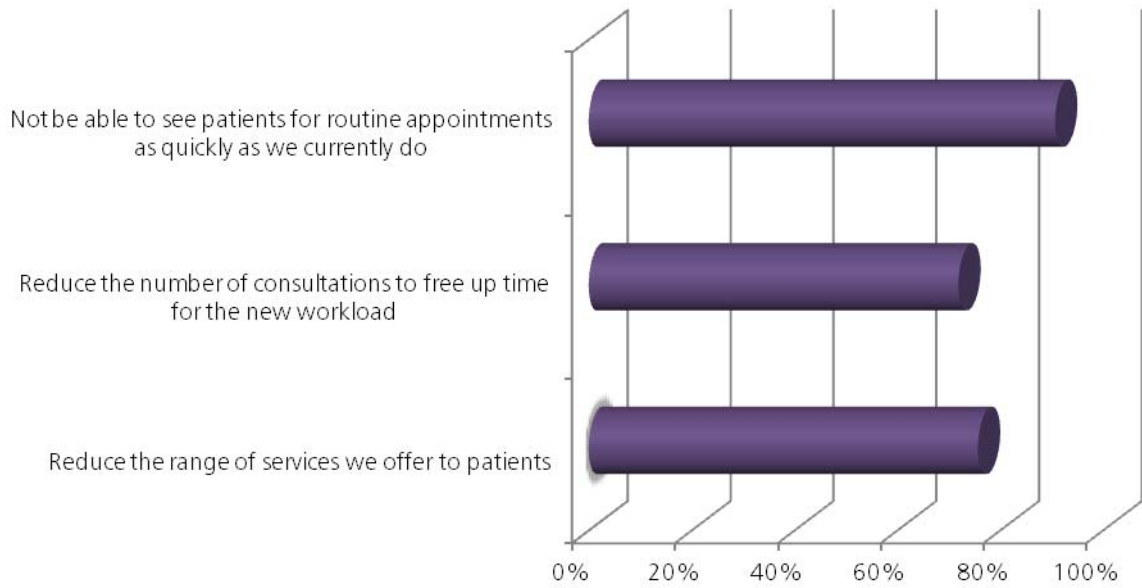
Most worryingly, 35 per cent of contractor GPs stated they would have to make administrative staff redundant. Furthermore, 22 per cent stated they would have to make clinical staff redundancies in the event of contract imposition (figure 5). Once again, PMS contractor GPs were more likely to take this course of action than GMS contractor GPs. This would make it virtually impossible to take on new workload.

Figure 5 - Please select the following options you may consider to make changes to (administrative or clinical) staff working hours or employment (Contractor GPs only)



Those contractor GPs (53 per cent) who indicated that access for patients will need to be reduced were asked to indicate what options they may consider if the proposed contract is imposed by the Government. The most common response for all contractor GPs was not being able to see patients as quickly as present (91 per cent). (figure 6).

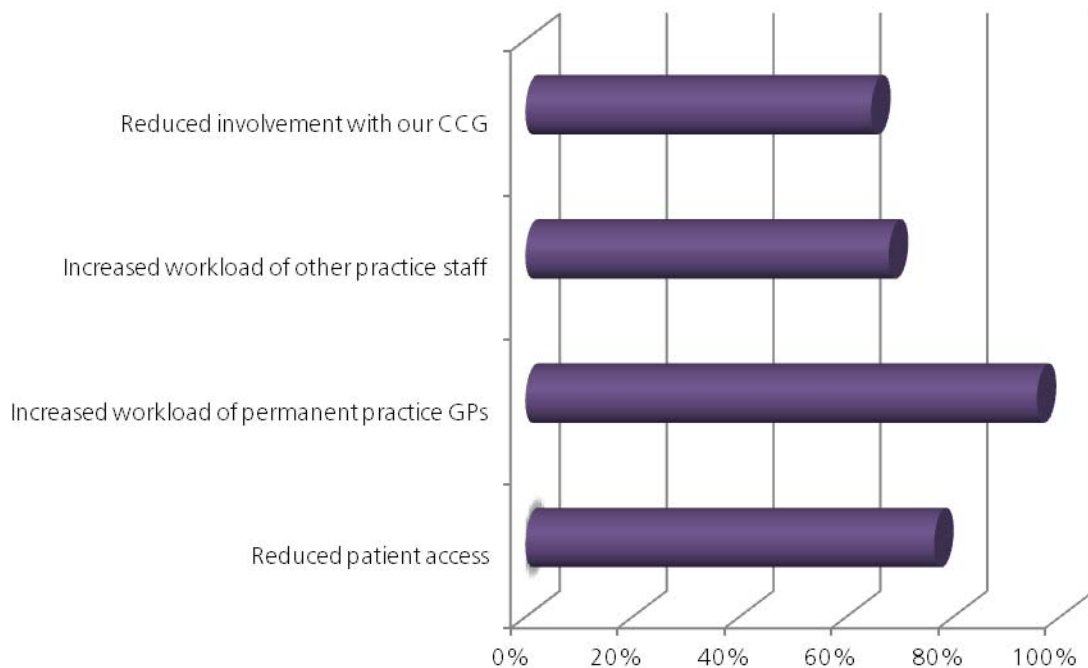
Figure 6 - Please select any of the following options you may consider if you have to reduce access to patients (Contractor GPs only)



