18 December 2013

Area Team Reference No 00936

To: Area Team Directors of Commissioning

CC Area Team Directors
Area Team Directors of Finance
Area Team Heads of Primary Care
Regional Directors
Regional Finance Directors

Dear Colleague

GP contracts: phasing out of the Minimum Practice Income Guarantee (MPIG) from April 2014

We have had a number of enquiries from area teams, GP practices, MPs and other parties about the potential impact of the phasing out of MPIG on certain practices, particularly those in rural areas. This letter sets out how we envisage that area teams will want to work with, reassure and support those practices in their area that will be affected.

We are also asking area teams to tell us about any planned support they intend to offer to outlier practices.

Background

The Minimum Practice Income Guarantee (MPIG) is a top up payment to some General Medical Services (GMS) practices. It was introduced as part of the 2004 contract to smooth the transition to new funding arrangements.

NHS England considers that MPIG payments are inequitable because practices serving similar populations may be paid very different amounts of money per registered patient. The changes that will start to take effect from April 2014 mean that the funding for GP practices will be properly matched to the number of patients they serve and the health needs of

those patients. Funding will also continue to take into account the unavoidable costs of providing services in rural areas.

This is not an issue that specifically affects only rural practices, as both rural and non-rural practices receive MPIG payments.

As part of the GP contract settlement in 2013, the Department of Health decided to phase out MPIG top-up payments over a seven year period, starting in the coming financial year (i.e. 2014/15). NHS England supports this decision as it enables GP practices, together with their area teams, to plan for any changes to their funding.

This means that MPIG payments to practices will be reduced by one-seventh every year for the next seven years from 1 April 2014. (The Statement of Financial Entitlements, Section 3 Minimum Practice Income Guarantee, 3.34 onwards, refers).

The money released by doing this will be reinvested in the basic payments made to all GMS practices, which are based on numbers of patients and key determinants of practice workload, such as patient age, health needs and the unavoidable costs of rurality. This means that no money will be taken away from GP services overall and that we are committed to making sure patients have access to high-quality GP services wherever they live.

Overall impact for practices

The analysis we have undertaken combines the effect of the MPIG reduction with the effect of other changes to the GMS contract that will come into force in April 2014. These changes will mean reductions to QOF and seniority payments and a recycling of these funds into global sum payments. This is explained further in annex A. As a result, we estimate that the majority of practices will gain extra funding as a result of these changes, whilst the remainder will lose some funding.

We appreciate that this is a matter of concern for some practices and their patients and that is why we supported the Government's decision to take the next seven years to implement the change fully. Phasing the changes over this period will allow the minority of practices that lose funding to adjust gradually to the reduction in payments.

We have also been looking carefully at how area teams can support those practices most affected. If practices believe that they will have

problems as a result of these changes – either in the short or medium term - area teams will need to discuss those problems with the practices affected.

In a small number of cases where there are exceptional underlying factors (not captured by the Carr-Hill formula) that necessitate additional funding, we anticipate that area teams will need to agree different arrangements to ensure appropriate services for patients continue to be available. We have identified 98 practices nationally that will fall into this category**.**

We have analysed those 98 “outlier” practices which will lose the largest amount of funding per patient and details of these practices, along with information about the impact on the other practices in your area, will be sent to you shortly.

Of course, in considering the issues faced by ‘outlier’ practices, area teams will also take into account the following factors that we have discussed with the BMA’s General Practitioners Committee:

- the annual average net reduction in total income from 2014/15 to 2020/21; and
- the annual average net reduction in total income from 2014/15 to 2020/21 as a percentage of total income.

This information will also be included in the practice details to follow.

In each case, the change in net income should take into account not only the reduction in MPIG payments but the increase in the size of the global sum that will offset this reduction. Annex A sets out indicative global sum payments for 2014/15 to 2020/21.

However, the underlying issue to identify is whether there are some exceptional factors, not captured in the Carr-Hill formula, that mean the practice cannot reasonably be expected to provide services for patients within its adjusted funding. This could, for instance, be because it is providing services for an atypical population.

