NHS England

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National Support Centre
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Quarry Hill
Leeds LS2 7UE

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To:

Area Directors

Cc:

Area Team Directors of Commissioning
Area Team Directors of Finance

Regional Directors
Regional Directors of Commissioning

Dear Colleagues,

Reviews of Personal Medical Services (PMS) contracts

As you know during 2013/14 we advised area teams of a moratorium on initiating any new reviews on PMS contracts. This was put in place while we undertook work with area teams to identify the national arrangements NHS England will apply to ensure the most effective use of PMS resources from 2014/15. This letter provides our conclusions to that review.

In summary, the conclusions of the review are that area teams should:

- begin a programme from April 2014 to review all local PMS contracts (unless they have already been subject to a review that meets the criteria below) and complete this review process by March 2016 at the latest;

- seek to secure best value from future investment of the ‘premium’ element of PMS funding by ensuring available resources for investment are deployed in line with the criteria set out in the annex to this letter. In short these criteria are that any additional investment in general practice services that goes beyond core national requirements (whether this is deployed through PMS or through other routes) should:

    - reflect joint AT/CCG strategic plans for primary care;
    - secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises;
    - help reduce health inequalities;
    - give equality of opportunity to all GP practices;
    - support fairer distribution of funding at a locality level.

- where funding is to be redeployed, decide on an appropriate pace of change that takes into account the impact on services to patients and the individual practices affected.

This approach has been determined following the national data collection exercise NHS Employers ran on our behalf with area teams to help understand PMS contract expenditure and identify its component parts. With the data produced, and following discussion with stakeholders, we have reviewed how area teams can best invest in quality improvement and innovation in primary care.

PMS ‘premium’ funding

The data collection exercise identified that the premium element of PMS expenditure nationally is £325 million. That is the value of how far PMS expenditure exceeds the equivalent items of GMS expenditure. This means that NHS England pays, on average, a premium of £13.52 for patients registered with PMS practices. The premium will reduce to around £235 million over the seven years to 2021/22, as the GMS Minimum Practice Income Guarantee (MPIG) is gradually phased out. This reduces the average premium per registered PMS patient to £9.80.

Of the £325 million, around £67 million was identified as linked to defined enhanced services or key performance indicators (KPIs). The remaining £258 million may be associated with enhanced services or populations with specific needs, but it has not been notified as such. Analysis of the data revealed there is no obvious relationship between current PMS expenditure and deprivation.

Our national level findings and analysis are provided in the accompanying presentation (see: http://www.england.nhs.uk/wp-content/uploads/2014/02/rev-pms-cont.pdf). The data identifying premium expenditure for individual PMS practices as at 1 April 2013 has been returned to area team Directors of Finance to support local plans for progressing reviews of PMS contracts.

Area teams will need to re-assess premium values once the implications of GMS implementation and mirroring in PMS are confirmed. This would include, for instance, the impact of QOF and seniority resources being recycled into global sum etc. Area teams should not therefore rely on the indicative global sum figures provided as part of the guidance for phasing out of the Minimum Practice Income Guarantee. We will provide an update to these following decisions on implementation of 2014/15 contract changes and uplift following recommendations from the Doctors and Dentists Pay Review Body in February 2014.

Principles on use of premium element of PMS funding

One of the purposes of this national review was for NHS England to consider how to apply the principles of equitable funding to PMS resources.

One of the options we considered was to move a portion of PMS resources into increasing ‘core’ funding, in other words, increasing the standard capitation price

that will apply to all GMS and PMS contracts. However, between a third and a quarter of current premium PMS funding will become part of core funding in any case, simply by virtue of MPIG erosion. It would, therefore, leave NHS England with very little funding to support quality improvement and local innovation in primary care if we were to move any further premium funding into core funding. This would significantly reduce the ability of area teams to support the transformation of primary care locally, in line with the original objectives of PMS contracts.

It is essential, however, that we apply the principles of equitable funding by moving towards a position where we can demonstrate that all practices (whether on GMS, PMS or APMS) receive the same core funding for providing the core services expected of all GP practice. Any additional funding above this must be clearly linked to enhanced quality or services or the specific needs of a local population, and practices should have an equal opportunity to earn premium funding if they meet the necessary criteria. These principles are reflected in the criteria in the annex that we have agreed area teams will apply when deciding how to use these resources.

