

**Primary Care Contracting
Commissioning
Paper PCC/C as below**

New Personal Medical Services Agreement

Guide for Practices (Updated October 07)

A. Introduction

Since March this year, the Local Medical Committee (LMC) and the Primary Care Trust (PCT) have been meeting to negotiate a new Personal Medical Services (PMS) Agreement.

The negotiations around the new agreement have been detailed and thorough, and the LMC as mandated by practices, have raised concerns and points of clarification to the PCT. The negotiations have led to a final position being reached on the key areas:

- Commitments under the new contract
- The reallocation of funding
- Return to General Medical Services (GMS)
- The approach to performance management

The LMC have had detailed negotiation and although practices have had briefings they can never capture the full details of the depth of the discussions that were had. Having now reached a final position, we need to make sure that practices have a clear understanding, and can easily work through the documents themselves.

This guide does not form part of the Agreement and is not legally binding but is intended as a tool to understanding the Agreement. At any time if you are unclear, please do not hesitate to contact Julian Herbert, Melanie Craig or Sadie Parker at the PCT, or Bill Robinson at the LMC.

B. Commitments under the new contract

The vast majority of the new Agreement follows the PMS national regulations and mirrors the previous Agreement held by practices. Like all PMS Agreements, as defined by the national regulations, the contract does not run for a fixed period of time. The main changes fall into three areas:

1. Opening Hours

The PCT wished to ensure standard hours so that patients would have the same opportunities of accessing their surgery wherever they lived. At present, some practices open throughout the day and over lunchtime, so that patients can collect prescriptions, arrange appointments or even attend nurse-led clinics, and this was viewed as best practice.

The final position that we have agreed is that practices will open their doors to patients from 8.00am until 6.30pm throughout the day. Practices will need to ensure that the reception is staffed throughout the day, and that as a **minimum**, a doctor is also available for emergencies.

Practices with branch surgeries need to make sure that at least one site is open during these times, but not all.

There may be some situations where individual practices agree to operate exceptions to the standard opening hours with the PCT, for example one afternoon a month for staff training.

The relevant sections to look at in the PMS Agreement on Opening Hours are clause 27A and clause 1 (definitions and interpretation).

2. Inclusion of Other Mandatory Services

The PCT has been keen to ensure that there is a minimum level of services available to patients, which is consistent across Suffolk.

A number of services will now be included in the core contract, many of which were formerly funded as Enhanced Services. Although GMS practices will continue to receive funding for providing these services, PMS practices will be required to provide these within their core funding, in recognition of the higher levels of funding that they already receive. PMS practices will still be able to access funding for other enhanced services, and this is currently being negotiated separately with the LMC. Please refer to clause 83A in the PMS Agreement for full details of other mandatory services.

a. Phlebotomy and Post-operative wound care

Many practices already provide these services for their patients, so we ask that this continues at a similar level of activity. For those practices that do not currently provide

phlebotomy or wound care services, these need to commence as soon as is practically possible. Where there may be constraints because of the practice premises, we will seek to agree a reasonable start date. The 'phlebotomy service' includes level 1 near patient testing and anti-coagulation services.

There have been concerns raised that acute hospitals may cease to provide any level of phlebotomy or post-operative wound care; this is not the intention and the PCT will continue to commission these services from the acute trusts. Hospital services will be monitored closely through the Service Level Agreement (SLA) process. Practices will be asked to regularly report activity levels so that we can also monitor activity changes. The PCT will agree an appropriate level of activity for these services on an individual practices basis, taking into account factors such as current levels of activity and premises.

b. Minor Injury Services

Many practices already provide minor injury services to their patients. In Ipswich and Felixstowe, patients also attend the minor injury unit (MIU) at the Riverside and Felixstowe hospital.

Practices will be asked to advertise that their practice also provides a minor injury service to its registered patients. Many patients may continue to attend the MIUs, and it is important to offer patients choice, but we ask that patients are reminded that the GP provides minor injury services 'in hours.'

c. Depo-neuroleptic Injections and Contraceptive Implant Removal

Where a practice has a competent clinician, depo-neuroleptic injections will be provided to patients. The mental health trust is also expected to fully support the practice, and continue providing this service, but some patients may prefer to attend the practice for the injection as is presently the case.

Concerns have been expressed that in some areas of the county this service has not traditionally been available in general practice. The PCT will ensure that there is training for practices that do not currently have a competent clinician.

