Department of Health

Gateway Ref: 11615

To: SHA Directors of Commissioning
SHA Primary Care Leads

Copy: SHA Directors of Finance

03 April 2009

Dear Colleague

FAIRER FUNDING OF GP SERVICES

1. Following the announcement of the Government's acceptance of the DDRB recommendations on the average uplift to General Medical Services (GMS) contract values for 2009/10, I am writing to:

    a. Confirm the estimated distributional impact at PCT level of the GMS contract changes agreed last year with the BMA

    b. Set out advice on the implications for practices with Personal Medical Services (PMS) contracts

    c. Outline how the Department will be uplifting the values for each Directed Enhanced Service (DES) and the issues that PCTs will wish to take into account in considering whether to uprate prices of Local Enhanced Services (LES) and payments made under National Enhanced Services (NES).

Background

2. As set out in my letter of 14th October 2008 (Gateway reference: 10704), the agreement reached with the General Practitioners Committee (GPC) of the BMA for 2009/10 is designed to start the move towards a more equitable system of funding of core services provided by practices. This will begin to reduce reliance on Minimum Practice Income Guarantee (MPIG) payments and phase in changes to the prevalence adjustment for Quality and Outcomes Framework (QOF) payments to reflect recorded prevalence of long term conditions.

3. DDRB has recommended, as set out in its 38th Report, that gross GMS contract payments be increased by an average of 2.29% in order to allow an average increase in GMS practitioners' net income of 1.5% after allowing for movement in their expenses. The Government has accepted all the DDRB's recommendations.

4. Under the formula agreed with the GPC, this 2.29% increase will be differentially applied as follows:

a. Every GMS practice will receive a national minimum uplift of 0.70% to their Global Sum Equivalent (i.e. global sum payments including protected income levels under MPIG).

b. In order to reduce reliance on MPIG, the formula gives a proportionately higher increase in underlying global sum payments (i.e. the price per weighted patient before any correction factor payment is applied to achieve a practice's protected income levels). In so far as this exceeds the minimum 0.7% uplift, this leads to a corresponding reduction in correction factor payments. These savings are then reinvested into the global sum, which releases further resources from correction factor payments (and so on and so forth). The cumulative effect of these changes is that the price per weighted patient, used in the Global Sum calculation, will increase from £56.20 in 2008-09 to £63.21 in 2009-10 (an increase of around 12.5%)

c. The value of Quality & Outcome Framework points will increase by 1.74% from £124.60 in 2008-09 to £126.77 in 2009-10.

d. There will be an increase of 1.74% in Enhanced Services payments (see paragraph 18).

5. Fuller details on the differential investment formula were set out in my letter of 14th October. If you have further questions on what I appreciate is a complicated issue, your local NHS Primary Care Contracting advisor should be available to assist. Their contact details can be found on the following website:

http://www.pcc.nhs.uk/contacts

Distributional impact at PCT level

6. The effect of these changes is to redistribute resources more equitably between GMS practices to reflect relative needs using the agreed Carr-Hill weighted capitation formula. The changes to the QOF prevalence formula have a further effect in distributing QOF payments more equitably. The combined distributional effect is such that the aggregate impact also varies between PCT areas. PCTs will already have been able to estimate this impact by aggregating the results from the practice-level ready reckoner which was published on the NHS Primary Care Contracting website in December 2008, and is available at the following link:

http://www.pcc.nhs.uk/news/757

7. To help SHAs and PCTs cross-check the results obtained from the practice-level ready reckoner, we have compiled the attached spreadsheet, which sets out for your SHA the estimated impact of changes in Global Sum and QOF payments, taking into account the 2.29% overall gross uplift in GMS contract payments.

8. The spreadsheet shows the overall estimated pressure or saving at PCT level compared with what expenditure would have been incurred on MPIG and QOF in the absence of any redistribution, i.e. if there had been a 2.29% across-the-board

increase in global sum, correction factor payments and QOF payments. The analysis shows those PCTs (excluding the two PCTs that have no GMS practices) that need to increase investment by less than 2.29% and those that will need to increase investment by more than 2.29% (all other factors being equal).