Contractor GPs who stated that the practice will have to reduce the use of locums (51 per cent) were asked what implications this was likely to have on the service delivered by their practice. Contractor GPs were most likely to indicate that the reduction of locum GPs will result in an increased workload of permanent practice GPs (96 per cent).

Two-thirds of all contractor GPs, indicated that their practice would have to reduce their involvement with their CCG if the use of locums was to be reduced as a result of the contract imposition (figure 7).

Figure 7 - Do you think a reduction in the use of locums will result in any of the following (Contractor GPs only)

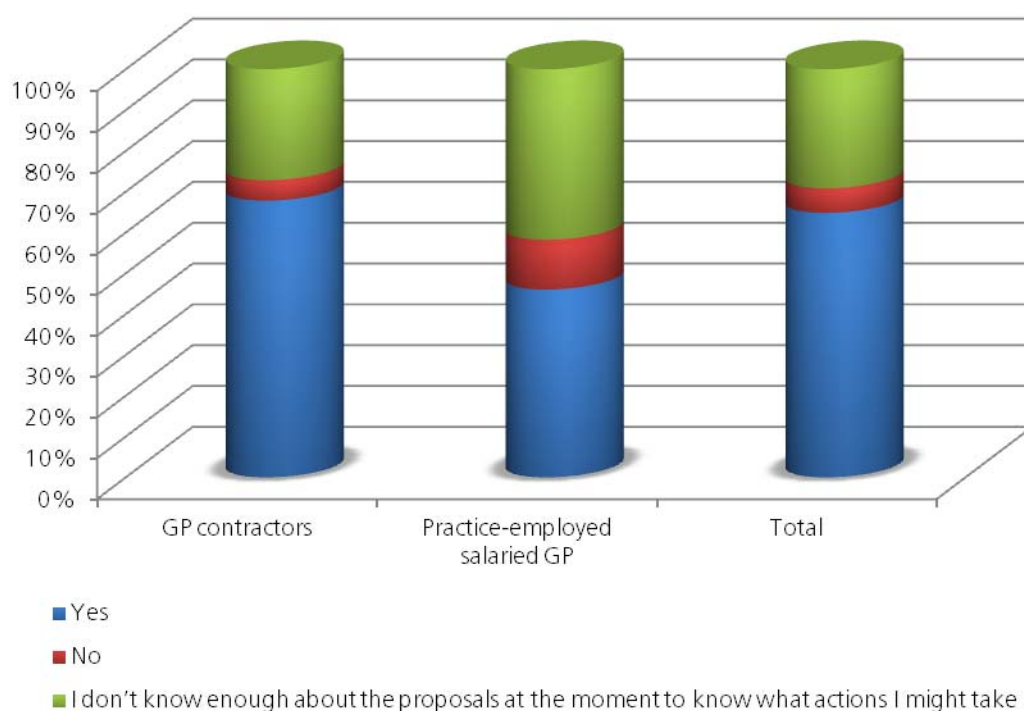


Implications for the individual GPs if the proposed contract is imposed

Contractor GPs and salaried GPs were asked to indicate if they would expect to make changes personally if the contract was imposed by the Government. Two-thirds of respondents indicated this would be the case. Contractor GPs (68 per cent) were more likely than salaried GPs (46 per cent) to indicate they intended to make changes as a result of the contract imposition (figure 8).