The same applies for contraceptive implant removal.

d. Smoking cessation services

An enhanced service will continue to be commissioned for a stop smoking service, but brief interventions and recording of data is regarded as part of the core contract.

e. Hormone injections including Zoladex

All PMS practices will be expected to provide hormone injections, including Zoladex as part of the core contract. The PCT is aware of the cost of the drug and will work with the

practice to ensure that the purchase is cost neutral to the practice for the supply of the drug.

f. Future arrangements

This list of other mandatory services seems appropriate today, and although there is no reason to believe that this may change, the PCT wished to have the ability to vary this in the future. Clause 83A is a detailed clause that the LMC and PCT have spent many hours discussing, and intends to reflect the PCT's wish for flexibility but the LMC's wish to ensure that any changes are reasonable.

A new policy has been created as result of this clause, which provides a framework for agreeing local changes to Clause 83A of the PMS Agreement. The policy is set out in Schedule 11 of the PMS Agreement. The policy sets out details of a new committee called the 'PMS Agreement Review Committee' which controls the changes to Clause 83A of the Agreement. LMC and PCT are represented equally on the committee, and in the case of a deadlock there is provision for an external facilitator.

The PCT is aware that this part of the agreement had generated considerable cause for concern, but we hope after significant constructive discussion with the LMC, practices may now feel more assured by the clear framework for approving any changes.

C. Reallocation of funding

1. How the contract value will be calculated

The principle is to ensure funding is allocated to practices on a needs based methodology, as opposed to being driven by historic levels.

The PCT originally proposed that the contract payment would be made up of two elements; a base contract payment linked to the Carr Hill formula and a 4% target payment. This concept was described in detail in the previous 'Guide for Practices' sent out in July. Following in depth negotiation with the LMC, payment of 4% conditional on meeting certain targets has been removed and it has then been returned to the baseline pool.

The total PMS contract payment is now completely linked to the Carr Hill formula which weights patient levels by practice at a rate of £84.35 per Carr Hill weighted patient. The total PMS contract payment will be made to practices monthly in twelfths through the year. The Carr Hill formula is an established method of establishing the primary care needs of a population based on adjustments for age, sex, additional needs, list turnover, market forces, rurality and presence of a nursing home within the practice area. Any national change to Carr Hill formula will be reflected in the calculation.

2. Introduction of funding changes

It is recognised, however, that moving too quickly to this position could destabilise practices and so there will be a phased transition over five years:

| | |
|-------|---|
| 08/09 | Maximum 2.5% change of Contract Payment pre any inflation changes |
| 09/10 | Maximum 2.5% change of Contract Payment pre any inflation changes |
| 10/11 | Maximum 2.5% change of Contract Payment pre any inflation changes |
| 11/12 | Maximum 2.5% change of Contract Payment pre any inflation changes |
| 12/13 | Balance of change made |

The finance schedules set out the impact to individual practices of the annual reallocation of funds. Whilst the maximum change has been capped at 2.5% per annum the increase to those practices that gain will be below this level in 08/09 to 11/12. This is because the overall level of funding made available for reallocation from those practices where the basic contract payment is being reduced is not sufficient to allow a full 2.5% increase in those years. This does not affect the contract payment level which will be fully completed for all practices in 2012/13.

3. List Size Adjustments

Weighted list sizes will be updated on a quarterly basis and increases/decreases will be adjusted at £84.35 (+ any subsequent agreed inflation level) per Carr Hill weighted patient.

A sample finance schedule is set out for practice XYZ (appendix A).

Following this example:

Practice initial weighted list size at start of contract 1/4/08: 4,400

| | | |
|------------------------|---|--------------------|
| Contract value: | 4,400 x £84.35 = | £371,147.00 |
| Payment | 15 th April 2008 = £371,147 ÷ 12 | £30,928.33 |
| | 15 th May 2008 | £30,928.33 |
| | 15 th June 2008 | £30,928.33 |

List size at 1/7/08: 4,413

Contract adjustment: 13 x £84.35 = £1,096.55

| | | |
|---------|---------------------------------|---------------------------------------|
| Payment | 15 th July 2008 | = £30,928.33+ £91.38 (£1,096.55 ÷ 12) |
| | 15 th August 2008 | = £31,019.71 |
| | 15 th September 2008 | = £31,019.71 |

