GP Agreement 2023

Parties: Department of Health, Health Service Executive and Irish Medical Organisation

Date: 3rd July 2023

An Roinn Sláinte
Department of Health

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

HSE

Contents

1. GP Agreement 2023

The Department of Health, the Health Service Executive (HSE) and the Irish Medical organisation (IMO) have concluded an Agreement under the terms of the Framework Agreement on a range of measures, including but not limited to, the extension of eligibility to Doctor Only Visit Cards to individuals and families whose annual reckonable earnings do not exceed the median income and to all children aged between 6 and 7 years (inclusive). The resulting Agreement (hereinafter referred to as the "GP Agreement 2023") sets out new contractual terms and conditions that will, in the case of the extension of Doctor Visit Card (DVC) eligibility to individuals and families whose annual reckonable earnings do not exceed the median income, apply to the participating General Practitioners under the GP Visit Card Form of Agreement and, in the case of the extension of DVC eligibility to all children aged between 6 and 7 years, under what will now be referred to as the Form of Agreement for the Provision of Services to Children Aged Under 8 years (Under 8 Contract). The terms of the GP Agreement 2023 pertaining to the median income provision are therefore incorporated in to the individual GP Visit Card Form of Agreement pursuant to Clause 41(1) thereof and in to the Under 8 Contract pursuant to Clause 21 thereof.

The GP Agreement 2023 is an interim Agreement pending the completion and recommendations of the GP Strategic Review and subsequent talks with the IMO, under the Framework Agreement, on contractual reform. The Strategic Review will identify the challenges facing General Practice in delivering a sustainable service into the future, and set out the actions necessary to address those challenges. It will examine a wide range of issues to do this, including training, capacity, E-Health, the Out of Hours services, and the financial support model necessary to ensure a sustainable service. The Terms of Reference to the Strategic Review are appended to this Agreement at Appendix 3. Discrete issues including the Maternity and Infant Care Scheme, work/life balance, gender related issues, establishment and succession issues will be considered under the Strategic Review. The IMO will be one of the stakeholders in the Strategic review and the outcome of the Strategic Review and its consideration by the Department of Health will be followed by engagement with the IMO under the Framework Agreement on the support model and contractual reforms to ensure a sustainable model of General Practice in to the future.

The Department of Health and the Health Service Executive acknowledge the IMO's position that the General Medical Services contractual arrangements that now exist between GPs and the Health Service Executive were originally framed on the basis of a defined ratio of 60/40 private: public mix. This was detailed in 1988 by the then Chairman of the Labour Court, who presided over the negotiations process that ultimately resulted in the introduction of the Capitation contract in replacement of the Fee per Item contract. The Chairman's letter dated 28th July, 1988 to the IMO, includes the following sentence- *"It is recorded that the negotiations were concluded on the assumption that the proportion of the population who will be issued with medical cards will not exceed 40%".* Any subsequent changes to the GMS Contract have been introduced by agreement with the IMO.

It is with the foregoing considerations in mind that the GP Agreement 2023 with the IMO includes a commitment from this Government that no further extensions of eligibility beyond those already announced by Government will be introduced, other than by agreement with the IMO and in the context of a new agreed Contractual Framework between the parties as an output following the Strategic Review. In the event that Government considers it necessary to provide overall health service supports for defined cases and in small groups then the IMO will be engaged with under the Framework Agreement to seek its views on any resourcing and/or capacity implications for general practice.

In order to avail of the terms of this Agreement (including the fee rate increases) existing GMS GPs are required to submit and return to the HSE a completed and signed Notice of Participation form in respect of their participation in the provision of General Medical Services to patients who qualify for a DVC under the median income provision and Child Patients aged 6-7, in accordance with the terms of the GP Visit Card Contract, the Under 8 Contract and the relevant terms of this GP Agreement 2023.

2. Extension of Doctor Only Visit Card

Department of Health modelling indicates that approximately 340,000 individuals are likely to take up eligibility for a Doctor Only Visit Card under the expansion of care to those earning no more than the median income. This number is in addition to the estimated 78,000 children who it is projected will become eligible under the expansion of care to all children aged 6 and 7 who will receive GMS services in accordance with the terms of the Form of Agreement with Registered Medical Practitioners for the Provision of GMS Services to Child Patients Aged Under 8 Years.

Table 1: Population Breakdown

Cohorts	Total
6-7 Years	78,000
Remainder Eligible Under Income Threshold	340,000
Total	**418,000**

The process of extending eligibility to individuals and families whose annual reckonable earnings do not exceed the median income and to all children aged between 6 and 7 years will commence on a phased basis as set out in sub-section 9.1 herein.

2.1. Current card-holder numbers

As of 1 April 2023, there were a total of 2,122,125 medical card and GP visit card holders; 541,720 GP visit card holders and 1,580,405 medical card holders. There are 251,896 GP visit card and 82,110 medical card holders under 6 years of age.

Table 2: Current Card Holders by Age

Card Holders By Age Inc. Discretionary Cards	*GP Visit Card*	*Medical Card*	*Total*
0 - 5	251,896	82,110	334,006
6 - 11	23,036	134,632	157,668
12 – 17	17,629	142,791	160,420
18 – 24	15,101	82,145	97,246
25 – 34	9,999	118,392	128,311
35 – 44	22398	170242	192640
45 - 54	20,410	187,801	208,211
55 - 64	13,781	183,231	197,012
65 - 69	6,452	93,276	99,728
70 - 74	69,365	120,754	190,119
75 - 79	51,665	110,878	162,543
80 +	39,988	154,233	194,221
Total	**541,720**	**1,580,405**	**2,122,125**

Table 3: Estimated number of new GP Visit Cards by Age

Age group	*New GP Visit Card*
6 - 7	78,000
8-10	16,320
11-12	10,880
13-15	11,560
16 – 44	197,880
45 - 64	89,760
65 - 69	13,600
Total	**418,000**

3. Variations to Under 6 Contract

The following variations to the Form of Agreement with Registered Medical Practitioners for the Provision of Services to Child Patients aged under 6 years have been agreed between the parties pursuant to Clause 21 therein.

3.1 The contract will now be referred to as "The Form of Agreement with Registered Medical Practitioners for the Provision of GMS Services to Child Patients aged under 8 years".

