



Implementing the 2017/18 GP contract

Changes to Personal Medical Services and Alternative Provider Medical Services contracts

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Document Status

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Implementing the 2017/18 GP contract

Changes to Personal Medical Services and Alternative Provider Medical Services contracts

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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.

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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 2017/18, 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 2017.

Clinical Commissioning Groups (CCGs) working under delegation agreements 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 the 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

2.1.1 Global sum funding and uplift

New investment for 2017/18 totals £239 million and includes:

- a pay uplift of 1 percent;
- an increase in the value of a Quality and Outcomes Framework (QOF) point to £171.20, resulting from the updated Contractor Population Index (CPI);
- An increase in the payment for Learning Disabilities Health Check Scheme;
- Changes and increased payments to the GP Retention Scheme;
- funding to cover expenses relating to additional Care Quality Commission (CQC) Business Improvement District (BID) levies costs that will be reimbursed, and
- costs and other increased business expenses.

NHS Employers, NHS England and GPC will work in 2017/18 to determine an agreed methodology for expenses which all parties might use in future.

The GMS global sum funding will also increase in 2017/18 as a number of funding streams are transferred:

- the phasing out of the Minimum Practice Income Guarantee (MPIG) - correction factor - payments began in 2014/15 and will continue through to 2020/21. MPIG payments are being reduced by one seventh of the 2013/14 payment and the

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aggregate funds reinvested into GMS global sum with no out-of-hours (OOH) deduction applied;

- the implementation of phasing out of seniority payments¹ began in October 2015 and will continue through to March 2020, with a reduction in payments and simultaneous reinvestment into core funding every year. In 2017/18, GMS seniority payments will be reduced by approximately £12m overall, and this will be reinvested into global sum; and
- there is a transfer of £157m from the avoiding unplanned admissions enhanced service into core funding.

In addition, a number of new funding streams have been added to global sum as follows:

- £5.0m for overseas visitors cost recovery administration;
- £3.8m in respect of the pensions administration levy;
- £2.0m for the non-recurrent workload associated with the transfer of patient records; and
- £1.5m for the administration of the workforce survey.

The net effect is that:

- Global sum payment per weighted patient increases from £80.59 to £85.35.
- GMS OOH deduction changes from 5.15 percent in 2016/17 to 4.92 percent in 2017/18.

These revised values take effect from 1 April 2017 as detailed in the Statement of Financial Entitlements (SFE).

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 2017/18. 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) increases will apply, for those GMS changes that also impact on these arrangements 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 table 1.

¹ NHS Employers. <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/gms-finance/seniority-factor>

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	GMS	PMS	APMS
	£/weighted patient	£/weighted patient	£/weighted patient
MPIG reinvestment	A [£0.48]	-	-
Seniority reinvestment	B [£0.31]	c [£0.31]	-
Elements of the deal	C [£0.21]	c [£0.21]	c [£0.21]
ES reinvestment	D [£2.69]	d [£2.69]	d [£2.69]
Inflation uplift	E [£1.06]	e [£1.06]	e [£1.06]
Total uplift	A+B+C+D+E [£4.76]	b+c+d+e [£4.27]	c+d+e [£3.97]

Note: the total uplifts above may not sum due to roundings..

Commissioners will need to apply the tariff(s) identified in table 1 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 the financial year e.g. 1 January 2017 (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.

Seniority reinvestment (B) is a redistribution of existing GMS and PMS funds. The resulting increase in GMS global sum price per weighted patient does therefore need to be reflected in any increase to PMS baseline funding but must not be reflected in the equivalent funding to APMS practices as no reduction of APMS seniority payments has been applied.

However, any new APMS contracts negotiated must exclude any payments in relation to seniority.

Elements of the deal (C) is the overall increase in GMS payments per weighted patient required to cover expenses relating to additional pensions administration levy costs, workforce survey administration, overseas visitors cost recovery, non-recurrent additional patient records workload and other increased business expenses. As PMS and APMS practices will also benefit from the additional funding for these items, the same increase per weighted patient needs to be applied.

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ES reinvestment (D) is the GMS weighted patient share of the Avoiding Unplanned Admissions direct enhanced service (DES) (£157m) that ceases on 31 March 2017.

This reinvestment supports the workload associated with transfer of the scheme from optional enhanced service to core contractual responsibilities for all practices in relation to frail patients. As PMS and APMS practices will be subject to the same contractual requirements, the increase will also apply (using the tariff identified (d) in table 1 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 (E) is the GMS price increase per weighted patient resulting from the Government's 1% uplift on pay, along with an appropriate uplift to expenses, leading to a contract uplift of 1.07 per cent. Commissioners will apply the equivalent uplift to PMS and APMS practices: tariff (E) in table 1 above.

Seniority reinvestment

As identified earlier there will be a further increase from April 2017 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 practices 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 April 2017.

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

Under the 2017/18 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.

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 2017/18 is therefore also £4.20. The PMS percentage reduction is determined by applying the GMS OOH cash deduction to the PMS price per weighted patient (which is GMS global sum price per weighted patient less cumulative MPIG reinvestment = £85.35 minus £2.08, giving £83.27). So £4.20 gives a reduction of 5.05% from £83.27.

Commissioners will apply the OOH deduction of £4.20 per weighted patient to the

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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.

2.4 Other funding changes

The funding/payment changes below also apply in 2017/18 following changes to the GMS 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 £165.18 to £171.20 as a result of Contractor Population Index (CPI) adjustment.
- b. **CQC and BID fees**- these will need to be reimbursed based on actual costs incurred in 2017/18.

Commissioners should refer to the main implementation guidance for details on changes to enhanced services in 2017/18 and this can be found on the [GP contract](#) pages of the NHS England website.

Other formats of this document are available on request. Please send your request to england.gpcontracts@nhs.net