Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Equalisation of Core General Practice Finances

Governing Body meeting

2 July 2015

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Is your report for Approval / Consideration / Noting

Approval

Are there any Resource Implications (including Financial, Staffing etc)?

Financial

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
To ensure there is a sustainable, affordable healthcare system in Sheffield.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No

PPE Activity

How does your paper support involving patients, carers and the public? Patients value receiving the affected services at their local practice and have come to expect them to be delivered in this setting. Depending on the outcome of the Governing Body decision, and the uptake of the proposed Locally Commissioned Service, further patient engagement activity may be required.

Recommendations

The Governing Body is asked to:

- Discuss the issues raised in this paper;
- Approve the proposed use of the PMS Premium and extra CCG resources to fund a Locally Commissioned Service to secure the continued provision of key non-core services;
- Note the CCG's intention to resource additional workload shifts which support the implementation of key commissioning priorities; and
- Approve the suggested approach to enable practices to demonstrate their exception circumstances for consideration.

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1. Introduction

National policy is requiring NHS England to equalise the finances available to general practice for the delivery of core general medical services on to a weighted patient fee base. This approach will detrimentally affect 62 out of the 87 practices in Sheffield, with 40 practices losing more than £5 per weighted patient (11 of which will lose more than £20 per weighted patient).

This paper advises Governing Body of the potential implications locally of this policy direction, recommends potential use of the Personal Medical Services (PMS) Premium and seeks consideration on how to manage the risk relating to practice viability**.**

2. Financial Implications on Practices

The Carr-Hill formula is used to distribute the core funding - called the global sum - to general practices for essential and some additional services. Payments are made according to the needs of a practice's patients and the cost of providing primary care services. The formula takes into account issues such as age, deprivation and patient turnover.

Since 2004, when the new General Medical Services (nGMS) contract was introduced, the Minimum Practice Income Guarantee (MPIG) has been used to top up the global sum payments for some practices, to match their basic income levels before the new contract. However, as part of the GP contract settlement in 2013, the Department of Health decided to phase out MPIG top-up payments over a seven year period, starting in the financial year 2014/15. When the MPIG is fully reinvested into the global sum £78.53 per weighted patient will be offered to practices for the provision of core general medical services. A similar approach is to be taken with PMS practices except the pace of change will be over a four year period starting 2015/16.

The table below sets out the number and types of practices in Sheffield along with an indication of the current price per weighted patient variation. It should be noted that there is no specific geographic spread of one type of contract against another within the city.

Type of Practice	Number of Practices	Variation Price /Weighted Patient	Number of gaining practices (price/patient variation)	Number of losing practices (price/patient variation)
APMS	**2 (both subject to reprocurement by NHSE)**	**£109.32 - £123.90**	**0**	**2**
GMS	**38**	**£73.56 - £103.88**	**23 (£0.10 - £4.97)**	**15 (£0.15 - £25.35)**
PMS	**47**	**£75.32 - £115.19**	**4 (£0.76 - £3.21)**	**43 (£0.51 - £30.97)**

3. Freed Up PMS Premium

National guidance is clear that any sums freed up via MPIG reductions will be ploughed back into the global sum at a national level. However, any money freed up via the release of PMS premium reduction to practices should be reinvested into general practice locally and as determined by the local CCG. Sheffield CCG has recently been advised by NHSE that the total sum which will eventually be made available for this purpose is in the region of £2.9m, the release of which will be phased on the following basis:

- 2015/16: 12.5% from October 2015. This will release £365 578
- 2016/17: 50% (cumulative). This will release £1,462,310
- 2017/18: 75% (cumulative). This will release 2,193,466
- 2018/19: 100%. This will release £2,924621

4. Proposed CCG Approach

This issue has been highlighted as a risk within the Governing Body risk register for quite some time, not only from the perspective of the provision of current services potentially ceasing due to the equalisation of core contract finances, but also with regard to the potential risk of practices disengaging with key priority areas which will require their participation in order to succeed. As practices start to understand the impact on their individual circumstances this risk is becoming more marked.

For a number of months the CCG and the Local Medical Committee (LMC) have been in discussion as to the best way to reinvest the freed up PMS premium resource. It has been agreed that for the most part (ie unless there are overwhelming and demonstrable cases where a practice and its population is notably different from the 'norm') the money should be offered on an equitable basis to all practices in the city. It is proposed that this should take the form of a Locally Commissioned Service (LCS) to encourage practices to continue to provide key elements of non- core work (as listed in Appendix 1) which has to this point been provided by practices and resourced from their core funding. To not take such an approach could result in a large number of practices ceasing to provide the services locally and to refer patients to the hospital for such services, thereby affecting patient access, increasing the financial risk to the CCG, and potentially detrimentally impacting on secondary care's ability to achieve key performance targets. It should be noted that the list of services to be included within the Locally Commissioned Service

reflects most, but not all, of what most practices in the city routinely provide. Those practices which currently provide over and above this list might take the view that they will now refer on to secondary care for those services not included within the list.

The final freed up sum of £2.9m equates to c £5 per weighted patient. It is proposed that the £5 per weighted patient offer is phased over the next three years (commencing October 2015) with the following annual sums being offered:

- 2015/16: £2 per weighted patient (to reflect part year effect)
- 2016/17: £4 per weighted patient
- 2017/18: £5 per weighted patient

This proposed approach would entail the CCG funding an extra £1.06m, £1.02m, £1.01m respectively, with a further £379, 221 being required in 2018/19.

