To all PMS GPs

15 October 2003

PMS GPs AND THE FUTURE

I last wrote to you on 5th June this year. Many of you will know that I spoke about the future of PMS at the NAPC Conference on 24 September. I used that opportunity to confirm that PMS will be a permanent, flexible local contract based on quality and patient needs. I also reiterated the promises set out in my last letter. I am writing to you today to set out in more detail how those promises will be delivered in the next phase of PMS.

This initial guidance will be of interest to those of you who are currently in pilots and for those of you who may be entering a wave 5B pilot shortly. Other issues referred to in my speech, such as specialist PMS, will be covered by future guidance.

Full technical guidance will be published alongside the GMS guidance in November.

John Hutton

JOHN HUTTON

INITIAL ADVICE FOR PMS GPs FOLLOWING MINISTER OF STATE's SPEECH TO THE NATIONAL ASSOCIATION OF PRIMARY CARE ON 24 SEPTEMBER 2003

INTRODUCTION

This advice follows the speech John Hutton – the Minister of State for Health in England - gave to the NAPC on 24 September. It covers:

- Uplift, seniority and quality preparation payments in 2003/04
- Permanence, including global investment
- Quality in PMS
- Out of hours in PMS
- Growth funding
- Return to GMS.

Further technical guidance will follow later this year, alongside guidance on GMS.

QUERIES

Any queries should be directed to the PMS helpline [0845 9000 008] or your SHA PMS lead. A list of PMS leads is included at the end of this document.

2003/04 - UPLIFT, SENIORITY AND QUALITY PREPARATION PAYMENTS

By 20 October PCTs will receive an increase of 3.225% in their PMS allocations to reflect the DDRB award for 2003/04. This increase includes the uplift for seniority and is the same as for GMS GPs. PCTs will be asked to ensure that increases in seniority are agreed locally in line with the new GMS contract agreement. PMS schemes should therefore expect a commensurate increase for 2003/04.

PMS providers will be expected to engage in developing quality-based schemes in 2003/04. Therefore, PCTs will receive allocations for quality preparation payments based on £9,000 per average practice, also around 20 October. This payment will be based on the patient list sizes of local PMS practices and will be passed to PMS practices to engage in quality-based schemes in 2004/05.

PMS & PERMANENCE

PMS will stay as a separate permanent local option. Local PMS will complement the new national GMS arrangements. From 1 April 2004, and subject to legislative change, PMS schemes will no longer technically be pilots and will be put on a "mainstream" statutory basis.

To all intents and purposes, PMS has been "permanent" for some time. Legal changes are required to make PMS a mainstream contractual alternative. So far, under piloting, there has been a heavily bureaucratic process to follow, requiring a legal oversight by the Secretary of State. Subject to the legislative changes, this process will be streamlined.

Wave 5B is the last "wave" of 'piloting'. After 1 April 2004, those wishing to enter PMS will not be subject to a national deadline. They will need to deal directly with their PCT or SHA as appropriate, which may decide to introduce its own 'wave' process for ease of application.

INVESTMENT IN PRIMARY CARE

PMS and new GMS practices will receive comparable access to the overall increase in investment in primary care, 33% UK-wide by 2005/06, from £6.1bn to £8bn per annum, guaranteed through the new Gross Investment Guarantee mechanism.

GPs in PMS will be eligible for the same changes to pensions as GMS GPs. The change to the dynamisation factor and the new flexibility between officer and practitioner pensions will benefit all GPs.

PMS GPs will access the same changes in HR improvements, IM&T and premises flexibilities as GMS GPs will receive.

QUALITY IN PMS

PMS has always been a quality-based contract. To lever quality further, PMS providers will have access to funds for increasing quality. These funds will be available for implementing quality schemes. As in GMS, these will be a source of extra capacity. Practices may wish to use these monies to fund workforce increases to achieve agreed quality outcomes.

PMS practices will be able to use the new GMS framework as the basis for quality payments. However, PCTs and practices will have the ability to develop local variations of the GMS quality framework, which may better reflect local circumstances or build on quality arrangements already in place. They will be required to demonstrate to the PCT or SHA that local variations will deliver broadly comparable levels of evidence-based quality improvements for their patients. Beyond that requirement, the arrangements will be a matter purely for local determination.

We will be developing additional guidance and support for developing quality mechanisms in PMS.

A NOTE ON QUALITY FUNDING

The additional investment for quality in PMS will be comparable to the new money going into GMS for quality.

Practices will need to note, however, that the GMS contract has been completely redesigned. Quality funding in the new GMS contract includes an element of monies carried forward from "Red Book" quality schemes as well

as new investment. It is the comparable new investment that will be available to PMS. That is because in accordance with the advice issued in June, we will not be unpicking existing financial baselines in PMS.

We will, in due course, set out how many of the 1050 points in GMS are new money and how many relate to existing funding. In this way we will provide a transparent basis for making the same amount of new money available in PMS for quality as will be available for GMS.

OUT OF HOURS

PMS practices will also be able to opt out of their out-of-hours responsibility, to the same timescale, using a similar process and at the same price as GMS GPs. The opt-out price will be calculated on the basis of £6,000 per average GP and then adjusted for list size. Subject to legislation, the current timescale means that, where GMS or PMS providers wish to opt out, the PCT must take the responsibility from 31 December 2004 at the latest. Of course, where PMS practices and their PCTs are ready to agree on handling out –of hours locally in a way that transfers responsibility to PCTs, they may do so after 1 April 2004.

