BMA

England

Focus on PMS reviews and transition to GMS

April 2016



FOCUS ON PMS REVIEWS AND TRANSITION TO GMS

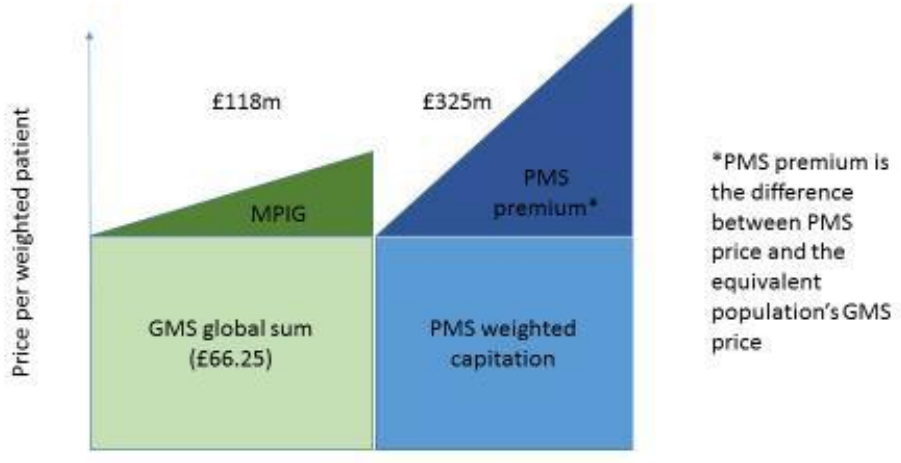
Background

As part of the 2013/14 contract imposition, the Government in England planned far-reaching changes to practice funding to reduce the wide variation in funding per patient between practices. Practices with above average levels of funding as a result of GMS correction factor payments are having their funding reduced over a seven year period starting from April 2014 and practices with historically high PMS payments will generally (though not where different arrangements were previously agreed by practices) have their funding reduced over four to seven years or will be recommissioned to provide defined enhanced services for the extra funding.

Following an NHS England national directive, NHS England teams (or CCGs if they have delegated responsibility) are currently reviewing local PMS agreements to bring PMS spending in line with GMS contracts. The initial intention was that these reviews were due to end in March 2016, after which PMS core practice income will gradually be brought in line with GMS practices, however in reality many have been completed and the outcomes are already being implemented in many parts of England, while in other areas they have yet to be finalised.

How the process works

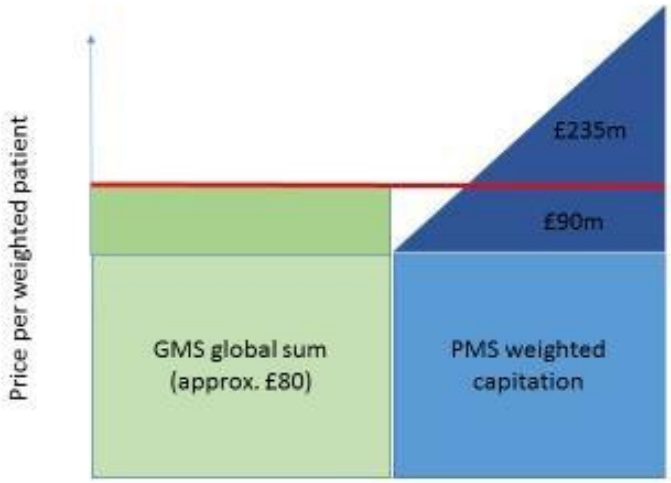
NHS England conducted a review of PMS contracts at individual practice level based on April 2013 data to determine how much PMS funding was paying for 'core' services and how much was paying for enhanced services or other services over and above core GMS. This was used to create a revised total baseline figure for PMS practices equivalent to core GMS funding.