Next steps and support

Given the operational implications, we have concluded that area teams should have up to two years, starting from 1 April 2014, to complete the process of reviewing PMS contracts. While it is essential that NHS England conducts these reviews in a reasonable manner, the pace and sequencing of these may be determined by area teams providing the approach decided on can be reasonably justified.

As part of the review process, area teams will need to make decisions both on how far to redeploy any premium funding and on the pace at which redeployment takes place. We have concluded that area teams should make local judgements on the appropriate pace of change for redeploying funding, balancing the need to ensure that funding is used more productively, equitably and transparently and the need to provide a manageable pace of change for the individual practices involved.

Area teams may find the attached FAQs helpful in informing their approach to sequencing local reviews and deciding on pace of change. Key messages for what this will mean in practice for GP practices are also attached and you may wish to communicate these locally. We strongly support area teams engaging with local medical committees to discuss and ideally agree on plans for the local review process.

Critical to embarking on the review process for both area teams and PMS practices will be to ensure up to date and properly recorded contract documentation is in place. To support this, standard variation notices will be made available to area teams for use with all PMS contracts to ensure compliance from 1 April 2014 with the mandatory requirements of the PMS Regulations. We expect these to be available on the NHS England website by the end of March 2014. This will ensure there is a firm foundation for area teams and PMS practices to begin contract reviews. We are also introducing a standard

model PMS contract that area teams should work to adopt with all PMS providers by April 2016 as part of the review process.

We have appointed Capsticks to prepare all standard primary medical care contract documentation and to provide guidance to support the use of these and on the review process generally for PMS contracts. Capsticks will be providing a helpdesk service for area teams from April to support queries they may have. There will be an opportunity for area teams to discuss the support arrangements for PMS reviews, plans for introducing a standard model PMS contract, and any additional requirements they may have at the Area Team Heads of Primary Care meeting in May 2014.

We consider that PMS contracts offer real flexibility for area teams and GP practices, working alongside CCGs, to commission and contract for services in innovative ways that help reflect local needs and priorities. We hope that these reviews will provide a real opportunity to harness that flexibility.

Should you have any queries about this letter before the support arrangements are in place from Capsticks please contact:

England.primarycareops@nhs.net

Yours sincerely

ANN SUTTON
Director of Commissioning (Corporate)

BEN DYSON
Director of Commissioning Policy & Primary Care

NHS England

Annex

PMS Review Criteria

To ensure NHS England is able to secure best value from future investment of the premium element of PMS funding area teams are asked to ensure available resources for investment over above core funding for core services expected from all GP practices meets the following criteria:

a) **Reflect joint area team/CCG strategic plans for primary care.** The use of any premium funding over and above funding for core services should reflect strategic plans for primary care that have been developed jointly between area teams and CCGs and support a more integrated approach to delivering community-based services, including general practice. This could include collaborative commissioning arrangements between area teams and CCGs including pooling of funding.

b) **Secure services or outcomes that go beyond what is expected of core general practice or improving primary care premises.** There should be no premium funding that is not tangibly linked to providing a wider range of services, or providing services to higher quality standards or providing services for a population with specific needs that are not adequately captured by the Carr-Hill formula. Funding could also be used to support improving the quality of primary care premises, for example, to support delivery at scale.

c) **Help reduce health inequalities.** Premium funding should be used as far as possible to help reduce health inequalities. This may include, for example, providing funding for practices that provide services for populations with specific needs, e.g. homeless people.

d) **Give equality of opportunity to all GP practices.** In line with the principles of equitable funding, all GP practices should have the opportunity of earning premium funding if they are capable of meeting the required standards. The only exception to this is when the funding is being used to reflect a specific population served by a particular practice. For instance, if an area team defines a basket of services that practices have to provide – and KPIs that they have to meet – in order to earn this funding, the opportunity to provide these services should not be restricted to current PMS practices. Equally if premium funding is intended to improve the quality of primary care premises this should also not be restricted to current PMS practices.

e) **Support fairer distribution of funding at a locality level.** Premium funding should be used in a way that, where possible, supports fairer distribution of overall funding at a locality level. The publication by area teams of primary care funding at an illustrative locality level will give a clearer sense of the total resources for a local health community and support area teams and CCGs in moving towards a fairer allocation of those resources.