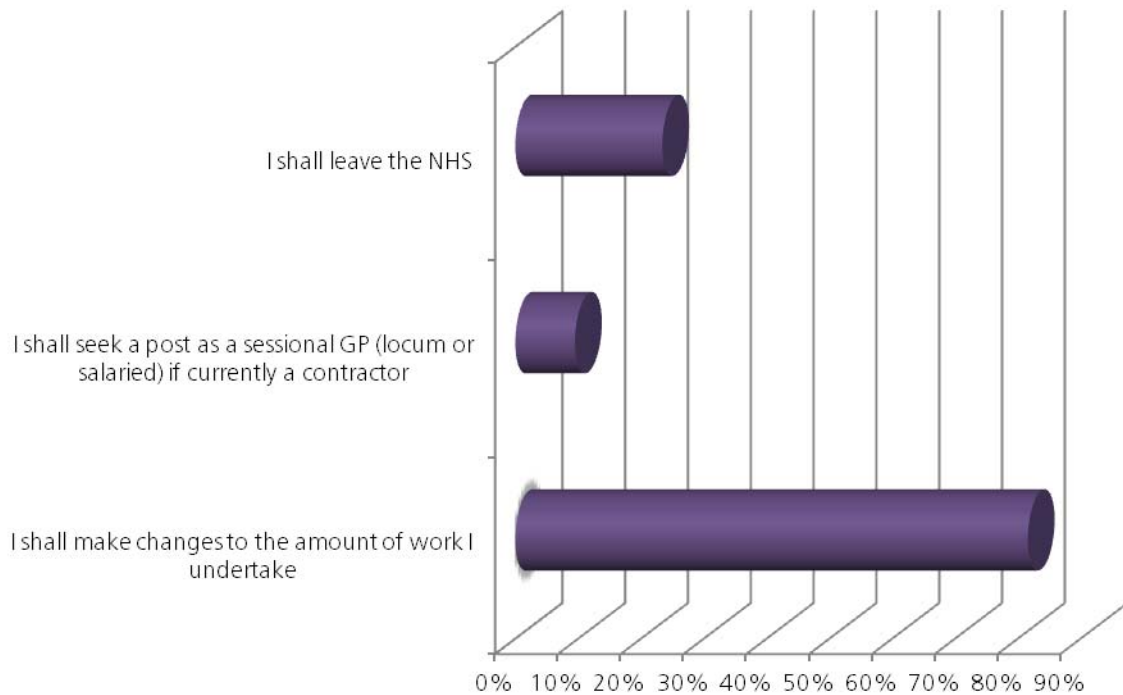
Respondents with higher levels of awareness of the details of the contract proposals were much more likely to indicate they would make changes, as an individual, if the contract were to be imposed. 88 per cent of contractor GPs and 79 per cent of salaried GPs with detailed knowledge of the proposed contract indicated they would make changes if the contract came into force.

Figure 8 - For you as an individual GP, do you expect to do anything differently?