PMS PILOTS & GROWTH MONEY

The Government's commitment to "no unpicking" means that you will be able to retain the baseline funding you receive now, together with any growth monies you have been awarded during the piloting process, as part of your PMS contract price after 1 April 2004. This includes those considering signing PMS contracts shortly. The growth money that has already been agreed will be for you to use flexibly as part of your local agreement. It will no longer be restricted to its current use for GPs and nurse practitioners.

The deadline for all bids for growth for current PMS pilots and those entering wave 5b has now passed.

There will no longer be a centrally held fund for increasing "growth" specifically for PMS after 1 April. Additional investment in future will be delivered mainly through the quality and outcomes framework, including the PMS flexibilities referred to above, and the unified budget. The national GMSNCL stream, out of which PMS growth is now funded, will disappear with the introduction of new GMS and permanent PMS arrangements.

PMS PILOTS MOVING TO GMS

Those of you currently in PMS pilots will wish to weigh up the benefits for your patients of each of the contractual alternatives. For those of you who currently have a PMS contract, and those of you considering entering one for wave 5B, there is no need for permanence to affect that contract in any way. It can simply continue if that is what you wish. There is no need for your contract to be unpicked as a result of the new GMS contract.

However, you will wish to consider your options. The rest of this document provides guidance on the arrangements around return to GMS and transfer to PMS.

THE RIGHT OF RETURN

Permanence in PMS does not imply a once and forever choice. PMS practices will be able to move to GMS on a practice basis, or vice versa, should they so wish after 1 April 2004 and given sufficient notice.

One of the features of PMS under piloting arrangements has been that individual GPs entering a PMS scheme from GMS have been given a preferential "right of return" to the medical list. Under Section 13 of the Primary Care Act 1997, the Secretary of State has a duty to determine whether each scheme's practitioners are to be given the right of return. From 1 April 2004, there will be a *single* PCT list for both PMS and GMS performers. Those on the list (including current PMS schemes) will have the

right to provide through PMS or GMS. Therefore the current concept of 'return' will no longer apply.

We are notifying you of this should you wish to exercise your right of return under the current arrangements, that is, by 1 April 2004.

What has been known as the "Right of Return" will, in effect mean the right to move, either way, between a nationally negotiated contract and a locally negotiated one. We want practices to be empowered and rewarded so that they are able to deliver a wide range of high quality services and build on the skills and expertise of primary care professionals. Modernised contractual arrangements – whether nationally determined through new GMS, or locally determined through PMS - are needed to achieve this.

RETURN TO GMS AND FINANCIAL PROTECTION

There is a Minimum Practice Income Guarantee in GMS. When PMS practices return to GMS, financial arrangements for such transfers will be fair for PMS GPs in relation to GMS GPs. Therefore, from 1 April 2004, there will be an arrangement protecting aspects of PMS practices' income if a decision is made to move to GMS. This arrangement will affect pilots from waves 1 to 5 remaining in PMS after 1 April 2004, if they decide to move to GMS. It will be based on the calculations and principles underpinning the MPIG for GMS practices.

Under GMS, the practice's MPIG is calculated by comparing the earnings for the global sum equivalent (GSE) items. If this is higher than their actual global sum allocation they will be protected to the level of their existing global sum equivalent income. However, under PMS, practices do not receive GSE payments, but instead receive payments for the contract price agreed locally with PCTs. In some cases this arrangement is now five years old, with adjustments being made for growth, uplift, list changes and so on in the interim. Therefore it is virtually impossible to calculate a completely accurate GSE for PMS pilots returning to GMS.

However, a PMS pilot practice could make a strong and robust case for having an MPIG for 1 April in discussion with the PCT. The practice would be expected to provide the data which could be assessed by the PCT using:

- the local data on payments for Global Sum Equivalent items that they may have available for the pilot; this might include some or all of growth monies relating to contract variations forming part of the practice's Global Sum Equivalent

- a national average calculation (if the supporting data are not robust enough to do the calculation) based on PMS earnings and GSEs.

In both cases there will be additional detailed guidance and advice on how the MPIG might work.

RETURN TO GMS AND GROWTH

PMS growth will not automatically form part of the Global Sum Equivalent calculations for practices moving to *n*GMS. However, growth monies will be retained by PCTs to be spent on primary care services for local patients in PMS and GMS. It will therefore be a matter for local agreement between PCTs and practices to determine where these retained growth monies are best spent to meet patient needs. Where a practice provides evidence that some growth should form part of the GSE, this will be allowed.

Under piloting there has been no opportunity to retain growth on return to GMS. Instead practices return to the medical list and earn fees and allowances under the Red Book.

TRANSITIONAL ARRANGEMENTS DURING IMPLEMENTATION

Many of you will be concerned about the tightness of the implementation period, and in particular, the requirement for parties to a PMS contract to give six months' notice either way. Ministers do not expect this to be strictly adhered to in the current circumstances of change. Both parties may alter the six month period by mutual agreement.

For those about to enter wave 5B from 1 October, there is a window of opportunity. What we need to know from SHAs is the number of definite new pilots with signed contracts by 22 October so that the necessary allocations can be made.

Annex A

Personal Medical Services (PMS)

Strategic Health Authorities (SHA) - Policy Leads

Avon Gloucester & Wiltshire	Jane Rennie	0117 9841887
Bedfordshire & Hertfordshire	Elaine Askew	01727 792846
Birmingham & Black Country	Rachel Loftus	0121 6952422
Cheshire & Merseyside	Gary Lucking Chrissie Connellan Viv Smith	01925 406044 01925 406038 01925 406016
County Durham & Tees	Debbie Edwards	01642 666745
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Essex	Jeff Franics	01376 302314
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Annex A

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Strategic Health Authorities (SHA) - Policy Leads

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