

Understanding PMS funding: baseline data exercise

Methodology for Area Teams

July 2013

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Section 1. Introduction

NHS England is committed to ensuring that:

- where PMS funding is being used to support innovation and local improvements to services and quality, we are able to sustain these benefits in the new system
- at the same time, we move towards an equitable system of 'core' funding between primary medical care contractors across GMS and PMS contracts, based on a common payment per weighted patient.

In order to identify how best to achieve these objectives, NHS England is collecting information to understand the basis of existing funding for each PMS practice. This will enable like for like comparisons to be made between GMS and PMS practices to understand variations in funding. This process was outlined on 5 June in a [letter](#) from Ann Sutton and Ben Dyson to Area Team Directors.

It is anticipated that this data collection exercise will be completed by 16 August with the data analysed by early September. This information will inform options and proposals for how we use this information to underpin decisions about handling of PMS resources from 2014/15 onwards, so that we can work collectively with external stakeholders to agree the best way forward.

The move to a more equitable system of 'core' funding will need to be consistent with the approach to Minimum Practice Income Guarantee (MPIG) correction factor payments for GMS contracts. NHS England is committed to recycling correction factor payments into weighted capitation ('global sum').

The review is not a precursor to a move to a single contract for primary medical care.

About this document

This document contains advice for Area Teams and is produced on behalf of NHS England.

Section 2. Understanding PMS Funding

The information collected from this exercise will enable NHS England to make collective decisions about:

- the amount of funding that should remain to support local commissioning of primary care services
- the amount of funding that should be included in the national target price per weighted patient across GMS and PMS practices.

It is critical that this process is carried out accurately to ensure that national decisions are fair and equitable.

This exercise is not a renegotiation of existing PMS agreements. It is designed to support decisions about the national framework that should govern future decisions on PMS funding. The collection of this information is not intended to stop Area Teams from reviewing existing PMS agreements to help ensure that they are getting best value from current levels of investment. However, we have indicated that, subject to two caveats, Area Teams will not initiate review of current levels of PMS funding. The two exceptions are where:

- there is LMC agreement to a local review of PMS funding
- PCT clusters had gone out to consultation on proposals for changes and it now falls to Area Team teams to consider the outcome of those consultations and put into effect the resulting changes.

Where local reviews of PMS funding meet the exception criteria set out above, please identify this on the return, along with the expected date of completion. This will enable the data to be further refined when the reviews are complete.

Section 3. Disaggregating PMS Baselines

The chosen approach to determining the variation in PMS contract spend, and in particular PMS baselines, is to compare current PMS contract spend with a scenario where an equivalent practice is paid under GMS funding arrangements.

By a process of comparing and matching funding streams across GMS and PMS financial arrangements, Area Teams should be able to identify the level of funding within the contract price of a PMS practice for delivery of essential and additional services (in comparison to those services funded by Global Sum/Correction Factor for the equivalent GMS practice).

This data collection process should enable the calculation of the best approximation to the global sum equivalent (global sum plus correction factor) of an equivalent GMS practice. Each Area Team will need to identify within the contract price of each PMS practice, the funding that relates to the provision of essential and additional services.

Some PMS arrangements included budgets for community services, prescribing or secondary care (often referred to as PMS Plus/PMS+). For the purposes of this exercise, the 'plus' services and related funding should be excluded as they are clearly outside the scope of essential and additional services. However, it should still be possible to identify a PMS baseline, or core contract funding, for these practices. Although there is no standard approach to PMS financial arrangements, in most cases the initial starting point will be the practice's PMS baseline.

3.1 Starting point

The starting point for this process should be the PMS baseline at 1 April 2013, after taking account of the impact of any PMS reviews already completed; i.e. the baseline inherited by NHS England updated and adjusted. Please note this baseline should be net of any out of hours deduction (please see the out of hours section below for more information).

Out of hours services

The underlying principle here is that the adjusted PMS baseline should include the funding associated with the provision of out of hours services to the practice population. Starting with a net baseline (the PMS baseline value after the deduction for opting out of the provision of out of hours services) and adding back any deduction where the practice has opted out of the provision of out of hours services identifies the current level of funding removed from PMS baselines to support the provision of out of hours services.