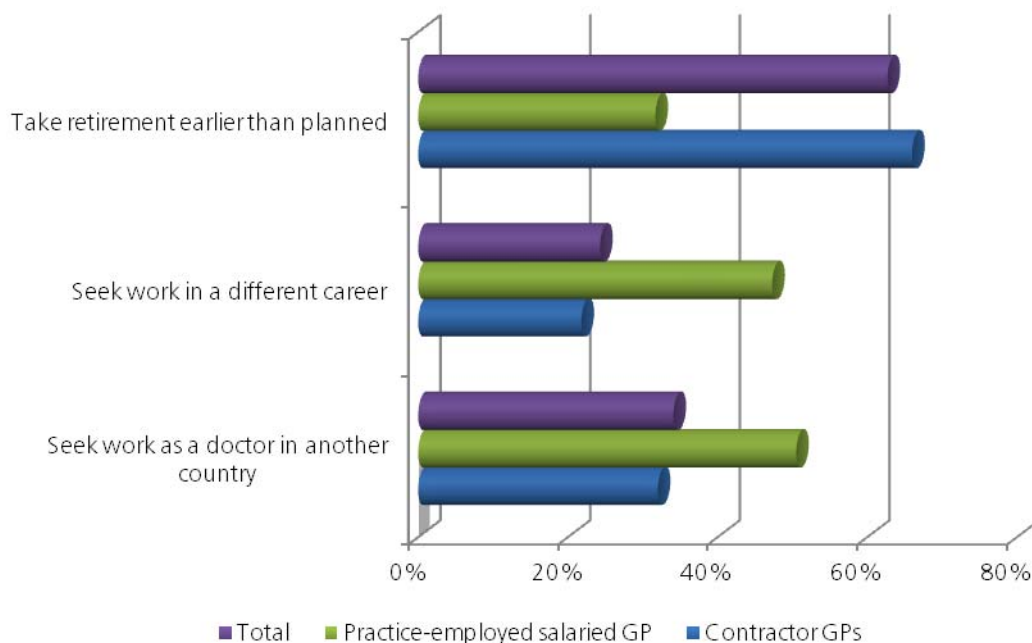
Those GPs who indicated they expect to personally make changes as a result of the contract imposition were asked to indicate what changes they expect to make. Overall GPs were most likely to indicate they shall make changes to the amount of work they undertake (82 per cent). One-quarter of respondents stated they will leave the NHS if the proposed contract is imposed in its current form (figure 9).

Figure 9 - If as an individual GP, do you expect to do things differently, what actions do you expect to take?



Of those GPs who stated they would leave the NHS as a result of the contract imposition, the majority of respondents indicated they would take retirement earlier than planned (63 per cent). This is particularly concerning as general practice is already facing a recruitment shortageⁱ. Contractor GPs were more likely to indicate they would retire earlier than anticipated (66 per cent). This was most prevalent amongst GPs in the 51-60 age bracket (75 per cent of cases) (figure 10).

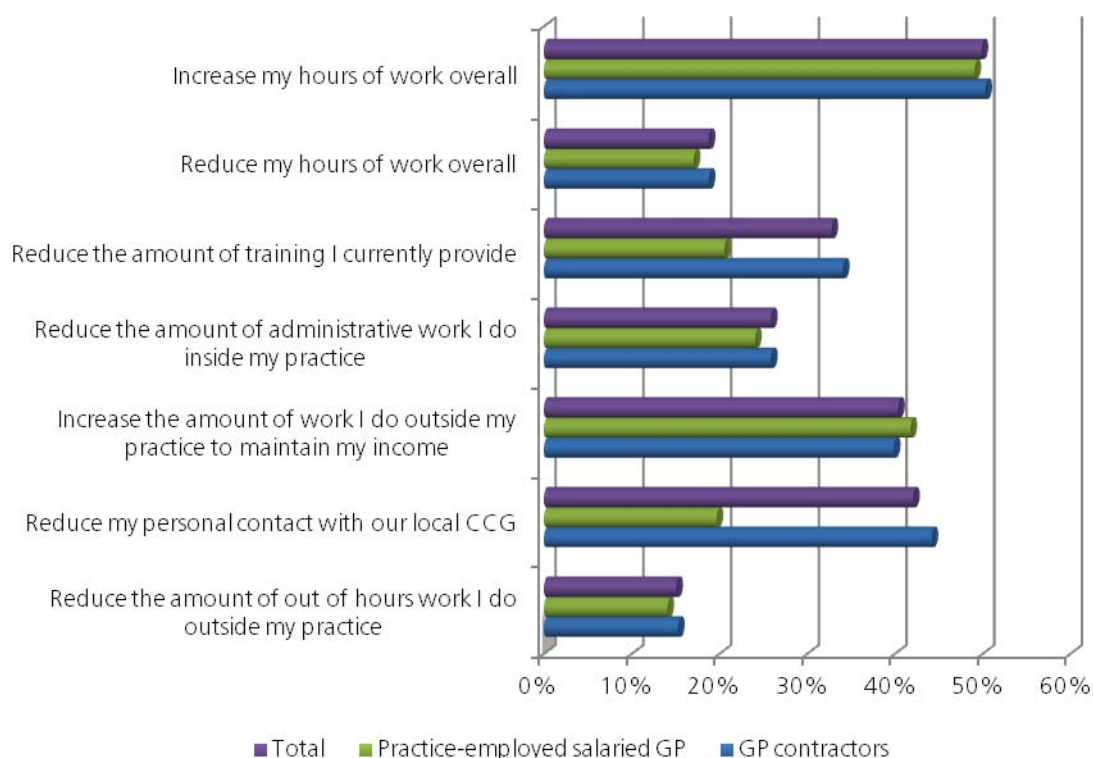
Figure 10 - If you leave the NHS will you:



