New PMS Contract

**Purpose of paper**
This paper sets out the new PMS contract and the principles on which payments would be made under the new contract, including how the payment amounts have been calculated. It recommends to the Commissioning Board that PMS contract holders be offered revised terms and conditions as set out in the attached specification.

**Background**
A Best Value Review has been conducted of PMS contracts because it was apparent that there is a wide variation in payments made to PMS contract holders, with average costs per patient in PMS practices being above corresponding amounts in GMS practices. A review identified that there was no contractual requirements for PMS practices to deliver services in excess of GMS practices and furthermore, that there was no good reason for variations in funding between PMS practices. The chart below illustrates the variation for 2008/9. It should be noted that the above comparison takes account of items where there is expected variation between practices, such as practices that have opted out of particular enhanced services.

![Comparison of Cost per Weighted Patient of GMS and PMS Contractors 2008-09](chart.png)

At the same time, the national direction on the GMS contract has been towards capitation based funding with the historically-based Minimum Practice Income Guarantee (MPIG) being phased out. As a result of this, GMS funding variation has reduced further in 2009/10 with an increase in capitation funding and reduction in MPIG. The work that is being undertaken in revising the PMS contract is consistent with this national approach.
**Contract specification process**

One of the problems identified above is that there was no definition of how PMS practices differed from GMS practices in order to justify the additional payments being made. To rectify this, consideration was given as to elements of general practice not currently included in the GMS contract but that are required by commissioners.

The Primary Care Commissioning Team therefore liaised with a number of colleagues across the PCT in order to identify possible areas for inclusion within a new PMS specification. Having drawn up an initial list of areas these were discussed with PMS practices at two workshops.

The new specification aims to:

- Ensure that poorly performing practices are identified and appropriately managed
- Ensure that patients with specific lifestyle problems are identified and managed, e.g. smokers, people who misuse alcohol, those identified as overweight, those identified as having high blood pressure
- Identify those who may be at high risk of ill-health, e.g. carers, people without a job, disabled people
- Ensure that staff are trained in child protection
- Stretch existing targets to ensure improved performance for childhood immunisations and management of CHD, Diabetes, Hypertension and COPD
- Ensure compliance with the care of the dying pathway
- Ensure services are accessible to patients
- Ensure that list sizes are managed at the appropriate national average level
- Ensure that business continuity and flu pandemic plans are implemented
- Ensure there is compliance with IM&T and information governance
- Ensure that practices support education and training for their staff

The specification includes key performance indicators that have defined levels for Excellent, Acceptable and Not Acceptable and are used for incentivising practices and for development and performance management purposes.

**Costing the new contract**

A spreadsheet model has been produced by the Finance Department that sets out current payments being made to practices together with the payments that would be made under a number of scenarios.

It is proposed that the following principles are adopted for costing the contract:

- The new contract should be funded from within existing budgets
- There should be a basic payment for each registered patient based on the Carr-Hill weighting in order to reflect patient need
- Given the additional benefits to the PCT of the contract (above GMS) there should be a small but significant premium for PMS costs per weighted patient compared with the corresponding GMS cost
- Enhanced service payments are outside of the scope of the contract costing
- Where a practice opts out of additional services, the deduction will be based on the actual patient numbers in the group that would receive that service. This
would be done by calculating the total that would be removed from all practices if every practice opted out of a service and then dividing that amount by the total of the group receiving the service

- All contractors would be required to opt-out of out of hours services
- Payments to practices will be based on actual weighted patient numbers at the end of the previous quarter, tolerances will no longer apply
- Payments for achieving key performance indicators should relate to the group being served and should be sufficient to encourage practices to achieve the indicator
- The current QOF points deduction for PMS practices should be removed
- There should be transitional relief for practices that lose out and this should be phased out over a period of time
- PMS practices will continue to be entitled to separate payments for seniority, premises, sickness and special leave etc as per the regulations
- PMS practices would be entitled to inflationary uplifts as per Department of Health guidance following DDRB recommendation

It should be noted that commissioners would have liked to offer the PMS contract to GMS practices, although this is unlikely to be possible given budgetary constraints.

Assuming that the above is agreed, the following variables need to be calculated:

- Basic cost per weighted patient
- Cost of additional services opt outs
- Payments for each key performance indicator
- Transitional relief period and percentage relief

A paper was produced for Executive Directors that considered possible options for funding of the PMS contract (attached) and the following results from the preferred option identified by Directors.

**Start Date and Transitional Relief**

It is proposed that the start date for the new contract is 1st April 2010. If approval is granted by the Commissioning Board at the end of July and PMS contract holders are informed at the start of September as to their funding under the new contract then, in effect, the period from then to the start of the contract would constitute more than 6 months of transitional relief. Given that, it is proposed that transitional relief would be calculated in the following way:

- Relief payments would be based on list size at the end of September 2009
- Relief payments would assume that the practice fully achieved all key performance indicators
- For each practice, the Finance Department will calculate what the practice would be entitled to under the old PMS contract for a full year and will calculate the maximum payment the practice would receive under the new contract for a full year
- Where a practice is due to receive a lower amount under the new contract it will receive the following transitional relief payments:
  - 75% of the difference in 2010/11
  - 25% of the difference in 2011/12
  - No relief after 2011/12
• The transitional relief calculated will be an actual amount and will not be adjusted for inflation or for list sizes changes that occur after September 2009

**Essential and additional services, including KPIs**

For the basic cost per weighted patient, it is proposed that a calculation is made as to the total that PMS practices would have been entitled to as a Global Sum under the new GMS contract, effectively providing a global sum equivalent and the redistributing this per weighted patient. The calculation gives a cost per weighted patient of £64.80 and gives a small premium of £1.59 or 2.5% above the current GMS cost per weighted patient at £63.21

The opt-out calculations based on the principles set out above are as follows:

<table>
<thead>
<tr>
<th>Additional Service</th>
<th>Deduction</th>
<th>How deduction is calculated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Surveillance</td>
<td>£2.60</td>
<td>Per patients aged 0-15 years</td>
</tr>
<tr>
<td>Minor Surgery (cryotherapy, curettage and cauterisation)</td>
<td>0.6%</td>
<td>% reduction of weighted price per patient as GMS</td>
</tr>
<tr>
<td>Childhood immunisations and pre-school boosters</td>
<td>£10.49</td>
<td>Per patients aged 0-4 years</td>
</tr>
<tr>
<td>Out of Hours Services</td>
<td>6%</td>
<td>% reduction of global sum weighted price per patient as GMS</td>
</tr>
</tbody>
</table>

Costs have not been calculated for opting out of the following services since no contractors are opted out:
- Cervical Screening Services
- Maternity Medical Services excluding intra partum care
- Contraceptive Services
- Vaccination and Immunisation Services

The Key Performance Indicators are set out in the specification take into account that requirements are stepped and that some requirements build on and stretch existing QOF indicators.

**Financial consequences**

Assuming that all practices achieve “Excellent” on all indicators, the PCT will make a saving of around £325k per annum at the end of the transitional relief period. Calculations have also been made to identify the impact on individual practices and this information will be shared with practices once the financial model has been agreed.

**Recommendation**

It is recommended that the Commissioning Board approves the above payments structure for the new PMS contract

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