April 2013 NHS England assessment of GMS and PMS funding

As the aim of the PMS reviews is to bring PMS per weighted patient income in line with that of GMS practices, PMS practices' target baseline core income per patient should be equivalent to the global sum in 2020/21 *including* redistributed correction factor payments. At the time, the published

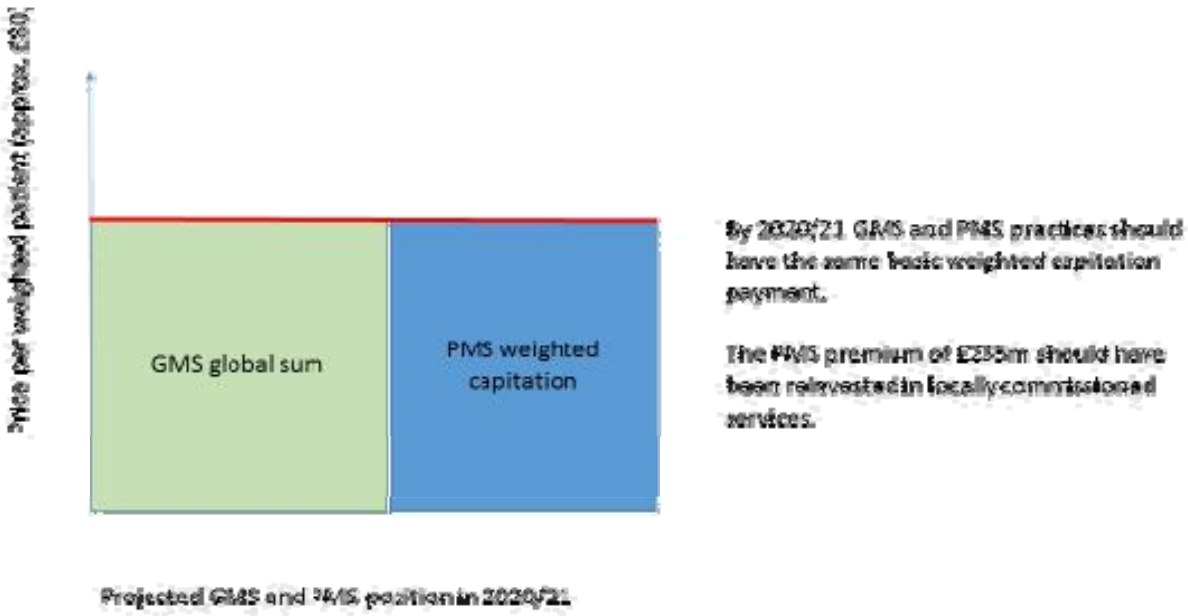
indicative GMS price per weighted patient was £78.33 in 2020/21, however uplifts to global sum since then, which apply equally to GMS and PMS practices, mean the anticipated figure for 2020/21 has now increased to £80 per weighted patient.



At the end of the MPIG redistribution in 2020/21 GMS global sum price will rise to around £80 per weighted patient. The higher GMS price means the PMS premium is reduced to £235m.

Projected GMS position in 2020/21, showing calculation of PMS premium

After budgeting for PMS practices reaching parity with GMS practices in 2020/21 (with £90 million set aside for increasing the weighted capitation sum in line with GMS correction factor reinvestment), NHS England identified £235 million of 'premium' PMS expenditure which will be removed from PMS contracts and reinvested by CCGs in local general practice services. Much of this money will be redistributed to both GMS and PMS practices within the CCG but some could be retained by individual practices as a result of local commissioning decisions. [NHS England identified £67 million of premium money that was already linked to defined enhanced services.]



Projected GMS and PMS position in 2020/21

PMS practices in the most unusual circumstances (e.g. those serving the homeless) may need to retain most or all of their current income. Many PMS practices will however inevitably lose a significant part of their current funding and there is a risk that some could be destabilised by the changes resulting in an unavoidable reduction in access or services to patients.

The GPC advises all PMS practices facing contract review to contact their LMC in the first instance. The LMC is best placed to advise practices on their options and ongoing negotiations with the CCG and NHS England regional team.

Ensuring reviews follow national guidelines

The national NHS England framework for PMS contracts reviews can be found here.

NHS England teams have been encouraged to engage with LMCs to discuss and ideally agree local PMS plans. The role of the LMC is absolutely vital in representing general practice, monitoring the use of freed up resources and negotiating on practices' behalf. In particular, LMCs should ensure that local PMS reviews are undertaken in line with the national principles contained in the guidance document, paying particular attention to the following features.

Unusual populations

NHS England teams should ensure that there is a case-by-case review of all affected practices to ensure that they are not serving special populations that merit continued additional funding. University practices and very rural practices for example, are likely to face particular challenges as they move towards weighted capitation based payments. While NHS England teams and CCGs have the ability to make appropriate local arrangements for these practices, the GPC is currently working

with NHS England at a national level to ensure that sustainable ways are found of supporting practices supporting unusual populations.