3.2 The Definition of Child Patients is amended to read as follows;- ***"Child Patients"*** *means persons under the age of 8 who are eligible for general medical and surgical services pursuant to the provisions of the Health (General Practitioner Service Alterations of Criteria for Eligibility) Act 2020 (or, as the context may require, the Parent(s)/Guardian(s) of the relevant child).*

3.3 The annual review provided for under the Asthma Cycle of Care will continue to be provided until the registered Child Patient has reached 8 years of age.

3.4 The Capitation fee rates for Child Patients will be the applicable rates as set out in Table 4 of Section 4 herein.

4. Adjustments to Capitation Fee Rates

Under the terms of the GP Agreement 2023 the parties have agreed a range of Capitation fee rates adjustments across the age groups from 6- 69 years inclusive. The rate for Children aged between 6 and 12 years (inclusive) will increase from an average of approximately €65.00 to €100.00. Rates for GMS patients aged between 13 and 69 years (inclusive) will increase by 10.00%. All new capitation rates will be applicable from 1st August 2023 provided the GP has signed up to this Agreement and submitted a completed and signed Notice of Participation Form to the HSE on or before the 9th August, 2023.

Details of the Capitation fee rate increases are set out in Table 4 below.

Table 4: Revised Capitation Rates	
Cohort	**Annual Capitation**
Child Patient Aged between 6 and 7 years (inclusive)	€100.00
Child Patient Aged between 8 and 12 years (inclusive)	€100.00
Male patient aged 13 years and less than 16 years	€70.71
Male patient aged 16 years and less than 45 years	€90.26
Male patient aged 45 years and less than 65 years	€180.29
Male patient aged 65 years and less than 70 years	€189.92
Female patient aged 13 years and less than 16 years	€71.52
Female patient aged 16 years and less than 45 years	€147.60
Female patient aged 45 years and less than 65 years	€198.10
Female patient aged 65 years and less than 70 years	€211.87

5. Supports to Enhance Capacity of General Practice

5.1. Background/Context

The GP Agreement 2023 includes additional supports to maintain and increase the capacity of GP Practices. Details in relation to the additional supports for practice capacity are set out below.

In addition to changes to the existing practice supports, each GMS GP with a weighted panel size of 500 or more, where weighting is such that over 70s count for two, will be entitled to access a new form of practice grant of €15,000. This grant can be used towards a practice nurse, practice administrator, practice manager or the new role of GP Practice Assistant (GPA). This grant will only apply to additional hours for existing staff (increase in hours must be on or after 1st July 2023) or staff hired after the 1st July 2023.

In addition to the above and across all grants, in determining the relevant point on the subsidy scales for a practice nurse, relevant nursing experience in an acute, community/primary care or nursing home setting will be taken into account in determining the relevant point. Heretofore, only General Practice experience was taken into account.

5.2. New Practice Grant for Additional Capacity

Scope of Grant

This new Grant is targeted at additional capacity and therefore may only be claimed by qualifying GMS GPs in respect of additional new employees recruited or for additional hours on the part of existing staff. In order to be eligible for the Grant each GMS GP must have a reckonable GMS list of 500 GMS patients or more. For the purposes of calculating a GMS GP's reckonable panel size, regard will be had to the double weighting that applies to each GMS patient aged 70 years and over registered on the GP's GMS panel.

The new Grant may be used as a contribution towards cost of employing Practice Manager, Administrator, Practice Nurse or new role of General Practice Assistant (GPA). The maximum refundable amounts for each grade on a full time basis (35 hours) are set out below:

Table 5:

Grade	Point	Maximum Refundable Salary Amount	ER PRSI at 11.05%	Maximum Refund (incl of ER PRSI)
General Practice Assistant	1	€ 32,000	€ 3,536	€ 35,536
Practice Nurse	4	€ 52,500	€ 5,801	€ 58,301
Practice Nurse	3	€ 47,250	€ 5,221	€ 52,471
Practice Nurse	2	€ 44,765	€ 4,947	€ 49,712
Practice Nurse	1	€ 42,276	€ 4,671	€ 46,947
Practice Manager	1	€ 50,000	€ 5,525	€ 55,525
Practice Admin	3	€ 32,000	€ 3,536	€ 35,536
Practice Admin	2	€ 29,715	€ 3,284	€ 32,999
Practice Admin	1	€ 27,428	€ 3,031	€ 30,459

For the avoidance of doubt the above table, should not be interpreted as being an agreed or recommended salary scale. Each practice will set its own rates and the table above is to show maximum refundable grant amounts only.

Under this new provision qualifying GPs (those with a weighted panel of 500+) will be eligible to claim an annual Grant of €15,000. This can be used for any of the above grades (i.e. General Practice Assistant, Practice Administrator, Practice Nurse or Practice Manager). However, the grant cannot be used to meet the shortfall between the practice support subsidy in payment and the cost to the practice of employing the practice staff member.

The amount that can be reimbursed to a qualifying GP under the new Grant provision cannot exceed the Grant amount. In circumstances where the annual cost of the additional capacity (whether through employment of an additional staff member or increase in the whole-time commitment of an existing staff member) is less than the Grant amount then the lower amount will be claimable. The maximum refund amounts are set out in the table above (inclusive of the Employer's PRSI contribution) adjusted, where applicable, to reflect the whole-time equivalent commitment of a new staff member or, as the case maybe, the net additional whole-time equivalent commitment of an existing staff member. However, under this Grant proposal the Grant amount claimable will not be pro-rated to take account of the GP's panel size. Examples of how the grant will work are set out below.

The State is providing resources for this Grant with the objective of increasing practice support capacity by up to 40% of the baseline whole-time equivalent value of existing subsidised Practice Support staff. The new Grant provision will be reviewed by the Department of Health, HSE and the IMO after one year of operation.

A Maximum Refundable Salary of €32,000 will apply to the new position of General Practice Assistant (GPA). In circumstances where the reckonable annual cost of employing the General Practice Assistant is less than the Grant amount then the lower amount will be claimable. As with the other grades comprehended by the Grant, the Grant amount claimable will not be pro-rated to take account of the GP's panel size. For the avoidance of doubt, a GP cannot claim reimbursement under the Grant provision for practice capacity in respect of which a Practice Support subsidy is already in payment.