In most cases, where a PMS practice has opted out of the provision of out of hours services, there will be an agreed deduction from the PMS baseline to take account of this opt out. To reflect the underlying principle, the agreed out of hours opt out deduction

for 13/14 should therefore be added back to the PMS baseline so that the adjusted baseline is gross of any out of hours deduction – i.e. is before the deduction is made. However, in some cases, there may be no agreed deduction for out of hours opt out – historically, the out of hours deduction may have been permanently removed from the PMS baseline. In these circumstances, an out of hours opt out price equivalent to GMS can be calculated by multiplying the practice weighted list size (at 1 April 2013) by £3.975 (which is 6 per cent of £66.25 – the opt out deduction percentage multiplied by the GMS global sum per patient for 13/14). Again, reflecting the underlying principle, this value should be added to the PMS baseline.

Where the practice continues to be contractually responsible for out of hours services, assuming that the value of those out of hours services is included within the PMS baseline, there is no need to adjust that baseline. However, if these out of hours services receive funding in addition to the PMS baseline, the relevant out of hours funding should be added to the PMS baseline i.e. the funding which relates to the provision of out of hours services to the population of that PMS practice. This will enable a like-for-like comparison of PMS costs with GMS Global Sum.

Growth funding

The development of PMS practices often included additional payments known as 'growth' funding. Growth funding should be added to the PMS baseline, if it is not already included.

In most cases, growth funding was used to fund new posts for GPs or nurse practitioners and was therefore intended for delivery of essential/additional services. However, in some cases growth funding was used to support a range of services specified in the local agreement that would not fall under the definition of essential or additional services. Such payments may be better considered as payments for local enhanced services (see the paragraph below to ensure that the baseline is adjusted appropriately).

The inherited baseline should be adjusted to reflect the impact of any list size adjustments made in arrears (i.e. 12/13 payments made in the first quarter of 13/14) so that the baseline reflects the cost of services to the practice population on 1 April 2013.

The inherited baseline should also be adjusted to reflect the impact of the 13/14 PMS uplift – i.e. the overall 1.32 per cent uplift referred to in the Primary Care Commissioning Newsletter 22 April 2013 (Issue 3).

Once completed, these adjustments provide Area Teams with an initial PMS baseline for 13/14 prior to the further adjustments specified below.

3.2 Further Adjustments

To support Area Teams, we have sought to identify the major areas of difference between PMS baseline and GMS funding arrangements. Due to the individual nature of PMS arrangements this list cannot be exhaustive.

For example, some funding within PMS baselines may be for enhanced services or key performance indicators (KPIs) over and above the equivalent essential/additional services paid for by the Global Sum/Correction Factor funding received by GMS practices in the local area. However, GMS practices will also attract further payments such as seniority or premises reimbursement which may or may not be available to PMS practices in addition to any PMS baseline payment. Therefore, notional adjustments will have to be made to PMS baselines to ensure that comparisons can be made on a like for like basis.

It is important to recognise that amounts shown in the data collection spreadsheet should indicate the value of any payments included within the PMS baseline. In other words, the cost to the NHS of those elements is covered by the payment of the PMS baseline – had the practice been under GMS arrangements the practice would have received further payment in addition to any global sum/correction factor payments.

Further information is provided below on specific payments that should be adjusted for.

GMS funding streams

In some areas, a number of payments equivalent to GMS funding streams may be made to PMS practices in addition to the PMS baseline, while in others, PMS baselines might include funding for:

- premises (rent and rates)
- seniority
- Directed Enhanced Services (DES)
- National Enhanced Services (NES)
- Local Enhanced Services (LES)
- personally administered drugs/dispensing.

If these elements are not funded separately to the PMS baseline, then the Area Team should provide the necessary information as part of this data collection exercise. This should be done by identifying either a reasonable estimate of the level of payment that would be due to the practice if it were operating under GMS arrangements, or a specific figure identified as part of the PMS baseline within the contract documentation, whichever is the most appropriate.