Frequently Asked Questions

Q. Where PMS contracts have already been reviewed do these need to be subject to further review?

A. Areas teams need to be satisfied that any premium expenditure in local PMS contracts satisfies the national criteria. If the criteria are judged to have been met by a former review then there is no need for area teams to conduct a further review.

Q. Is the expectation all PMS premium funding identified will continue to be invested in primary care?

A. Our new allocations formula for primary care services will, from 2014/15, start to share resources more equitably across the county, which will mean that some areas will have extra resources for investment, while others will need to make some savings – but the overall impact at national level will be to sustain current levels of investment.

Q. Do area teams need to review all PMS contracts at the same time?

A. Area teams have two years to complete the review of PMS contracts and have discretion in how they organise these.

Area teams will need to decide on an approach that allows them to manage their resources appropriately and ensure the rationale underpinning the approach is logical and practical.

In prioritising local reviews, area teams could take into account which contracts have the largest levels of premium funding per patient and/or which contracts have gone the longest period without review.

Q. Pace of change – is there a minimum or maximum pace of change?

A. Area teams will need to have completed local reviews within a two year period but are being asked to make local judgements on the appropriate pace of change for any redeployment of funding arising from these reviews.

This will mean balancing the need to ensure available resources are used more productively, equitably and transparently and the need to provide a manageable pace of change for the individual practice involved.

Area teams will ensure that there is a clear and objective rationale underpinning their judgements, which takes into account the impact on patient services and the impact on practice income and liabilities. :

Q. How will area teams ensure equality of opportunity for GP practices?

A. This will depend on the nature of the investment and the services that practices would need to provide or the quality requirements they would need to meet in order to qualify for funding. In some cases, practices may need to agree

to take up (or remain on) a PMS agreement. In other cases, area teams – or CCGs acting under delegated authority from NHS England – could offer an enhanced service to practices that are able to meet the relevant requirements. Where funding is pooled with CCGs, one or more CCGs could also commission services through the NHS standard contract, either from individual practices or from a provider consortium working across a number of practices.

Q. What is NHS England position on the use of termination notices?

A. PMS reviews should not be started under the threat of termination. The basis for issuing a termination must be rational and made on an individual contract basis. If an area team decides after due consideration and a proper review process that a contract does not represent value for money then it may be terminated. Such instances can give rise to further negotiation.

PMS REVIEW

KEY MESSAGES FOR GP PRACTICES

- NHS England is moving to a position where all GP practices, whether GMS, PMS or APMS contracted, can expect to receive the same core funding for providing the core services expected of all GP practices.

- Any additional funding NHS England chooses to invests over and above this core funding, for example through PMS contracts, will need to be clearly linked to enhanced quality or services or the specific needs of a particular population.

- We want to move to a position where there is equal opportunity for GP practices in a locality to earn this additional funding if they are able to satisfy the locally determined requirements.

- Core funding for GMS practices is increasing over the next seven years from April 2014. This is because Minimum Practice Income Guarantee payments to GMS practices are being reduced by one-seventh every year and the subsequent savings added in to core (global sum) funding.

- The indicative increase in GMS price per weighted patients is from £66.25 in 2013/14 to £78.33 in 2020/21. These figures are likely to change following implementation of 2014/15 GP contract changes and decisions on uplift following recommendations from the Doctors and Dentists Pay Review Body in February 2014. .

- For PMS practices, area teams will, where necessary, be reviewing local contracts to ensure additional investment paid over core funding (i.e. equivalent to GMS core funding) is used in a way that is clearly linked to enhanced quality or services or the specific needs of a particular population.

- NHS England area teams will complete these reviews over a two-year period starting in April 2014.

- Where the outcome of a local review is to redeploy funding from PMS practices, areas teams will decide on the appropriate pace of change for affected practices.

- GP practices can expect Local Medical Committees to be engaged in the review process locally by area teams.

- In reviewing local arrangements, area teams will also ensure PMS contracts meet the national legislative requirements and have terms and conditions that are properly recorded. To achieve this NHS England will be using a single set of standard PMS contract documentation.