Subject to the foregoing provisions of this Section, GPs in Group Practices will be permitted to pool Grants to optimise enhancement of the Practice's capacity. Furthermore, and subject to the foregoing provisions of this Section, GPs, while not in group practice arrangements, who wish to coalesce for the purposes of optimising the enhancement of capacity of GP services for their shared GMS communities, may also pool Grants provided that no practice is more than 30kms from one of the other practices in the proposed configuration. Under this provision the number of GMS practices that may participate in each such configuration will be limited to 5, save in exceptional circumstances where, at the discretion of the HSE following consultation with the IMO, a greater number of practices may be permitted.

Set out hereunder are a number of examples for the New Practice Grant only. Separate examples will be provided for changes to the existing subsidy arrangements.

Example 1

4 doctor group practice

Each doctor in this practice has a weighted GMS panel of over 500 patients. They are entitled to access €60,000 under the new system. However, maximum refundable amounts per grade as set out above apply.

This practice may employ a full time (35 hours or greater)) nurse paying a salary of €52,500 and employers PRSI of €5,801.25 (total €58,301.25) and be reimbursed the full amount. In the event that the practice was paying a salary of €62,000 they would still only be able to take the maximum nurse subsidy amount of €58,301.25. In the event they were paying €45,000 then the maximum grant payable would be €49,972.50 (€45,000+Emp PRSI €4,972.50).

Example 2

A single handed GP wishing to employ a nurse for 0.4 WTE (14 hours per week) and paying the nurse €50,000 WTE salary (€20,000 actual salary) would be reimbursed €15,000 towards the cost of the nurse.

Example 3

A single handed GP wishing to employ a nurse for 0.2 WTE (7 hours per week) and paying the nurse €10,000 actual salary would be entitled to claim €10,000 plus the employers PRSI

Example 4

A GP wishing to employ a practice assistant for 0.4 WTE and paying a WTE salary of €35,000 (actual salary €14,000) would be entitled to be reimbursed

1.) €32,000 (maximum allowable for grade) *14/35-€12,800
2.) €12,800 +Emp PRSI (8.8%)=€13,926.40
3.) GP is entitled to €13,926.40 rebate

5.3. Proposed enhancement to Current Practice Support Subsidy Provisions.

With effect from 1st July, 2023 Practice Support Subsidies for existing Practice Staff will be based on total maximum refundable amounts, as follows;

Table 6:

Grade	Point	Maximum Refundable Salary Amount	ER PRSI at 11.05%	Total Maximum Refund (incl of ER PRSI)	Subsidy Ceiling 75%
Practice Nurse	4	€ 52,500	€ 5,801	€ 58,301	€43,725.75
Practice Nurse	3	€ 47,250	€ 5,221	€ 52,471	€39,353.25
Practice Nurse	2	€ 44,765	€ 4,947	€ 49,712	€37,284.00
Practice Nurse	1	€ 42,276	€ 4,671	€ 46,947	€35,210.25
Practice Manager	1	€ 50,000	€ 5,525	€ 55,525	€41,643.75
Practice Admin	3	€ 32,000	€ 3,536	€ 35,536	€26,652.00
Practice Admin	2	€ 29,715	€ 3,284	€ 32,999	€24,749.25
Practice Admin	1	€ 27,428	€ 3,031	€ 30,459	€22,844.25

Practice Manager

The total maximum refundable amount for the purpose of subsidy calculation for a Practice Manager will be €55,525p.a. including Emp. PRSI. The current criteria for claiming subsidy towards cost of employing a Practice Manager will continue to apply.

5.4. Subsidy calculation

In calculating the subsidy that is claimable for Practice Staff the following formula will apply.

Step 1: Calculate the Maximum Refundable Salary Amount.

The maximum refundable salary amount is the annual Salary relevant to the grade category and incremental point (based on experience as set out above) multiplied by the staff member's whole-time commitment.

For example in the case of a whole-time Administrative staff member with 3 or more year's salary the Maximum Refundable Salary Amount will be €32,000. In the case of a Practice Nurse with 2 years' experience, who is contracted on a 0.5 wte, basis the Reckonable Salary will be €22,382.50. In determining WTE, 35 hours will be the divisor, such that a nurse working 28 hours a week would be a 0.8 WTE (28/35).

Step 2: Calculate the Total Maximum Refundable Amount inclusive of Applicable Employers PRSI Contribution.

To calculate the **Total Maximum Refundable Amount** inclusive of Applicable Employers PRSI Contribution you add employers PRSI contribution to the **Maximum Refundable Salary Amount** In the first example involving the Whole-time Administrative staff member (hereinafter referred to as Example 1) the **Total Maximum Refundable Amount** inclusive of the Applicable Employers PRSI Contribution will be €35,536. In the second example involving the 0.5 wte Practice Nurse (hereinafter referred to as Example 2) **Total Maximum Refundable Amount**, inclusive of the Applicable Employers PRSI Contribution will be €24,855.75.

Step 3: Calculate Subsidy Ceiling Amount.

The Subsidy Ceiling amount will be 75% of the **Total Maximum Refundable Amount,** inclusive of Applicable Employers PRSI Contribution for the staff member in question. In the case of example 1 it will be €26,652. In the case of Example 2, it will be €18,641.81.

Step 4: Calculate the Claimable Subsidy Amount.

The Claimable Subsidy Amount will be the Subsidy Ceiling Amount pro-rated to take account of the GP's GMS panel Size (for these purposes the GMS panel size will be comprised of medical card, DVC and Child patients aged 0-7 years (inclusive) in accordance with current provisions. Therefore, a GP with a weighted panel size of 1,200 or more (as well as recipients of the RPSF) will be eligible to claim the full amount of the Subsidy Ceiling amount, while, for example, a GP who is not a recipient of the RPSF with a weighted panel size of 600 would be eligible to claim half the value of the Subsidy Ceiling amount.

Worked Examples:

A)

A GP with a weighted panel size of 1,200 currently employing a nurse, with 4 or more years' experience, working 35 hours per week on a salary of €52,000 would receive a subsidy refund of €27,822.72 under the existing system.