It is envisaged that the spreadsheet provided as part of the data collection exercise will enable Area Teams to identify and indicate the appropriate values for any adjustments. The template should cover the vast majority of necessary adjustments identified by Area Teams but due to the individual nature of PMS arrangements this list cannot be exhaustive and so an 'other' column has been included for use in exceptional circumstances.

Premises

GMS practices are not funded by global sum or correction factor payments for anything relating to premises (i.e. rent and rates). These are separate funding streams. Therefore, if any of these elements form part of PMS baseline funding, then Area Teams should determine the appropriate value of the included elements and identify these on the data collection spreadsheet.

Seniority

While many PMS arrangements may have separately identified a level of funding equivalent to GMS seniority payments (and adjusted these each year in line with GMS changes), others included seniority payments within the PMS baseline.

Where seniority is included within PMS baselines, Area Teams should calculate the amount of seniority payable if the practice were to return to GMS. The amount thus identified as seniority should be shown on the data collection spreadsheet.

Directed Enhanced Services (DES)

PMS baselines were developed from historic GMS items of service payments and may include payments for services now referred to as DESs. Examples include minor surgery and childhood immunisation target payments. It may also be that newer DESs are paid for from PMS baselines.

Where the services provided by a PMS practice include the provision of a DES but the payment (or some of the payment) for those services is included in the PMS baseline, an appropriate adjustment to the PMS baseline should be made. This will require the separate identification of a sum relating to the relevant DES and the amount thus identified should be shown on the data collection spreadsheet.

The current NHS England DESs as of 1 April 2013 are:

- Childhood Immunisation Scheme (Target Payments)
- Influenza and Pneumococcal Immunisation Scheme
- Violent Patients Scheme
- Extended Hours Access Scheme
- Patient Participation Scheme
- Alcohol Risk Reduction Scheme
- Learning Disability Health Check Scheme
- Facilitating Timely Diagnosis and Support for Patients with Dementia
- Risk Profiling and Care Management Scheme
- Remote Care Monitoring (Preparation) Scheme

- Improving Patient Online Access Scheme
- Minor Surgery Scheme
- Dispensing Services Quality Scheme.

National and Local Enhanced Services (NES and LES)

Some PMS baselines include payments for services beyond those considered to be essential, additional or Directed Enhanced Services. Such services will have been agreed locally by the PCT with each PMS practice and may be either:

- essential or additional services delivered to a higher specified standard (as evidenced by an agreed set of Key Performance Indicators (KPIs) and a payment mechanism)
- wider services not provided through essential or additional services [as evidenced by an agreed service specification, performance indicators and a payment mechanism]. These might include services addressing specific local health needs or more specialised services undertaken by GPs or nurses with special interests and allied health professionals, and other services at the primary-secondary care interface.

Where national or local enhanced services are funded from the PMS baseline, the value of any payments relating to these services should be adjusted for. For the purposes of this exercise, these payments should be separately classified as either payments for (essential/additional services with) enhanced KPIs or payments for wider services.

It is recognised that some PCTs, having undertaken PMS reviews, may have already identified the core equivalent GMS funding of a PMS practice and agreed additional payments to PMS practices for achieving specified performance indicators over and above delivery of the equivalent GMS essential or additional service levels. These arrangements should be classified as LES-Key Performance Indicators. In order to understand at a national level the funding committed to these arrangements, the full cost of such KPIs should be included within the initial baseline value and the amount dedicated to KPIs should be shown separately on the data collection spreadsheet.

It may be that the level of payment for such services cannot be clearly identified. In such circumstances, a reasonable estimate should be made of the level of payment included within the PMS baseline and that value identified within the data collection spreadsheet.

Personally administered drugs / dispensing

While many PMS arrangements will have continued to fund dispensing services (including personal administration) separately to the PMS baseline, others may include either the payment of fees or the reimbursement of drug costs or both. Therefore, if either or both of these elements form part of PMS baseline funding, then Area Teams should determine the appropriate value of the included elements and identify this value within the data collection spreadsheet.