Those respondents who stated they would make changes to the amount of work they would do on imposition of a new contract, were asked what options they would consider.

Respondents were most likely overall to indicate that they would have to increase hours of work overall. Whether and how far this would be possible was not tested explicitly as part of this survey, but other BMA surveys have consistently shown a rising volume, intensity and complexity of workload that cannot be sustainable in the longer-termⁱⁱ.

Figure 11 - If you have indicated you shall make changes to the amount of work you undertake, which options would you consider?



Further analysis revealed that the vast majority of respondents who indicated they would have to increase their overall hours of work had previously indicated that they anticipate their practice would have to decrease the use of locums and/or would have to make changes to the numbers of clinical and administrative staff (92 per cent; 1,385 of 1,495). Therefore, this would reinforce the previous finding that existing GP practitioners would have to absorb more work – if feasible - if the proposed contract was to be imposed.

In addition, 42 per cent of respondents indicated they will have to reduce the amount of personal contact they have with their local CCG. Furthermore, those with greater involvement were more likely to indicate that that their contact with CCGs would be negatively affected.

The finding that one-third of respondents indicated they would have to reduce the amount of training that they provide, has significant consequences. In May 2012 the Health Secretaryⁱⁱⁱ reinforced the Governments' pledge to increase the proportion of speciality training places taken by GP registrars, from 41 per cent currently to 50 per cent by 2015. There are also plans to increase general practice training from three years to four years; therefore, a reduction in the number of GPs providing training is likely to have a significant impact on the proposed increase in general practice training places, and on the future of general practice itself over the longer-term (figure 10).

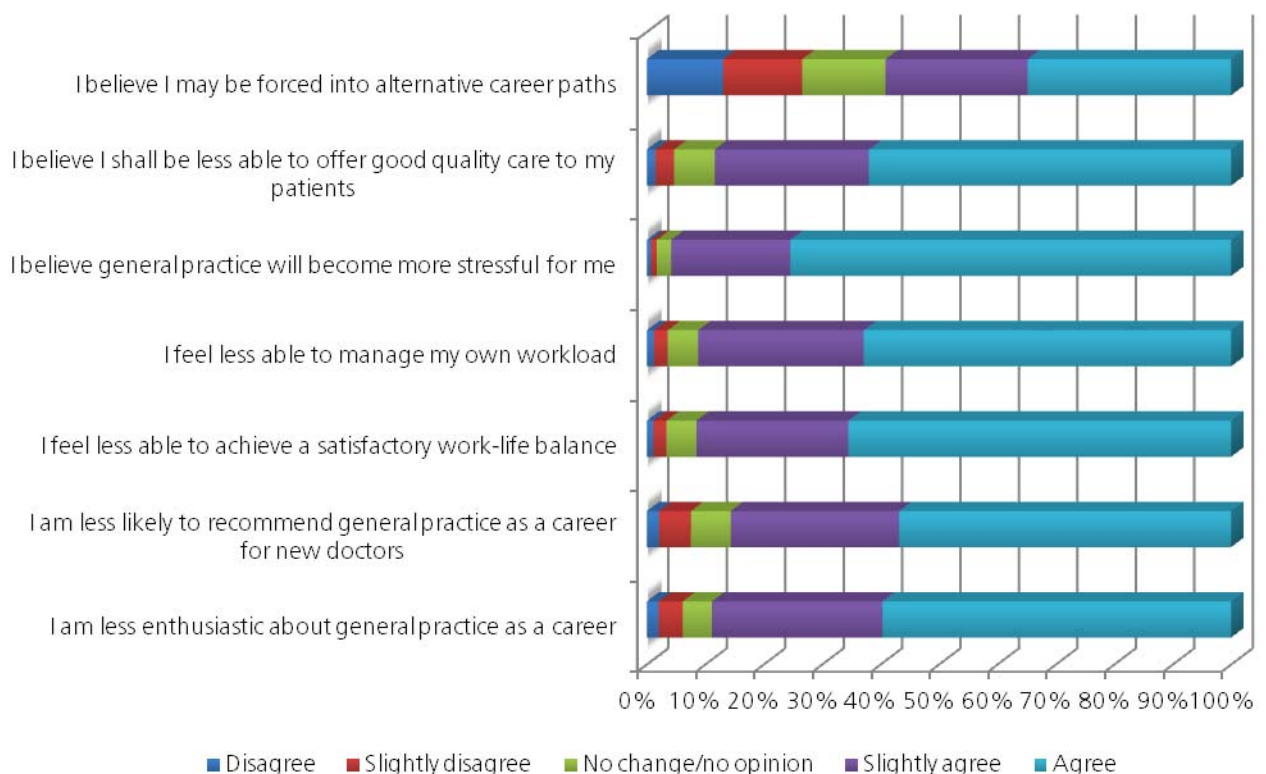
The impact of the proposed contract imposition on views on general practice