Under the new system the GP would be reimbursed as follows:

Refundable Salary Amount: €52,000

PRSI 11.05%: €5,746

Total Refundable Amount: €57,546

Subsidy Ceiling Amount: €43,309.50 (75% of Total Refundable Amount)

Claimable Subsidy Amount: 1,200/1,200 * €43,309.50= €43,309.50

B)

A GP with a weighted panel size of 600 patients employing a nurse, with 4 or more years' experience, on 20 hours paying a salary of €30,000 currently receives a subsidy refund of €9,455.50 under the existing system.

Under the new system the GP would be reimbursed as follows:

Maximum Refundable Salary Amount: €52,500* 20/35=€30,000

PRSI 11.05%: €3,315

Total Refundable Amount: €33,315

Subsidy Ceiling Amount: €24,986.25 (75% of Total Refundable Amount)

Claimable Subsidy Amount: 600/1,200 * €24,986.25=€12,493.13

5.5. Payment of Practice Support Subsidy During Maternity Leave

GMS GPs who meet the qualification criteria for Practice Support Subsidies will be eligible to claim Practice Support Subsidy for a member of the Practice Team, in respect of whom the GP is either in receipt of a practice support subsidy or the additional Practice Capacity Grant, as described in section 1.4 above, during the period when such member of staff is on Maternity Leave. In circumstances where the GP is receiving a Subsidy towards the cost of employing the staff

member in question the GP will be eligible to claim the weekly value of the Claimable Subsidy Amount (as described in Step 4 of calculation above) for the 26 weeks of the maternity leave period abated by the value of the Statutory Maternity Benefit payable to the Staff member (i.e. 75% of (the Reckonable weekly Salary inclusive of Applicable Employers PRSI Contribution minus the value of the weekly maternity benefit)). Where the GP is in receipt of the new Practice Capacity Grant then he/she will be eligible to claim the equivalent of 26 weeks of the annual grant amount in payment for the staff member on maternity leave abated by the value of the Statutory Maternity Benefit payable to the Staff member. In circumstances where the cost to the GP of maintaining the salary of the staff member during the maternity leave period is lower than the Net Claimable Subsidy Amount then the lower amount will be claimable.

GMS GPs will be eligible to claim subsidy towards cost of employing a replacement staff member to cover the period of maternity leave. In such circumstances, the Claimable Subsidy Amount (or grant as the case maybe) will be calculated in accordance with the formula set out in the immediately preceding paragraph. It is acknowledged however that the Statutory Maternity Benefit abatement will not be applicable in these circumstances.

5.6. Other Matters of Clarification

Those in receipt of the RPSF (and those GPs who continue to receive the former RPA on a red circled basis) and whose weighted GMS panel size is less than 1,200 will be treated the same as those GMS GPs whose weighted panel size is 1,200 or more for the purposes of calculating practice supports, contributions towards locum expenses for leave and medical indemnity rebate.

In order to avail of these enhanced capacity support measures from the 1st July, 2023 (as outlined in sub-sections 5.2-5.5 above) GPs must have signed up to the terms of the GP Agreement 2023 and submitted a completed and signed Notice of Participation form to the HSE on or before the 9th August, 2023.

6. Out of Hours

In March 2020, at the beginning of the pandemic, the HSE agreed with the GP Out of Hours (OOH) Co-operatives changes in the way they would be paid to deliver services in respect of GMS patients. Rather than provide payment on a fee-per-consultation basis, OOH services have since then been paid a flat grant, based on 2019 levels of activity. This change allowed for the maintenance of services in the uncertain environment of the time, when the potential for greatly reduced income levels might have threatened the services' viability, and was implemented at no additional cost. The same level of payments were provided to the OOH services in 2021, 2022 and up to 30th June 2023. Under this Agreement the parties agree that OOH Co-Ops can revert to the pre-covid contractual arrangements, that being the OOH STC rate of €41.63 for each in person consultation (treatment Centre based and Domiciliary) provided by the Co-ops, with effect from 1st, September, 2023. However, recognising that some OOH Co-Operatives have significantly revised their business arrangements during Covid, and wish with the agreement of their members to continue on the existing grant system, this will be facilitated by the HSE.

6.1. Additional Supports for Out of Hours Services

In addition to the foregoing, Co-ops will receive a supplementary grant to assist with the provision of innovative services, such as telephone consultations in respect of patients in nursing homes, those receiving palliative care, or to avoid hospital attendance. The annual grant amount will be €2.00m and will be distributed across the grant funded Co-ops on a pro-rata basis, having regard to the GMS populations served by each.

Each OOH Co-op, in line with existing SLAs with HSE CHOs, provide monthly activity reports to the HSE setting out the number of contacts, number of contacts subsequently triaged, no of in-person consultations in treatment centres, no of in-person consultations in domiciliary setting, other contacts and referrals to Accident and Emergency Service. As part of this new arrangement each CO-OP will be required to provide the information split between activity levels for GMS and non-GMS patients. For those cooperatives reverting to the Pre-Covid contractual arrangements, all in-person out of hours consultations provided by the GP Out of Hours Co-ops will transition to being claimed by the GP Out of Hours Co-ops using a dedicated number assigned to them by PCRS.

The parties to this Agreement acknowledge that the foregoing measures are interim in nature pending the outcome of further engagements following the completion of the Strategic Review of GP Services. It is expected that the Strategic Review will provide an opportunity to give consideration to the appropriateness of other/emerging service responses such as teleconsultations with doctors in the out of hours context.

7. Provision of Contraception Services

In 2022 a free Contraception Service was introduced. Initially it was for all women aged between 17 and 23 years of age irrespective of eligibility status and was subsequently extended to cover all women up to the age of 26. The Scheme will be further extended in September of this year to include women up to the age of 30 years. Further age based extensions of the Scheme are expected to take place in to the future in line with Government policy and subject to overall budgetary parameters. With the extension of DVC eligibility to individuals and families whose annual reckonable earnings do not exceed the median income, women who qualify for a DVC but are not comprehended by the age parameters of the free Contraception Service, as they apply at the time the service is required, will be able to access contraception services in accordance with the scope of service of the GMS contracts.

