NHS England

Implementing the 2015/16 GP contract

Changes to Personal Medical Services and Alternative Provider Medical Services contracts

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Cross Reference	
Superseded Docs (if applicable)	
Action Required	Regions, clinical commissioning groups (CCGs) and contractors taking part should ensure they have read and understood the document.
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Document Status

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Implementing the 2015/16 GP contract

Changes to Personal Medical Services and Alternative Provider Medical Services contracts

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The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities."

Contents

1 Introduction

NHS England is committed to an equitable and consistent approach to funding the core services expected of all GP practices.

Following the changes agreed to the General Medical Services (GMS) contract for 2015/16, this document sets out the approach to the funding changes that NHS England will apply to Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts.

NHS England teams will update local PMS and APMS contracts as soon as possible, applying the funding changes identified with effect from 1 April 2015.

Clinical Commissioning Groups (CCGs) working under delegation agreement will also apply the changes to local PMS and APMS contracts in line with this guidance. For the avoidance of doubt this guidance represents guidance CCGs must comply with and implement under provisions of Part 1 of Schedule 2 (Delegated Functions) of the Delegation Agreement made between NHS England and the CCG.

The arrangements set out here are without prejudice to any potential changes to the premium element of PMS or APMS funding as a result of local reviews and renegotiations.

2 Delivering a common increase to core funding

2.1 Increases to GMS global sum

The GMS global sum price per weighted patient is increasing from 1 April 2015/16 due to the following factors[1]:

a. The phasing out of the Minimum Practice Income Guarantee (MPIG) and reinvestment of this funding into GMS global sum.

b. Changes to Enhanced Services (ES) and reinvestment of funding into GMS global sum.

c. Inflationary uplift of 1.16 per cent following the Government's decision to implement the recommendation of the Doctors and Dentists Review Body and also apply an appropriate expenses uplift.

The overall impact will be an increase in the GMS global sum price per weighted patient from £73.56 in 2014/15 to £75.77 from 1 April 2015.

Exceptionally, there will be a further increase in the GMS global sum price per weighted patient from 1 October 2015. This is to reflect changes to the seniority scheme and reinvestment of funding into GMS global sum. The annual reduction in GMS seniority payments will be applied and achieved via the combined effect of net attrition (due to retirement and closing entrants to the scheme, less the increase in payments due to progression up the scales) and a reduction to the seniority payment

[1] Subject to Directions amending the GMS Statement of Financial Entitlements.

scales (evenly across all increments). These sums will be simultaneously reinvested into global sum. The level of spend in 2014/15 will not be known until July 2015.

A ready reckoner has been developed which GMS practices can use as a rough guide to estimate the change in their funding as a result of the contractual changes in 2015/16. The ready reckoner is **indicative only** and does not constitute financial advice to practices. Nor does it reflect any national modelling for assessing practice-level impacts of contract changes.

2.2 Increase to PMS and APMS contracts

To deliver an equitable and consistent approach to uplifting PMS and APMS contracts commissioners (NHS England teams or CCGs under delegation agreement) will apply, for those GMS changes that also impact on these arrangements, increases that are equivalent to the value of the increases in the GMS price per weighted patient.

In summary, GP practices will receive increases in core funding as set out in the table below.

	GMS	PMS	APMS
	£/weighted patient	**£/weighted patient**	**£/weighted patient**
MPIG reinvestment	A [£0.55]	-	-
ES reinvestment	B [£0.41]	b [£0.41]	b [£0.41]
Inflation uplift	C [£1.25]	c [£1.25]	c [£1.25]
Total uplift	A+B+C [£2.21]	b+c [£1.66]	b+c [£1.66]

Commissioners will apply the tariff(s) identified in the table above to calculate the increases due to individual PMS and APMS practices.

To calculate the increase due will require the appropriate tariff(s) to be multiplied by the weighted list size of the practice (or raw list if the local contractual agreement requires). Typically this will be the list size at the beginning of the quarter prior to the commencement of financial year e.g. 1 January 2015 (unless the contractual agreement specifies otherwise.

MPIG reinvestment (A) is a redistribution of existing GMS funds. The resulting increase in GMS global sum price per weighted patient does not therefore need to be reflected in any increase to PMS baseline funding or equivalent funding to APMS practices.

ES reinvestment (B) includes the GMS weighted patient share of the Patient Participation Scheme (£20.0m) and the Alcohol Risk Reduction Scheme (£3.5m) that cease on 31 March 2015.

This reinvestment supports the workload associated with transfer of the scheme from optional enhanced services to core contractual responsibilities for all practices. As PMS and APMS practices will be subject to the same contractual requirements, the increase will also apply (using the tariff identified (b) in the table above). However, where the associated ES funding is already included in PMS and APMS practices' core funding (e.g. PMS baseline funding), then those elements of the uplift should not be applied.

