

14 October 2008

Dear Colleague

### **GMS contract 2009-10**

I am writing to give you details of the agreement we have reached with NHS Employers about the GP contract for 2009/10. There is also an online video clip explaining some of the implications of the agreement. You can access it by following this link: <http://uk.youtube.com/BMAtv><sup>1</sup>

### **Role of the Doctors' and Dentists' Review Body**

In accordance with standard practice, the level of pay award for GPs for 2009/10 will be based on a recommendation of the Doctors' and Dentists' Review Body (DDRB) to each of the four country Governments, which, in turn, decide whether or not to accept and implement the recommendation.

We believe that it is very important for GPs that the level of their income increase is decided by an independent body, i.e. the DDRB, in the light of evidence from all parties, including the BMA, and taking account of inflation and other economic factors. Because of this, we have not been prepared to agree any settlement based on the rate of increase in GP pay with NHS Employers or the Health Departments.

In its report earlier this year, the Review Body asked us to work with NHS Employers to agree a mechanism whereby the DDRB can make recommendations on GP net incomes. Our negotiations over the summer have been focused on agreeing such a mechanism to enable the DDRB to recommend on GP pay when it reports early in 2009.

We deliberately brought forward our negotiating timetable this year, to ensure that everything was concluded in time for the DDRB's evidence deadlines.

### **Agreed mechanism for the 2009-10 pay award**

We have therefore agreed a mechanism for the DDRB with NHS Employers which is to be applied for this year as a one-off. Clearly, we did not want a repeat of last year's Review Body's recommendation of increasing global sum only and decreasing correction factor, because this has resulted in a freezing of income for the majority of practices. This recommendation was, at the time it was made, not legally possible. However, we recognise the political imperative to gradually reduce reliance on correction factor and thus the proportion of practices which are dependent on MPIG.

We have therefore agreed with NHS Employers a ratio formula which we have presented jointly to the Review Body with the Health Departments. This will be applied to each of the main funding streams for the

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<sup>1</sup> If you cannot access YouTube, the video can also be viewed at this address:

<http://feeds.feedburner.com/bmadownloads>

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contract, not only global sum and correction factor. This will be the best method of ensuring that there is an increase in funding to all practices, including those which remain reliant on MPIG.

The ratio that has been agreed is as follows:

Global sum 7

Correction factor 2

QOF 5

Enhanced services 5

A pay award would therefore be apportioned in nineteenthths as defined by this formula. I should stress the overall level of uplift will be decided by the DDRB; the ratio will then be applied to determine the relative levels of uplift to the different funding streams.

Providing the DDRB does not recommend a 0% uplift, the agreement of the ratio will avoid a situation in which practices receive no increase. We are also particularly concerned about practices being in a position to meet increases in expenses and the modelling we have done has shown that this should be possible, depending upon the DDRB's decision on the level of uplift.

Further information about how the ratio will apply are given in a joint letter which sets out all the details of our agreement: [www.bma.org.uk/ap.nsf/Content/gmsagreeOct08](http://www.bma.org.uk/ap.nsf/Content/gmsagreeOct08) as well as our joint letter to the DDRB: [www.bma.org.uk/ap.nsf/Content/PayRecommendsOct08](http://www.bma.org.uk/ap.nsf/Content/PayRecommendsOct08)

### Future of MPIG

We have also started work with NHS Employers on how reliance on MPIG might be eroded over a number of years without reducing practice funding, using a variety of possible models. In embarking on that work, we laid down a number of important conditions that needed to be met, not the least of which was that practices should not be destabilised through loss of resources. It has quickly become apparent to all parties that it will take some time to carry out all of the necessary work and prevent any unintended consequences. Having established that it was unlikely that the work would be concluded for 2009/10, we have agreed the ratio model for 2009/10 without making a commitment to use this model again in future years.

### Quality and Outcomes Framework

Changes to the Quality and Outcomes Framework have also been agreed and will come into effect from April 2009.

We have worked hard in negotiations to ensure that the 1000 QOF points are retained, thresholds stay at their current level and a UK QOF is maintained without local variation. The Health Departments no longer wish practices to carry out the QOF patient survey and intend to replace this with a new postal national patient survey which will combine some elements of the current QOF survey with the access survey questions. The 55 patient experience points (PE2 and PE6) have been reallocated and a small number of points (17 in total) have been removed from several areas (and recycled) to demonstrate "efficiency savings". These 72 points have been distributed to new clinical areas and these changes are in line with recommendations in the 2008 expert panel report.

The reallocated points are to be invested in the following clinical areas:

- advice on long term contraception
- cardiovascular disease primary prevention
- new depression indicator on assessment of severity
- beta blockers for heart failure
- improvement to chronic kidney disease indicators
- improvement to diabetes indicators
- improvement to chronic lung disease indicators

These changes are to apply to all four countries across the UK.

More details on the agreed changes to the 2009/10 QOF are available at the following link: [www.bma.org.uk/ap.nsf/Content/QoFChangesOct08](http://www.bma.org.uk/ap.nsf/Content/QoFChangesOct08)

**I fully accept our position that there should be no new work without new money to fund it and our negotiations on QOF changes have been based on the work that GPs currently perform that has not been included in QOF so far.**

### **Prevalence**

In line with LMC Conference policy, we have been discussing the fairness of QOF funding and whether this should reflect true prevalence. Since the new contract was negotiated, it has become apparent that many GPs are extremely dissatisfied with the square rooting mechanism and the unfairness in the way that prevalence is applied. We have therefore sought a way to remedy this situation. As the change is to be cost neutral, any move towards true prevalence will disadvantage certain practices and benefit others, and there will be significant financial implications for a small proportion of practices. We agreed with NHS Employers that the resource implications for those who are likely to lose substantial amounts of money as a result of the move to raw prevalence would be dealt with locally by PCOs, provided that PCOs were given strong guidance to ensure that such outliers are dealt with fairly.

In the light of this, we have agreed that the current prevalence arrangements (used to determine QOF payments) will be removed over two financial years:

- on 1 April 2009, the square rooting component of the current arrangements will be discontinued
- on 1 April 2010, true prevalence will be used to determine QOF payments, i.e. the current cut off arrangements will be discontinued.

The following guidance will be issued by Health Departments to their PCOs:

*"PCOs should work with practices which identify themselves as experiencing a significant loss in their income to understand the impact of the changed arrangements on their current service provision.*

*PCOs will also wish to use the opportunity to consider the local health needs of populations and, working with LMCs and practices to identify whether new services or improvements in care should be commissioned to address these local needs."*

### **Seniority**

The complex mechanisms for calculating seniority payments are currently under discussion but as yet no agreement has been reached.

### **Next steps**

While we have written jointly to the DDRB about the ratio formula and the other aspects of this agreement, all parties are preparing their own evidence to the DDRB on what would be an appropriate level of uplift. With the BMA, the General Practitioners Committee will be making the strongest possible case on behalf of GPs, including the facts that our pay has been frozen for three years, our expenses have been rising rapidly, inflation has risen and the recruitment environment is not encouraging practices to take on new GPs.

We recognise that this agreement does not provide any guarantees about next year's pay award, but we hope it will prove to be a pragmatic way forward and help to improve the position of practices' funding for 2009/10. In the present economic and political climate, I hope that you will recognise this as a fair arrangement that will offer the prospect of increased practice incomes with a greater likelihood of stability.

Yours sincerely



Dr Laurence Buckman  
Chairman, General Practitioners Committee