Under this Agreement the fees paid in respect of the insertion and removal of long-acting contraceptive devices will be increased so that they are aligned with the equivalent fee rates that apply under the Free Contraception Service. GPs may also claim a single fee per annum in respect of an eligible woman between the ages of 31 and 44, inclusive, in respect of a consultation for the purposes of obtaining contraception. These measures will apply both to existing GMS/DVC holders and those who become newly eligible for a DVC under this Agreement.

The new fee rates under the GMS Contracts are set out in Table 7 hereunder;

Table 7: Revised Fee Rates under GMS Contracts

Applicable Services Rendered by a Registered Medical Practitioner on behalf of the Health Service Executive under the General Medical Services Scheme.	
Description	**Amount**
Consultation provided to an eligible woman aged between 31-44 years (inclusive) for the purposes of obtaining a prescription for accessing relevant products.	€55.00
Fitting by a Registered Medical Practitioner of a relevant product that is a Coil for an eligible woman aged over 30 years.	€160.00
Removal by a Registered Medical Practitioner of a relevant product that is a Coil for an eligible woman aged over 30 years.	€50.00
Fitting by a Registered Medical Practitioner of a relevant product that is a contraceptive implant for an eligible woman aged over 30 years	€100.00
Removal by a Registered Medical Practitioner of a relevant product that is a contraceptive implant for an eligible woman aged over 30 years	€110.00

Note: For the purpose of this Agreement a Relevant Product is as defined in Section 6 of the Health (Miscellaneous Provisions) Act, 2022 (no.20 of 2022).

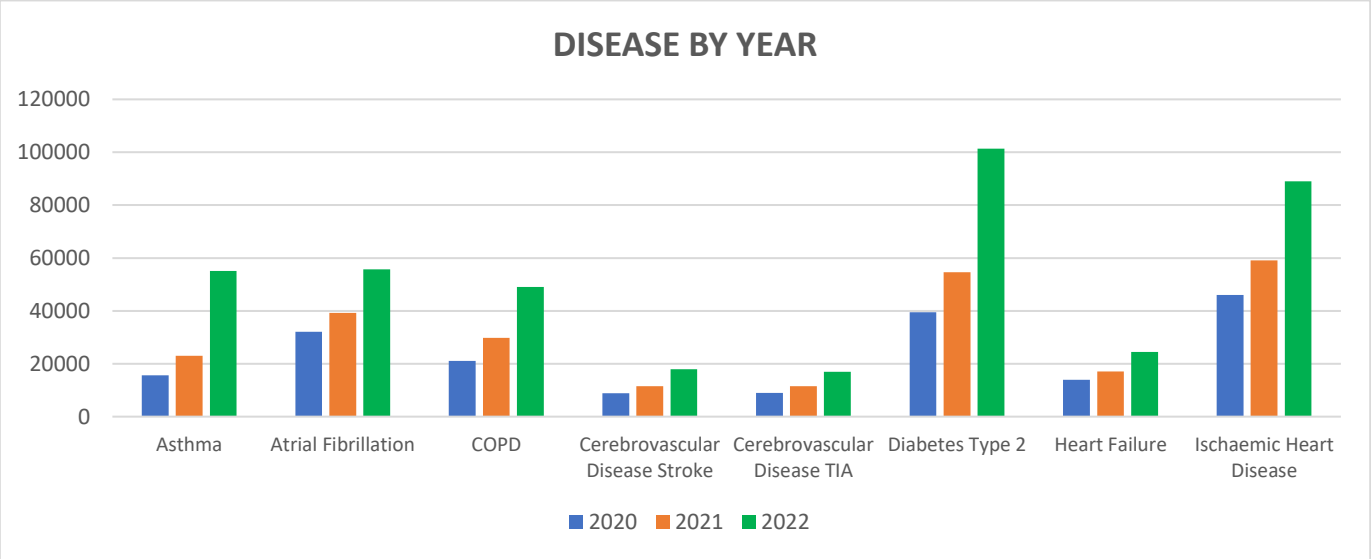
8. Chronic Disease Management- Roll out of Phase 3

In 2020, the Health Service Executive published The National Framework for the Integrated Prevention and Management of Chronic Disease (2020-2025) which adopted a whole system approach to integrated care for people with Chronic Diseases. The framework describes a significant programme of reform in how we deliver chronic disease care. These reforms are now underway as part of the Enhanced Community Care Programme, with the implementation of the chronic disease component being rolled out under the leadership of the Office of National Clinical Advisor Group Lead Chronic Disease. The GP Agreement of 2019 provided for the introduction of an integrated model of a structured Chronic Disease Management Programme, which provides GP reimbursement for opportunistic case finding, prevention and care for people with chronic disease. Self-Management, education and support are a central part of the Structured CDM Programme in General and has been rolled out on a phased basis over a period of four years (2020 – 2023) as follows:

Table 8: CDM Phasing Table

Programme Delivered	2020	2021	2022	2023
Treatment Programme	Age 70 and over	Age 65 and over	Age 18 and over	Programme continues
Opportunistic Case Finding	-	-	Age 65 and over	Age 45 and over
Prevention Programme	-	-	Age 65 and over	Age 45 and over

Figure 1: CDM Programme - Disease by Year 2020, 2021, 2022



8.1. Phase 3 Roll Out

The parties to this Agreement have agreed the following service enhancements as part of the roll out of Phase 3 of the CDM Programme. The commencement of Phase 3 roll out is dependent on the development of the necessary IT developments with a target implementation timeline of Autumn 2023.

- Hypertension for patients with GMS/DVC over 18 years and including stage 1 hypertension will be included in the CDM Prevention Programme.
- All women (GMS and non GMS) who suffered gestational diabetes or pre-eclampsia since January 2023 will be included in the Prevention Programme and where such women develop diabetes, they will be included in the CDM Treatment Programme.
- Health Amendment Act Cardholders (HAA) will be eligible for registration on the CDM programme.
- A number of measures to update and streamline the Care Plan have been agreed, the details of which are set out in Appendix 1 to this Agreement

The effective roll out of Phase III requires a number of enhancements to the CDM Programme, the addition of functionality and consolidation / streamlining of the Programme, which incorporates feedback from relevant stakeholders. Details of the enhancements are set out in Appendix 1 of this Agreement.