All respondents who indicated they had at least some awareness of the terms of the contract⁹ were asked how the proposed imposition has affected their personal view of general practice.

Figure 11 reveals that 97 per cent of respondents indicated that general practice will become more stressful as a direct result of the proposed contract imposition. Furthermore, 91 per cent of respondents stated that they feel they will be less able to manage their own workload and 92 per cent indicated they will be less able to achieve a satisfactory work-life balance. This finding is concerning as a good work-life balance is one of the primary attractions to doctors who choose to specialise in general practice^{IV}. In addition, 87 per cent of respondents with some knowledge of the details of the contract feel that they will be less likely to recommend general practice as a career for new doctors. This creates further risks for future recruitment and retention into this specialty.

Worryingly, 88 per cent of all respondents with at least some awareness of the terms of the contract indicated they feel that patients' quality of care will be negatively affected as a result of the contract imposition.

Figure 12 - How has this proposed imposition affected your personal view of general practice?



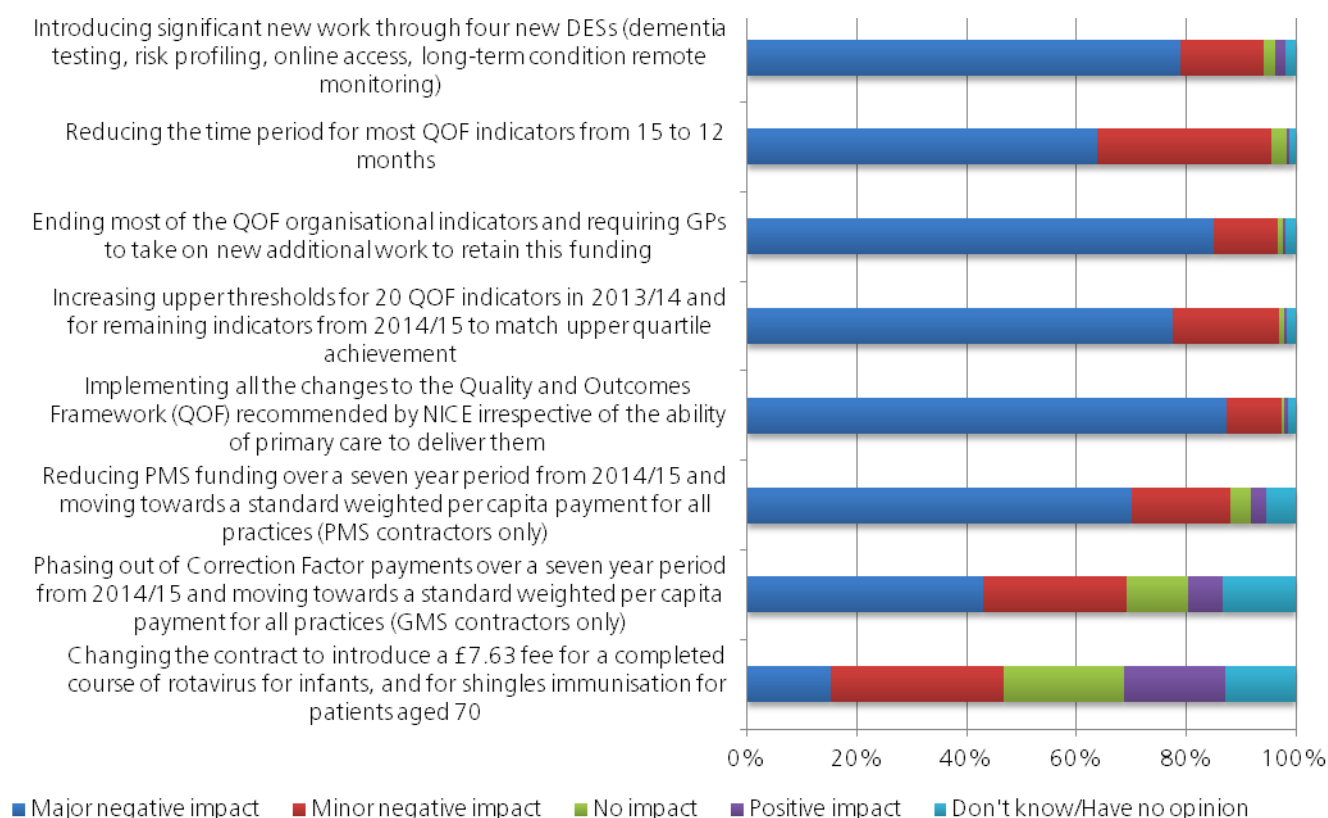
⁹ Respondents who responded; I am/are aware of the proposed contract imposition, I have a broad understanding of the terms but have not investigated in greater detail, I have reviewed all the proposals in detail, I have estimated the impact of the proposals on my practice and personal income and workload.

The details of the contract imposition

Those respondents who indicated they worked as a contractor GP or as a practice employed salaried GP and who indicated they had some awareness of the terms of the contract were finally asked to indicate the impact of the specific terms of the contract on their practice.