It should be noted that it is the CCG's aspiration that the £5 per weighted patient offer by 2017/18 will be the minimum amount offered to practices and reflects the resourcing of non-core services currently being delivered in a primary care setting. As the CCG's commissioning plans come to fruition and it becomes increasingly clearer on the expectation on practices in the delivery of those plans it is the CCG's intention to look to resource any resulting workload requirements as soon as practically possible.

The CCG will continue to work with the LMC and local practices in working up the detail of both the non-core Locally Commissioned Service and the emerging ambition for service delivery in primary care settings.

5. Practice Concerns

Many practices are clearly concerned by the financial equalisation move, whilst others are set to gain to some degree by the approach being taken. It is likely therefore that the approach taken by the CCG will not be sufficiently satisfactory to many: Practices which have a deprived population continue to state that the Carr Hill formula is not sufficiently sensitive to enable them to meet the needs of their most deprived patients, whilst practices in the less deprived area which are losing significant sums due to the Carr Hill weighting resulting in them having a significantly less weighted population than their actual registered list state that it is the actual patient list that they treat and they are therefore being penalised unfairly.

An added complication is that the GMS MPIG reduction is over a longer period than the PMS reduction which, depending on the approach taken may perpetuate for a further few years the financial inequity for core provision. However on the basis that a Locally Commissioned Service is to be developed and offered to all practices regardless of their financial position this is not a key issue for the CCG.

Finally, despite the CCG's best efforts to reinvest the £5per weighted head and our looking to appropriately supplement the offer in time, there will still be a significant number of practices in the City which will lose significant sums over the next few years and as yet it is not clear as to how this will impact on practice viability and potential practice closures.

6. Consideration of Special Circumstances

GMS practices which were losing significant sums via the MPIG withdrawal were given the opportunity in 2014/15 to make a special case to NHSE for transitional funding using what is being called the London criteria. This requires practices to demonstrate:

Criteria	Rationale
There must be a reduction in GMS global sum funding greater than £3 per weighted patient in 2014/15 and 2015/16	There must be a negative financial impact on the practice
No doctor in the practice should have declared pensionable earnings in excess of £106,100 p.a. (Source: DDRB 2014 England Average 2011-12) (pro rata'd for part time GPs)	Support not designed to increase pensionable income of GPs
Practice expenses must be evidenced to be greater than 63%	National average ratio of expenses: profit is 63:37
No contract breaches for any reason issued since 1 April 2013	Marker of poorer quality practice
No "live" cases with NHS England performer machinery or GMC, including the Interim Orders Panel	Marker of poorer quality practice
Fewer than five outliers on the GPHLIs on current system	Potential marker of poorer quality practice
There must be evidenced extenuating circumstances within the practice population related to 1. Workload 2. Patient demographics …that impact practice business and patient services NHSE (L) defines this for the purposes of this exercise as there must be an IMD score of 35or higher for the practice population	Must be evidence that local demographics dictate workload that are not adequately reflected in Carr Hill IMD is a marker of deprivation with a consequential impact on a practice workload.

It is proposed that a similar opportunity should be offered to those PMS practices which are set to lose significant sums and which feel they have a special case to be considered. To support this approach it is recommended that a separate budget of £200k be established from the freed up sum from the 2015/16 PMS Premium. This can be called upon to extend support to any PMS practice if they can demonstrate they have a strong case against the London criteria. This sum would be used in the first instance to extend support rather than funding of on-going service delivery. The financial model has assumed a small fund on an ongoing basis to support practices deemed to have a proven case for ongoing support.

7. Recommendation

Governing Body is asked to:

- Discuss the issues raised in this paper;
- Approve the proposed use of the PMS Premium and extra CCG resources to fund a Locally Commissioned Service to secure the continued provision of key non-core services;
- Note the CCG's intention to resource additional workload shifts which support the implementation of key commissioning priorities; and
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Paper prepared by Katrina Cleary, CCG Programme Director Primary Care and Dr St John Livesey, Clinical Lead, Urgent Care

June 2015

Appendix 1:General Practice Work To Be Included within LCS

- Phlebotomy (1/3 core; 1/3 QOF; 1/3 LCS)
- supervision of, and prescribing on behalf of, secondary care employed specialist nurses in lieu of consultant supervision and secondary care prescribers
- ear care - syringing and toilet
- certification whist patient is under hospital care
- prescribing whilst hospital care continues
- spirometry
- ordering, reviewing, undertaking investigations for people under secondary care e.g. cytotoxic/rheumatology
- pre chemotherapy blood testing
- pre referral examination or investigation that does not influence the referral decision e.g. fertility clinics
- vault cautery (post op)
- depot injections (mental health)
- palliative care meetings
- serial PSA monitoring in non-cancerous patients
- in house 24 BP monitoring
- pre-op MRSA screening
- almost all dressings
- use of administrative staff/resources by community staff
- zoladex and contraceptive implants (*APG to advise)*
- IUS fitting - for HRT adjunct/menorrhagia
- ongoing provision of pharmacotherapy for malignant conditions without direct consultant supervision
- sole medical supervision of patients on antipsychotics or with eating disorders
- supervision or prescribing of secondary care started medications that require monitoring
- anticipated post-operative care
- walk in service
- gatekeeper/triage/telephone advice
- prescribing budget work
- admission avoidance work
- PSA monitoring in malignancy
- Pre-op preparation, eg blood pressure monitoring and control, continence checks etc
- Supervision of dementia patients on cognitive enhancers