List size at 1/10/08: 4,390

Contract adjustment: -23 x £84.35 = £1,940.05 reduction

| | | |
|---------|--------------------------------|--|
| Payment | 15 th October 2008 | = £31,019.71 less £161.67 (£1,940.05 ÷ 12) |
| | 15 th November 2008 | = £30,858.04 |
| | 15 th December 2008 | = £30,858.04 |

List size at 1/1/09: 4,500

Contract adjustment: +110 x £84.35 = £9,278.50

| | | |
|---------|--------------------------------|---|
| Payment | 15 th January 2009 | = £30,858.04 + £773.21 (£9,278.50 ÷ 12) |
| | 15 th February 2009 | = £31,631.25 |
| | 15 th March 2009 | = £31,631.25 |

D. Return to GMS

If a practice wishes to return to a GMS Contract, the funding will be as follows:

1. Global Sum which is calculated at £54.72 per weighted patient (using the Carr-Hill formula). This is the contract value and is not time limited.
2. The second part is a five year Local Enhanced Service (LES) for providing the Other Mandatory Services set out in clause 83A of the new PMS contract. The payment for this LES is calculated at £14.85 per weighted patient.

This brings the total funding to £69.57 per weighted patient which is the Suffolk average GMS practice earning. List size adjustments will be calculated in accordance with GMS regulations.

To return to a GMS contract, practices need to let the PCT have three months notice, so the GMS contracts would also start on 1st April 2008. Like the PMS agreements, GMS contracts are not time-limited, but GMS do not have a termination notice clause.

E. Development Framework

The Development Framework is set out in the PMS Agreement as Schedule 12. During our discussions with the LMC, we have spent a great deal of time trying to ensure that the tone of this document is appropriate, and that practices should feel supported by this development framework rather than threatened by a performance framework.

We have reviewed a number of examples from around the country and in the end chose a model developed by Liverpool and Essex PCTs and LMCs, adding a local element to reflect the PCTs views on other activity that should be included.

The content of the framework is divided into two sections: core (in blue) and developmental (in brown.) The core standards are all quality driven, based on statutory regulations. Rather than asking practices if they are achieving a specific percentage target, the framework sets out a series of prompts with a 'yes' or 'no' answer. Practices will be asked to carry out an annual self assessment against these indicators before the start of the financial year, and are expected to fully achieve these core standards, by answering yes to all the prompts, and producing supporting evidence as described in the right hand column.

The developmental indicators cover a range of targets which are mandatory and form part of the contract. Practices will be asked to agree an Annual Development Plan with the PCT, following their self assessment and production of supporting evidence. The Annual Development Plan should set out how the practice will progress towards meeting the developmental standards, highlighting where they may need support from the PCT.

Appendix A**Sample Finance Schedule****Financial Information – Practice XYZ**

| | |
|--------------------------------|--------------|
| Raw list size at 1/x/200x | 3,963 |
| Weighted list size at 1/x/200x | 4,400 |

Current Data

| | |
|-----------------------------|------------------------|
| Current gross baseline | £415,443 |
| Out of Hours deduction | <u>-£12,682</u> |
| Current Net Baseline | <u>£402,761</u> |

New Data

| | |
|--|------------------------|
| New Contract Value (weighted list size x £84.35) | £371,140 |
| Out of Hours Deduction | <u>-£12,682</u> |
| New Net Payment | <u>£358,458</u> |

Transitional Funding Arrangements

| | | |
|--|---------|-----|
| Contract Value difference to current baseline (10.99%) | £44,303 | |
| 08/09 Amendment to contract value (£44,303 less 2.5% of current baseline) | | - |
| £34,234 | | |
| 09/10 Amendment to contract value (£44,303 less 5.0% of current baseline) | | - |
| £24,165 | | |
| 10/11 Amendment to contract value (£44,303 less 7.5% of current baseline) | | - |
| £14,096 | | |
| 11/12 Amendment to contract value (£44,303 less 10.0% of current baseline) | | - |
| £4,027 | | |
| 12/13 Amendment to contract value (Nil) | | Nil |

Return to GMS Package

| | |
|---|------------------------|
| Global Sum (weighted list size x £54.72) | £240,768 |
| Additional sum for other mandatory services (weighted list size x £14.85) | <u>£65,347</u> |
| Return to GMS Value | <u>£306,115</u> |