Locum Allowances

For GMS practices, the SFE allows for further payments to be made to practices in specific circumstances. For example, the practice may need to employ a locum to maintain the level of services that it normally provides e.g. when a performer goes on sickness leave or maternity, paternity or adoptive leave.

Many PMS practices will directly access such payments as and when required. However, there may be some PMS practices where such allowances are built in to the PMS baseline and no further payment is required from the Area Team when those circumstances specified in the SFE arise. Where such funding is already included within PMS practice baselines (such that the PMS practice cannot access further funding from the Area Team), the amount of that funding should be clearly identified on the data collection spreadsheet.

Locum Employer Superannuation Costs

In most cases, PCTs will have been responsible for paying the employer's element of the superannuation costs of locums employed by the practice. However, it may be that some PCTs renegotiated the local PMS contract such that growth funding covered the full cost of locum provision i.e. including the 14 per cent employer superannuation cost. Where the PMS baseline includes funding for the employer's element (in addition to the employee's element) of superannuation for any locums employed by the practice, the amount of the employer's superannuation cost only should be separately identified within the data collection exercise.

There has not yet been a decision as to how the costs of employer's element of superannuation cost for locums will be applied to PMS practices. It is hoped that the data collected as part of this process will help inform that decision.

PMS providers pension contributions

In GMS, employer's and employee's pension contributions for providers (the individual contract holders) form part of the contract price. This is also usually the case for PMS providers i.e. employer's and employee's pension contributions for PMS providers are paid for from contract funding.

However, despite the favourable adjudications when the removal of this funding by PCTs was disputed by contractors, there are some cases where PCTs continued to pay the employer's element of PMS providers pension contributions in addition to the contract funding awarded to the practice. If this is the case, the level of employer's contributions paid in addition to the baseline is an additional cost to the NHS and should be clearly identified on the data collection spreadsheet.

Temporary patients

GMS practices receive a Temporary Patients Adjustment in addition to their weighted

capitation payment. This additional payment supports the provision of primary medical care services to temporary patients.

For PMS practices, funding for services to temporary patients is often included within the PMS baseline. If this is the case, then an appropriate adjustment to the PMS baseline should be made. This will require the separate identification of a sum for services to temporary patients if such is indicated in the contract documentation, or a reasonable estimate of the payment that would be due to the practice were it operating under GMS arrangements. This value should be clearly identified on the data collection spreadsheet.

In GMS, the value of the Temporary Patients Adjustment is subject to discretion (“a reasonable annual amount which is an appropriate rate for the area where the practice is located”) although it may have been based on historic data. Where possible, any available historic information should be used to identify an amount for the PMS practice. Alternatively, a suitable average per patient could be used, or a value benchmarked against practices with similar characteristics.

3.3 Other

This category should be used only by exception, where the payment/cost does not fall within any of the other identified areas. An analysis of these payments should be provided.

Examples of funding that might fall within this category (funding which would normally be paid separately to the baseline but that might possibly be included within a PMS practice baseline) include payments for GP training provided by the practice.

3.4 Comparison with GMS global sum

For PMS practices, the adjusted PMS baseline will reflect the funding for services provided by the practice e.g. if the practice does not provide minor surgery, then we would not expect funding for minor surgery to be in the PMS baseline. However, for the equivalent GMS practice, the global sum would be reduced by the relevant opt-out percentage specified in the SFE.

To ensure a fair comparison with an equivalent GMS global sum value, it is therefore necessary to consider whether the PMS practice provides the full range of additional services and whether the practice has opted out of out of hours provision. Where the PMS practice does not provide an additional service (the cost of which will therefore not form part of the PMS baseline) or has opted out of out of hours provision, the information should be clearly provided so that the relevant deduction can be applied to the calculation of an equivalent global sum value for comparative purposes.

Section 4. Queries process

Any queries should be sent to pms@nhsemployers.org

There are also a number of frequently asked questions which can be found at www.nhsemployers.org/pms which will be updated periodically during the data collection period.

NHS Employers

The NHS Employers organisation is the voice of employers in the NHS, supporting them to put patients first. Our vision is to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.

We work with employers to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

NHS Employers is part of the NHS Confederation.

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