Inflationary uplift (C) is GMS price increase per weighted patient resulting from the Government's decision to implement the Doctors and Dentists Review Body (DDRB) recommended uplift on pay, along with an appropriate uplift to expenses, leading to a contract uplift of 1.16 per cent. Commissioners will apply the equivalent uplift to PMS and APMS practices: tariff (c) in the table above.

Seniority reinvestment

As identified earlier there will be a further increase from 1 October 2015 to reinvest seniority payments into core funding. This will see an increase in GMS global sum based on weighted patient share once the quantum of funding being reinvested is identified.

As many PMS arrangements have separately identified levels of funding equivalent to GMS seniority payments, commissioners will apply an increase based on the PMS weighted patient share. Where PMS and APMS practices do have separately identified levels of funding for seniority payments these will also need to be reduced in accordance with the reductions applied to the GMS seniority scale from 1 October 2015. Guidance will follow in the summer.

2.3 Out of Hours (OOH) 'opt out' deduction

Under the 2015/16 GMS contract agreement, where MPIG, enhanced service and seniority funds are reinvested in GMS global sum, this will be done without any OOH deduction.

NHS England will achieve this by reducing the percentage value of the OOH deduction for opted-out GMS practices to a level that discounts the reinvestment of funding.

Again, exceptionally, there will need to be two adjustments applied to the GMS OOH deduction in 2015/16. The first, applying from 1 April 2015, will reduce the deduction to discount MPIG and enhance service reinvestment. The second adjustment will apply from 1 October 2015 to reduce the deduction to discount the seniority reinvestment.

OOH deduction to apply 1 April 2015

The OOH deduction reduces from 5.46 per cent in 2014/15 to 5.39 per cent for the period 1 April 2015 to 30 September 2015.

As the recycling of MPIG with no OOH deduction is a redistribution of existing GMS funds the resulting decrease in the OOH deduction does not need to be reflected in the equivalent OOH deduction made to PMS or APMS practices.

Where no OOH deduction is made in PMS or APMS contracts (i.e. OOH opt out never featured in the contract or was permanently removed) no further action is required. Where there is an agreed deduction, this should be consistent with the revised GMS OOH deduction.

The cash value of the PMS OOH deduction per weighted patient for 2015/16 is therefore £4.09. This is determined by applying the OOH deduction (not including adjustment for MPIG) to the GMS global sum price per weighted patient (5.434 per cent x £75.22, excluding the £0.55 MPIG reinvestment).

Commissioners will apply the OOH deduction of £4.09 per weighted patient to the weighted list size (unless contractual agreement provides for raw list size) of the PMS or APMS practice to calculate the value of the OOH opt out deduction. This will apply for the period 1 April 2015 to 30 September 2015.

OOH deduction to apply 1 October 2015

The OOH deduction to apply 1 October 2015 will be confirmed later in the summer once the quantum of funding being reinvested is known.

2.4 Other funding changes

The funding/payment changes below also apply in 2015/16 following changes to the GMS Statement of Financial Entitlements (SFE) and commissioners will need to replicate the terms set out in the SFE in PMS and APMS contracts as appropriate:

a. **Quality and Outcomes Framework** – the pound per point value increases from £156.92 to £160.15 to reflect population growth and relative changes in practice list size from 1 January 2014.

b. **Childhood immunisation (target payments)** – the value of the two-year old quarterly target payments reduce to £632.11 for achieving the 70% target and £1,896.82 for the 90% target due to changes in the Men C schedule meaning only administration of 1 dose is now required to count towards the calculation of achievement rather than 2 doses.

c. **Shingles (providers of the vaccination and immunisation additional service) -** payment entitlement (£7.64 per dose) for shingles immunisation for persons aged 70 is now extended to allow claims for catching up anyone in the financial year who was aged 70 years on or after 1st September 2013 but who has not yet received immunisation.

d. **Human Papilloma Virus (HPV) Booster and Meningitis C (MenC) Booster vaccination (providers of the vaccination and immunisation additional service) -**- two new payment entitlements (both at £7.64 per dose) are being introduced for vaccination of children who miss immunisation through the national school age programme and require a booster to complete immunisation.

e. **GP cover for maternity/paternity/adoption leave** - payment to reimburse for locum (and now in house GP) cover for maternity/paternity/adoption leave is now £1,113.74 for the first two weeks; and, £1,734.18 for weeks three to 20 (or the actual invoiced costs during that period – whichever is the lower). NHS England medical policies will set out the arrangements for administering claims.

Contract regulations also now allow all GP practices to register armed forces personal authorised by the Defence Medical Services for up to two years. Funding will be as any other registered patient during that period.

Commissioners should refer to the main implementation guidance for details on changes to enhanced services in 2015/16 and this can be found on the GP contract pages of the NHS England website.