Pace of change

NHS England teams have some discretion on the pace of change for local PMS funding. Though the national guidance states that changes arising from local reviews should be managed at a pace that does not unduly destabilise practices, it also states that (without prejudice to agreements that have already been reached with practices, and unless there are compelling reasons otherwise) freed-up PMS resources should be redeployed over a minimum four year period (year one being 2014/15) in some areas, but in others this has yet to start. Several areas have negotiated a more gradual pace of change that is more in line with the seven year arrangement for the removal of correction factor payments from GMS practices.

Target income

Practices and LMCs must ensure that the target income per weighted patient for PMS practices is set using the most up to date projected global sum figure in 2020/21 *including redistributed correction factor payments.* The current global sum figure should not be used as a target. Remember, the target figure is indicative only and practices should expect it to be uplifted year on year in line with increases to GMS payments.

Reinvestment of PMS resource

Resources removed from PMS practices must be used to secure additional general practice services locally. Local practices – both PMS and GMS - should be given equality of opportunity to access this local investment. There is nevertheless scope for PMS practices which currently offer services to patients that go beyond what is expected of core general practice to secure continued investment in these services. This has the potential to retain valuable established patient services and to stabilise practice income.

The decision to recommission is one which will be taken locally by the CCG and/or the NHS England team depending on co-commissioning arrangements, which is expected to have regard to its strategic plans for primary care, reduction of health inequalities, fairer distribution of funding and local improvement and innovation in primary care. In some cases, PMS practices may be able to repackage existing services as services more widely available to the local population. Decisions on the local reinvestment of freed up resources should be made before funding for PMS practices is reduced. **Practices currently providing services which the CCG does not wish to recommission are not obliged to continue to provide those services to patients. Indeed in most cases it will be inevitable that provision of such services must cease in order to ensure the ongoing safe provision of core primary medical services, which must be the priority for the practice.**

As membership organisations, CCGs should be held to account by practices for the reinvestment of PMS resource including quantification and tracking of money removed and associated reinvestment. The move to co-commissioning in some CCGs may facilitate this process.

Patient consultation

The guidance states that where changes to services result in different services being available to patients, there is a need to engage with patients or their representative groups. PMS practices might want to pursue this avenue where they are concerned about harm to patient services. This might be supplemented by local political lobbying and highlighting the impact of any funding cuts using local press and other media where appropriate. GPC is aware of at least one legal challenge to the process on the grounds of lack of patient consultation.

The Framework also states that where changes to services are proposed which result in different services being available to patients, there is a need to engage with patients and/or patient representative groups, to ensure NHS England complies with its various duties to consider the impact of its decisions on patients.

GPs with concerns about the local review process should contact their LMC in the first instance. LMCs should inform the GPC where local reviews do not appear to follow NHS England guidelines.

Negotiating PMS reviews

As noted above, NHS England teams should ensure that there is a case-by-case review of all practices affected by the PMS changes. Practices can and should discuss any enhanced or 'non-core' services provided to patients with the LMC and NHS England team or CCG, with a view to securing recommissioning or creating new arrangements to support the needs of the local population.

In some cases, the review process is complicated by the practice and NHS England/CCG working from different contract documentation. PMS practices should try to find any original documentation to support these discussions. This might set out more clearly any additional services, access or quality the practice was originally commissioned to provide. The two parties then need to agree the documentation they are working from.

The current NHS England national template PMS agreement document can be found here. GPC has concerns about a number of provisions in it; legal advice suggests some go beyond those of the PMS Regulations. We would advise all practices to properly scrutinise their agreements, seek the advice of their LMC and if necessary take legal advice on them before signing. If practices are expected to sign such agreements, then they should seek to negotiate an appropriate premium. LMCs and practices should ensure they negotiate so that whatever they sign up to is recognised in contract prices which are higher than the global sum, even if no explicit additional services are contracted. It is these provisions and the fact the agreement can be unilaterally terminated (see below), which should attract the premium. Unless a practice is satisfied the funding offered reflects the additional burdens which this places on them they should reject it and opt to return to GMS instead.

Backdating

GPC is aware of practices being asked to sign the current agreement, which is dated July 2015, but backdated to April 2015. While it is open to practices to accept the proposed backdating of the new PMS agreements, our advice is not to do so and to resist unless the threat of termination is actually raised.

PMS agreements can ultimately be unilaterally terminated by the NHS England team, or CCG if they have taken on primary care contract management through a shift in co-commissioning responsibilities, with six months notice. This could happen where variations promoted by the national PMS review initiative cannot be agreed with practices.