9. Operationalisation Issues

9.1. Phasing

In order to facilitate an effective and efficient patient application and registration process, and to ensure an orderly implementation of the GP Notice of Participation process, the extension of DVC eligibility to the cohorts in question will be done on a planned phased basis as follows;

- Children Aged between 6-7 years - Commencement of registration 11th August 2023
- Phase 1 of Median income registrations - 11th September 2023
- Phase 2 of median income registrations - 13th November 2023

9.2. Assignment of Patients Under GMS Contracts

Patient choice of doctor has been and remains a bedrock principle of the General Medical Services Scheme. For the vast majority of individuals who are approved for either a Medical Card or DVC their choice of doctor is accommodated and they therefore are registered on the GMS panel of their doctor of choice. In 2022 out of a total of circa 348,000 individuals who were approved for either a DVC or medical Card some 3,927 (i.e. 1.1%) of these new applicants were unable to get placed on to the GMS panel of their doctor of choice.

It is not the HSE's intention to utilise the assignment provision as the default mechanism for assigning patients qualifying for Doctor Only Visit Cards under the terms of this Agreement, to the GMS panel of any participating GP, where such patients were not formerly registered with the participating GP in question. As part of this Agreement the Table below sets out the maximum patient assignment arrangements which will apply to those GPs who sign up to the Agreement.

Table 9: Patient Assignment Arrangements – All DVC and Medical Card Patients

Panel Size	1-500	501-1000	1001-1500	1501 +
Cap on assignments-patients per GP	6	10	13	15

PCRS will operate the patient assignment process with consultation, as appropriate, with local offices. The GP should be contacted prior to any assignment by PCRS.

In addition to the foregoing a joint HSE/IMO working group will be established to review the operation of the patient assignment protocol with a view to ensuring that it is framed and operating in a fair, equitable, patient and GP centred manner and that due regard is being had to health and safety considerations relating to GP practice teams in terms of how it is being operationalised.

9.3. Panel Sizes

The current Limitation on panel numbers is defined in Paragraph 7 of the GMS Contract and Paragraph 6 of the Under 6 Contract. Under this Agreement the number of persons whose names may be placed on a General Practitioner's GMS List will remain at 2,200. In exceptional circumstances where the additional patients under this agreement bring the GPs list over 2,200, this will be considered on a GP by GP basis.

10. Maintaining GMS GP Services in Isolated Rural and Urban Disadvantaged Communities:

10.1. Introduction

While the number of GMS vacancies is relatively low, there are a number of long standing vacancies within rural and urban disadvantaged areas which have proven challenging to fill. There are currently 10 such vacancies which are in place for 12 months or more. Many of these practices are single-handed, rural practices with small panel sizes with limited potential for private income, limited support staff, absence of formalised GP Out of Hours Co-Op arrangements, limited investment in computerisation and practice premises or where same is available to potential successors they would require significant upgrading.

10.2. Addressing the current challenges in filling vacancies in rural and urban deprived areas:

The key aim of this feature of the Agreement is to address the challenges in filling long term vacancies - 10 of which have been vacant for 1 year, 3 of which are now vacant from 6 to 11 months and have therefore potential to be longer term, making a total of 13 Vacancies. 5 of the 13 vacancies are eligible for the Rural Practice Support Framework.

10.3. Pilot Initiative on Hard to Fill GMS Vacancies

The following package of targeted solutions to maintaining GP services in isolated rural and urban disadvantaged communities will be available for application, as appropriate, to the practices in the pilot Initiative.

10.3.1. Affiliation/partnering of qualifying GMS practices, where a vacancy has arisen due to retirement /resignation/death of the outgoing single-handed GP with a larger practice involving two or more GMS GPs within the nearest population centre will be supported by the HSE. The population centre must be located not more than 30 kms from the former practice premises of the now vacant qualifying GMS practice, save in exceptional circumstances where the HSE, in the exercise of its discretion and following consultation with the IMO, determines that a greater distance is permissible.

The vacancy must have either:

- been advertised on at least two occasions without success , or;
- in certain circumstances where HSE considers it appropriate, following consultation with the IMO, immediately on the creation of the vacancy.

Under such an arrangement the GMS GPs in the larger practice would subsume the vacant GMS panel into their practice. A nominated GMS GP in the practice would be assigned the vacant panel on an interim basis pending the appointment of an additional GMS GP in to the practice. On the commencement of the GMS contract with the new GMS GP in the practice the vacant GMS panel will transfer to the new GMS GP. GP capacity would be augmented by the creation of a GMS panel either by the "Open Entry" route or via the Assistant with a View to Partnership route within a specified time period (e.g. six months). The vacant GMS panel will remain frozen during this interim period and for a period of 3 months following the commencement date of the GMS contract with the new GMS GP.

Where the new GMS GP is joining the GMS via the "Open Entry" route and where an existing partnership agreement exists it will be updated to include the accession of the new GMS GP into the partnership. Where a partnership agreement does not exist the GPs in the practice, including the new GMS GP, will enter in to a formal partnership agreement. In either scenario a copy of the revised or newly created Partnership will be lodged with the HSE. On the commencement of the GMS contract with the new GMS GP in the practice the vacant GMS panel will transfer to the new GMS GP.

Where the new GMS GP is joining the GMS via the Assistant with a View to Partnership route and a partnership agreement already exists among the existing GMS GPs in the practice, it will be updated to include the accession of the new GMS GP to the partnership when the new GP obtains a GMS contract in his/her own right. Where a partnership agreement does not exist the GPs in the practice, including the new GMS GP, will enter in to a formal partnership agreement. In either scenario a copy of the revised or newly created Partnership will be lodged with the HSE. When the new GP in the practice obtains a GMS contract in his/her own right the vacant panel will transfer to him/her.

The practice post affiliation/partnering must maintain services to and in the practice area of the qualifying GMS practice with hours of scheduled availability in the area agreed in advance with the HSE and same cannot be altered without the prior approval of the HSE.

10.3.2. Affiliation/partnering of a qualifying GMS single-handed GP with a larger practice within the nearest population centre within 5 years of retirement of the GMS GP in the qualifying GMS single-handed practice.