The respondents indicated that all of the different elements were likely to have a negative impact; however, respondents indicated that the most negative impact would come from implementing all the changes to the Quality and Outcomes Framework (QOF) recommended by NICE, irrespective of the ability of primary care to deliver them (98 per cent). The vast majority of respondents identified negative consequences if the upper thresholds for 20 QOF indicators in 2013/14 were increased and if the remaining indicators from 2014/15 were to match upper quartile achievement (97 per cent). 97 per cent of respondents also identified that ending most of the QOF organisational indicators and requiring GPs to take on new additional work to retain this funding would have a negative impact (figure 12).

Now, looking at the different elements of contract imposition, for each change below please indicate what the impact on staffing, services and income will be for your practice



References

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- i Centre for Workforce Intelligence. Shape of the Medical Workforce: Starting the Debate on the Future Consultant Workforce (2012). Available at <http://www.cfw.org.uk/publications/leaders-report-shape-of-the-medical-workforce>. Last accessed 12 February 2013.
- ii British Medical Association. Evidence to the DDRB (2013). <http://bma.org.uk//media/Files/PDFs/Working%20for%20change/Negotiating%20for%20the%20profession/Pay%20negotiations/BMADDRBevidence2013.pdf> Last accessed 12 February 2013
- iii Pulse. Lansley agrees 20% rise in GP training places in radical workforce overhaul. <http://www.pulsetoday.co.uk/lansley-agrees-20-rise-in-gp-training-places-in-radical-workforce-overhaul/13991574.article#.URkYbPK0bTo>. Last accessed 11 February 2013.
- iv British Medical Association, Career Choices, Findings from the BMA Cohort Studies (2012). Available at http://bmaopac.hosted.exlibrisgroup.com/F?func=find-b&request=cohort+study&find_code=WRD&local_base=W-BMA01. Last accessed 12 February 2013.

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