PMS to GMS transition

As many PMS practices have their funding reduced over the next few years, the GPC strongly encourages consideration of a return to the nationally negotiated GMS contract. Many PMS practices have made this change since the review process began. The GMS contract offers greater stability and security than PMS agreements. It is not subject to local negotiation, which is likely to place obligations on practices over and above those required by the regulations; or to unilateral termination with six months notice without reason.

PMS contractors have a right to move to a GMS contract under the PMS Agreement Regulations (Part 6, regulation 19). The contractor must notify the NHS England team, or where appropriate the CCG, that it wants to enter into a GMS contract three months before the date on which it wants the GMS contract to take effect. The notice to the NHS England team must specify the date on which the contractor wants to terminate the PMS agreement, the names of the persons with whom the contractor wishes the NHS England team to enter into a GMS contract and to confirm that those persons meet the relevant conditions (as set out in regulations 4 and 5 of the GMS Contracts Regulations).

Under national arrangements, Minimum Practice Income Guarantee (MPIG) payments once

available to some GMS practices are being removed over a seven year period and reinvested in core global sum payments. 2016/17 is the third year of this process. This will increase the value of global sum funding and is likely, over time, to make a return to GMS a more attractive and viable option for some, if not most, PMS practices. This consideration may not apply to some practices with unusual populations, for whom PMS contracts may remain the best option.

NHS England and the GPC are unable to predict exactly how the global sum will increase in the next few years but, based on what is known at this point in time – i.e. in advance of contract negotiations for future years - payments per weighted patient will be approximately as below. This assumes no further reinvestment of QOF income and does not include any prediction of national uplifts to contract value or other potential contract changes, so is subject to change and indicative only.

15/16	16/17	17/18	18/19	19/20	20/21
£75.77* (forecast)	£76.88	£77.80	£78.72	£79.64	£80.42

*2015/16 forecast figure owing to calculation of seniority reinvestment in October.

This information, though imperfect, should help each PMS practices to consider its financial position against GMS income. Some practices may be willing to accept a small reduction in per patient funding in the short term in order to secure the relative stability and security of a GMS contract.

LMCs can advise PMS practices whether other local practices are considering or pursuing a transition to GMS. Some local areas have negotiated area wide agreements on PMS to GMS transition.

There is no automatic right for PMS contractors moving to a GMS contract to receive correction factor type payments (i.e. transitional funding along the lines of MPIG which would be subject to gradual year on year reduction in line with other practices' correction factor payments). It is the GPC's position that PMS practices should receive such payments upon moving to GMS and in some areas LMCs have successfully negotiated this. In some cases this has resulted in a seven year period of transitional premium funding in line with the seven year correction factor applied to GMS practices.

The LMC should be able to advise on the feasibility of this agreement being reached with the NHS England team or CCG.

Salaried staff contracts after transition to GMS

PMS practices are not obliged to offer the model salaried GP contract to employed GPs. GMS contractors are however contractually obliged, by the regulations, to offer employment to GPs on terms and conditions which are no less favourable than those contained in the model contract. It is our interpretation of the guidance that existing practice staff would not need to have their terms and conditions of employment changed if the practice contract changes to GMS. However, the BMA encourages all practices to employ GPs on terms and conditions no less favourable than the model. In the case of PMS practices moving to GMS contracts, this also reduces any risk of employees raising a grievance about differing terms and conditions of existing and incoming practice staff. Any new salaried GPs employed by the practice once it has transferred from PMS to GMS must be employed on the BMA model contract or terms no less favourable.

Adjusting to reduced funding

As noted above, PMS practices may be able to retain some or all of their existing funding through recommissioned service provision. Some practices will however be financially destabilised by the changes. In these cases the GPC would remind practices:

- that they are not obliged to continue to provide services which the CCG does not wish to recommission
- that there may be ways to manage workload and increase efficiency. See GPC guidance *Quality first: Managing workload to deliver safe patient care* (2015) for some ideas
- that some unusual populations will require special consideration and different commissioning arrangements.
- to discuss their circumstances with the LMC
- to raise any concerns about local process with the LMC, which if necessary will inform the GPC of particular problems
- before making any staff redundant, to approach the LMC and the BMA (members only) for advice and support. The LMC may be able to suggest ways to avoid redundancy, for example by offering services to a wider patient population through a network or other mechanism of working at scale.