Under such an arrangement the single-handed GP would form an affiliation/partnership with the larger practice which would effectively result in the qualifying GMS single handed practice being subsumed in to the larger GMS practice. The larger practice must be located not more than 25kms from the practice premises of the qualifying GMS practice, save in exceptional circumstances where the HSE, in the exercise of its discretion and following consultation with the IMO, determines that a greater distance is permissible. The practice post affiliation/partnering must maintain services to and in the practice area of the qualifying practice with hours of

scheduled availability in the area agreed in advance with the HSE and same cannot be altered without the prior approval of the HSE.

When the GMS panel of the qualifying GMS practice that has been affiliated with the larger GMS practice becomes vacant the succession arrangements will be in accordance with those as set out at 10.3.1 above.

10.4. Financial Support Measures for the Affiliated/Partnered Practices

The following supports will apply where a qualifying GMS practice is affiliated/partnered with a larger GMS practice in the nearest population centre in accordance with the provisions set out at 9.3.1 and 9.3.2 above;

- Retention of Rural Practice Support Framework, where it currently applies – 5 vacancies at present have RPSF applied
- Additional Top up Allowance of €5,000 p.a. for a three year period (to augment existing RPSF/RPA where applicable or as an additional allowance in the case where RPSF/RPA is not applicable)
- Once-Off Practice enhancement Grant of €5,000 for practice with which the qualifying GMS practice is affiliating with.
- Maximum Practice Support Subsidies and Locum Expenses Contribution and Maximum Medical Indemnity Refund will apply to the smaller affiliating GMS panel holder. This will also apply where the qualifying GMS panel does not qualify for the RPSF.
- Entitlement for the GMS GPs post affiliation with the qualifying GMS panel to pool their surplus GMS numbers for the purposes of maximising practice support subsidies will apply
- the new GMS GP will also be entitled to an enhanced payment that is equivalent to 50% of the former DMO Salary, in addition to their capitation until the GMS panel reaches 1,200 (to take account of the requirement to engage an additional GP in the practice). The enhanced payment will cease at the end of the Calendar year in which the GMS panel first reaches 1,200 provided that it has remained at or above this number as at 1st December of the year in question.

The above provisions to be introduced on a trial basis initially, as part of a pilot scheme confined to a maximum of 13 qualifying GMS practices.

10.5. Supports for GMS GP Practices in Rural Communities in Sourcing Locum Cover

Among the many challenges being faced by GMS GPs in rural Communities is the issue of obtaining locum cover for approved leave periods. Not only is this issue impacting on the quality of working life of GMS GPs in these communities but it is also an impediment to attracting GPs to apply for GMS vacant panels in these communities when such vacancies arise.

While the number of GMS vacancies overall is relatively low, there are a number of long standing vacancies within rural communities which have proven challenging to fill with many of them being in place for 12 months or more. Many of these rural practices are single-handed, with small panel sizes and limited potential for private income, limited support staff. Some of these practices experience difficulties in accessing formalised GP Out of Hours Co-Op arrangements, limited investment in computerisation and practice premises or where same is available to potential successors they would require significant upgrading.

10.6. Addressing the current challenges for Rural based practices in sourcing locum cover:

The key aim of this feature of the Agreement is to address the challenges being experienced by GMS GPs with practices located in rural communities in sourcing locum cover for approved leave periods. In this regard the HSE will collaborate with the IMO and other relevant stakeholders in implementing a pilot initiative aimed at supporting GPS who are in receipt of the Rural Practice Support Framework to source locum cover for approved leave periods.

10.7. Fund for Pilot Initiatives

Under this Agreement a ring-fenced fund of €0.600m is being made available to support the delivery of the above initiatives.

12th July 2023

Signed by a duly authorised representative of the Department of Health **Date**

12th July 2023

Signed by a duly authorised representative of the Health Service Executive **Date**

12th July 2023

Signed by a duly authorised representative of the Irish Medical Organisation **Date**

Appendix 1- CDM Phase 3 Requirements

CDM Programme Enhancements – 8 Items

Description
Treatment Programme Annual Review: Add - How many ED attendances related to their chronic disease (not admitted) / Unscheduled Admissions within last 12 months – based on patient recall
Treatment Programme Annual Review: Add – How many COPD / Asthma exacerbations requiring treatment or antibiotics or steroids within last 12 months – based on patient recall
Inclusion of Hypertension Stage 1 in the CDM Prevention Programme
Inclusion of Gestational Diabetes & pre-eclampsia in the CDM Prevention Programme
Inclusion of HAA Cardholders as eligible for registration
Care Plan to be streamlined / updated
Addition of a Data Field to retire a patient from the CDM Programme with associated message to the CDR to update patient records. To include a transfer to nursing home/opt out or death of the patient.
Diabetic patients only - Insert-[Is the patient registered in the RetinaScreen? Yes/no]

Streamlining / Consolidation of Current CDM Software – 17 items

Description
Non HDL Cholesterol – auto calculate from the software
Add Hyperlink to relevant CD Clinical Guidelines to the ICGP Landing Page & insert the hyperlink at the top of each review.
Amend the HBA1C Data Field to ensure the value captured from the Lab result is the mmol/mol value as opposed to % value.
In the “Outcome from OCF Review” Data Field in the existing OCF Dataset – add Asthma and COPD to the drop down list of Conditions “Diagnosed with a Chronic Disease – Register on Treatment Programme”
Removal of BNP Data Field from existing CDM Programme Datasets and retaining current NTproBNP data field
Remove the foot check for diabetic at an interim review
Implementation of current IHI field included in CDM Datasets
Change the FBC to a non-mandatory field for Asthma
Addition of “New Diagnosis” prompt field at the beginning of each CDM Treatment Programme Review
Remove ECG date – change to [Has there been an ECG since the last review? yes/no]
Remove ECHO date - change to [Has there been an echo since the last review? Yes/no]
Remove Spirometry date- to be [Has there been a Spirometry since the last review? Yes/no]
Information button on diagnostic criteria for Pre Diabetes
Raised LDL Cholesterol-Ensure that the [Not available] option is available across all the GP Vendor systems.
Pneumococcal vaccine not auto populating at present
CHADSVasc score should save after first visit – currently have to enter details every time
Autopopulation of baseline details in system from CDM for height, weight, BMI, Blood Pressure – working for some fields. From baseline details into CDM is working for height weight BMI but not for BP From CDM into baseline details not working for any system.