9. The spreadsheet also shows these pressures or savings in the context of PCTs' overall allocations growth for 2009/10, which includes a minimum growth floor of 5.2 per cent. The analysis shows that, where there is a pressure, this is in most cases less than 1% of the overall increase in the PCT's allocation. There are 21 PCTs where the pressure is between 1.0% and 1.9% of the overall increase in the PCT's allocation and 9 where the increased pressure is above 2.0%.

Implications for PMS practices

10. As set out in my letter of 14 October, whilst the agreement applies to GMS contracts, we are committed to ensuring an equitable approach for PMS and other local Primary Medical Care contracts. While the PMS and APMS contracting arrangements provide PCTs with flexibility in commissioning services, PCTs need to be able to demonstrate that funding decisions between all primary medical care contractors are fair and equitable and represent value for money.

11. Given the differential effect of the DDRB award on GMS practices, as described above, PCTs will wish to consider the implications for PMS practices on a case-by-case basis, with specific reference to the contractual agreement the PCT has with that practice.

12. Most PMS practices have baseline funding that is based on historic GMS income. This closely mirrors the effect of the Minimum Practice Income Guarantee in GMS. (It is these historic incomes on which Global Sum Equivalents and hence correction factor payments were derived for GMS practices.) In addition to this baseline funding, PMS practices often receive 'PMS growth' funding.

13. For these reasons, we would expect that applying the DDRB recommendation to PMS practices (in an equitable way to that applied to GMS practices) may result in PMS practices more typically receiving a percentage uplift to their core funding that is comparable to the minimum uplift for GMS practices, as opposed to the higher uplifts for GMS practices with no MPIG or low levels of MPIG.

14. In looking at this, PCTs may find it helpful to compare the funding that a PMS practice receives for delivering the equivalent of GMS essential and additional services with the equivalent GMS Global Sum funding (ie the number of registered patients adjusted by the Carr-Hill formula). If the practice's income at 1st April 2009 (for these essential and additional services) is more than £63.21 per patient (after adjusting by the Carr-Hill formula), it is receiving more income than it would do under the Global Sum formula in GMS – and (if it were a GMS practice) would receive no more than a 0.7% increase in core contract payments under the DDRB's recommendation (see paragraph 4a above).

15. We anticipate that increases in payments in respect of QOF achievement and delivery of enhanced services are likely to mirror GMS arrangements.

Implications for Local Enhanced Services (LESs) and National Enhanced Services (NESs)

16. As set out in paragraph 4d above, the effect of the differential investment formula will be to increase the value of Enhanced Services payments by 1.74%.

17. There are three types of Enhanced Services:

    a. Directed Enhanced Services (DESs), where the prices paid and what will be delivered are agreed nationally;

    b. Local Enhanced Services (LESs), which are locally developed services commissioned by PCTs to meet local health needs, and;

    c. National Enhanced Services (NESs), which are services which PCTs commission to national specifications and benchmark pricing to meet local needs.

18. The Department of Health will increase DES payments in the Statement of Financial Entitlements by 1.74%. It is for PCTs to consider the implications of the DDRB recommendations for the LESs they commission and payments made under NESs which they administer locally on a case by case basis. In principle, we would expect PCTs to honour the spirit of the negotiated agreement and, other things being equal, increase contract prices in line with the 1.74% increase for DESs. However, PCTs are responsible for ensuring value for money from the services they commission and will need to consider with local practices the pricing of individual commissioned services.

Conclusion

19. You may wish to share this letter with PCTs in your area, so that they can begin to take forward discussions with PMS practices and practices contracted to deliver Local Enhanced Services and/or National Enhanced Services.

BEN DYSON
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Commissioning and System Management Directorate