Options for area teams to consider

Some suggested approaches and options for handling these ‘outliers’ are set out below, but ultimately, decisions on how to address the issues will need to be taken by area teams, after a full assessment of all the local circumstances.

For practices with very small list sizes, the area team may wish to explore the following options with the practice:

- collaborating (e.g. through federation or networking) or merging with other nearby practices to provide a more cost-efficient service;

- identifying other ways in which the practice might potentially improve cost-efficiency, such as reviewing staffing structures; and,

- where appropriate, reviewing other commissioning and/or contracting options

Practices providing a range of services outside their core contracts

If a practice is providing a range of services outside its core contract, or is providing services for an atypical population (e.g. a homeless population), the area team might wish to consider:

- whether these are services that should be funded at least on a transitional basis as enhanced services, either directly by the area team or via the local Clinical Commissioning Group; and

- agreeing a new contract type (PMS or APMS) with the practice involved to fund some of these services through core contract, if there are special factors that warrant this approach.

Next steps

We would be grateful if area teams could indicate to Linda Reynolds (linda.reynolds4@nhs.net) by the end of January 2014, the nature of any support from within their existing budget, whether transitional or otherwise, that they intend to provide to “outlier” practices.

We will be sending information on all practices, including “outlier” practices on an individual basis to each area team, via their Regional Director of Finance for onward dissemination to the area team Director of Finance on 23 December**.** Please contact england.finance@nhs.net with any queries.

David Geddes

Head of Primary Care Commissioning

Annex A Indicative Global Sum Payments

Year	Price per weighted patient
2013/14	£66.25 (actual figure in the SFE this year)
2014/15	£72.74
2015/16	£73.69
2016/17	£74.63
2017/18	£75.57
2018/19	£76.50
2019/20	£77.42
2020/21	£78.33

These figures:

- are based on reinvesting one seventh of the value of the 2013/14 Minimum Practice Income Guarantee (MPIG) payments into Global Sum payments each year so that it is redistributed to all General Medical Services practices through the Global Sum funding formula;
- are based on the current formula for calculating Global Sum payments and are without prejudice to any possible future changes to that formula;
- are based on the current numbers of practices;
- are based on Exeter extracts as of October 2012 using data for 4,517 practices, of which 2,863 receive MPIG of some form, with monthly MPIG payment data pro-rated for the year;
- assume population growth based on national ONS estimates applied equally to all practice weighted list estimates; and

- QOF modelling for 2013/14 is based on achievement levels in 2012/13.
- 2012/13 indicators have been mapped to 2013/14 where possible, to model changes from 2013/14 to 2014/15
- There are some issues with this
    - On 48 indicators the timescales within the definition have changed (e.g. reducing from 15 to 12 months)
    - On 22 fractional indicators the thresholds have changed
    - There have been changes to the definition of 15 indicators
    - All of the above could have impacts upon achievement levels, meaning 2013/14 actual achievement is likely to be different to 2012/13
- In addition there are 18 new indicators in 2013/14 which cannot be mapped to achievement in 2012/13

    - For these indicators we have assumed 100 per cent achievement for all practices to give a maximum money released scenario
    - This also includes the new Rheumatoid Arthritis domain for which we have no prevalence data, therefore no prevalence adjustment has been applied to this domain
- 103 points from QOF have not been recycled into global sum, funding from these is being funnelled into Direct Enhanced Services.
- Therefore this modelling does not include funding from those points, either in the baseline or in the year on year QOF figure

- Seniority modelling has been done on a simple year on year reduction of 15 per cent per year for the first six years, then 10 per-cent for the final year to reduce to 0.
- Practice level seniority payments for 2012/13 have been estimated based on quarterly data extracted from Exeter
- In the model this figure has been frozen and annual payments calculated simply based on this figure reducing each year. This does not take into account GPs moving up the seniority scale or attrition rates. Further work will be done to model this and revised indicative global sum figures will be produced.