Additional CDM Software Functionality – 5 Items

Description
Add functionality to enable the CDM notes to be converted to PDF and to enable the export of CDM data.
Development of the Web checker to facilitate Patient Movement between GP’s in order to maintain patients on the correct care pathway on the CDM Treatment Programme
Develop a patient recall functionality across all the GP vendor systems to identify a patient is enrolled in the CDM Programme.
Develop a finder type functionality to search for a set list of codes for patients who are not already on the CDM Programme
Develop functionality to enable a GP to amend patient enrolment errors.

Appendix 2: General Practice Assistant – Outline Role Description

The role of General Practice Assistant is to be created within General Practice and the new Practice Grant for Additional Capacity described at Sub-Section 5.4 of this Agreement may be used towards employment of such a role. The purpose of the role is to carry out certain basic tasks which would improve patient experience, patient flow through the practice, practice efficiency and free up nurse and doctor time for more clinical tasks.

A non-exhaustive list of the duties and responsibilities that such a role could undertake is set out hereunder. Each practice will have its own requirements but at all times General Practice Assistants will have the necessary training and indemnity for the tasks they are required to do.

Duties and Responsibilities:

- observing, monitoring and recording patients' conditions by taking temperatures, pulse, respirations and weight
- communication with patients, relatives and carers
- assisting with clinical duties
- personal care including infection prevention and control, patient communication and overall reassurance, comfort and safety
- promoting positive mental/physical/nutritional health with patients
- checking and ordering supplies/restocking consultation rooms
- covering administrative duties
- taking urine samples
- sterilising equipment

Appendix 3: Terms of Reference of Strategic Review of General Practitioner Services

Introduction

The Government has previously set out its intention to undertake a strategic review of the contractual framework for GP services in the context of implementing Sláintecare. The 2019 Agreement on Contractual Reform and Service Development between the Department of Health, the HSE and the IMO includes the following commitment:

> *The Government intends in the context of Sláintecare, to undertake a fundamental review of the contractual framework for GP services so as to develop and put in place arrangements which will ensure a sustainable GP service as a core element of Primary Care, focused on facilitating integrated provision of care in the most appropriate settings.*

Approach

The Department of Health, with the support of the HSE, will undertake this review and will engage with key stakeholders to identify the challenges facing general practice in ensuring the delivery of a sustainable general practice service within the community and to identify the measures necessary to address those challenges in the context of delivering on the principles of Sláintecare. The review work will be led by a Department of Health Review Project Group supported as necessary by external expertise. Its programme of work will be supported by a Review Steering Group supported by and with input from external GP expertise. To support the review process the HSE GP Oversight group co-chaired by the Chief Operations Officer and Chief Clinical Officer will be the mechanism for the coordinated agreed input from the HSE to enable referral of issues from and input to the process. Responsibility for the output report and its submission to the Minister rests with the Department of Health.

Terms of Reference

A. Department of Health Review Project Group

1) Agree and progress a structured programme of ongoing consultative engagements between the Review Project Group and/or the Department and the HSE with key sectoral stakeholders to:
    a. further explore and define the issues, listen to stakeholder views and identify potential approaches to respond to the issues;
    b. gather information, evidence and data as required from stakeholders to inform the work of the Group;
2) Direct the collection and analysis of required data and information, including demand and capacity projections;
3) Prepare thematic discussion papers to support the work of the group as appropriate;
4) Use available evidence to inform the review and in particular examine the following:

GP Training

    a. Ensure an adequate supply of general practitioners to meet the changing needs of the population, and identify measures to address retention of GP graduates at every stage of their career;

GP Capacity

b. Expand the GP team to ensure efficient and effective service delivery with all members of the team working as closely to the top of their licence as possible, with particular focus on: the role of GP nursing; administrative support for practices; and consideration of the value of the development of other potential roles that would improve service delivery while taking account of the development of wider community services through the Enhanced Community Care Programme;

c. Ensure service provision within the community, focussing in particular in areas where service delivery is challenging – this will include consideration of the possible role of HSE-employed GPs and other mechanisms to attract GPs to rural and urban deprived areas;

d. Maximise available and future GP capacity, including panel sizes;

e. Provide for practice establishment and succession planning;

f. Integrate and interface with wider health services including the Enhanced Community Care Programme;

eHealth Agenda

g. Identify the requirements, including supports to provide necessary infrastructure and IT and consideration of potential approaches of existing and future practices to provide a sustainable GP service in the community;

Out of Hours Reform

h. Identify the requirements necessary to reform of Out of Hours GP services to ensure delivery of an accessible, high quality Out of Hours GP service throughout the country;

Support model

i. Consider the scope of service to be provided to patients on a universal basis;

j. Develop the support model necessary to underpin the provision of sustainable GP services in the Sláintecare vision; and

k. Examine the tax treatment of practices and identify barriers and potential enablers to support enhancement of capacity.

5) Prepare recommendations as appropriate and associated indicative costings;

6) Within 6 months, develop a report for the consideration of the Minister for Health providing:

a. An outline of the key findings on a thematic basis;
b. Recommended actions to respond to the identified findings, as appropriate, including indicative costs and a proposed response plan.

B. Strategic Review Steering Group

The Review and the Review Project Group will be supported by a Review Steering Group which will include the Department, the HSE and GP expertise, which will:

1) provide direction, guidance and support to the Project Group in examining these issues;
2) agree the broad programme of work proposed by the Project Group;
3) review and provide input, including expert advice, into discussion papers and other outputs prepared by the Review Group;
4) facilitate national and/or international expert input to inform the work of the Group;
5) support the referral of issues to and/or input from the HSE GP Review Oversight Group;
6) advise, assist and provide input to the Department Review and recommendations prior to its finalisation by the Department;

Engagement

The review process will undertake a structured programme of engagements with key sectoral stakeholders in line with their respective roles and responsibilities. The Review Project Group may also request written submissions on specific themes, as relevant, from stakeholders.

Output

A Department of Health report of the findings of the strategic review will be developed for submission to the Minister within 6 months, providing:

a. An outline of the key findings on a thematic basis; and

b. Recommended actions to respond to the identified findings, as appropriate, including indicative costs and a proposed response plan.