

NHS Employers' evidence to the Pay Review Body on Doctors' and Dentists' remuneration 2009/2010 – General Medical Services

November 2008

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1. Summary

Based on the available evidence and in particular on the views of Primary Care Trusts (PCTs), **NHS Employers recommends an overall gross uplift of up to 1.5% be applied to General Medical Services (GMS) contract payments for 2009/10.** It is this figure that should be used to determine the set of differential uplifts that will be applied to agreed components of the GMS contract at the start of 2009/10.

NHS Employers believes that an uplift of 1.5% to the gross GMS contract value **will result in broadly a 2% increase in average General Medical Practitioners (GMPs) net pay in 2009/10.**

A recommendation of 1.5% takes into account the:

- opportunities that will likely be available to GMPs during 2009/10 to gain significant additional income outside of GMS contract payments
- extent to which practice costs are directly reimbursed by PCTs
- ability of independent contractors to manage practice costs and maintain their profits
- lack of any recruitment and retention problems amongst GMPs
- level of uplift being sought for other healthcare professionals in 2009/10.

An uplift of 1.5% will significantly reduce general practice reliance on correction factor payments, i.e. it is estimated some 17% of GMS practices would no longer require income protection payments under the Minimum Practice Income Guarantee (MPIG) arrangements. This would enable the redistribution of some £125m (the saving on correction factor payments that arise from a recommended uplift of 1.5%) on a more fair and equitable basis.

2. Introduction

2.1. The new GMS contract

Since the introduction of the new GMS contract in 2004, there has been a significant increase in the level of care provided by General Medical Practitioners due to substantial and sustained new investment by PCTs and the delivery of a range of new services (in particular through the Quality and Outcomes Framework and the growth in Enhanced Services).

NHS Employers has worked with the General Practitioners Council (GPC) to ensure that the contract provides a service that is increasingly better for patients, fair to the profession and represents good value for public money.

2.2. Agreed changes to the 2009/10 GMS contract

The outcome of discussions between all parties on the role of the Doctors and Dentist Review Body (DDRB) in making a recommendation on GMPs' net incomes for 2009/10, and the changes agreed to the 2009/10 GMS contract, were reported to the DDRB in the joint letter to the Chair dated 14 October.

A copy of that letter (plus the follow up letter clarifying the agreed process) and the letter of agreement posted to the websites of the various stakeholders, that spells out the 2009/10 changes in detail, are all contained in the attached Annex.

In summary, the DDRB has been requested by all parties **“to recommend an overall gross uplift in GMS contract payments**, taking into account its views on the average increase in net income that GMPs should receive and its views on movements in practice expenses”.

This **single gross percentage uplift figure** recommended by the DDRB (and if accepted by the Government) will be used to determine a set of differential uplifts that will be applied to agreed components of the GMS contract at the start of 2009/10. The computation of these differential uplifts will be based on a methodology that has already been agreed by all the parties.

2.3. Collation of evidence

NHS Employers has previously submitted evidence to the DDRB based on the outcomes of PCT completed questionnaires. However, in preparation for this year's submission, NHS Employers commissioned NHS Primary Care Contracting to facilitate a focus group comprised of PCT commissioners, finance and primary care leads to capture the views and opinions of PCTs on the 2008/09 and 2009/10 pay awards. A broad cross section of PCTs was represented and the views of the group have been used to inform this evidence. NHS Employers has also engaged with the NHS Confederation's PCT Network in the preparation of this evidence.

The use of a facilitated focus group is consistent with the approach NHS Employers has taken in preparing the evidence it submitted to the DDRB on General Dental Services.

2.4. 2008/09 General Medical Practitioners' pay award

The 2008/09 award (based on the recommendation contained in the DDRB's thirty-seventh report) was welcomed by NHS Employers, as it afforded PCTs considerable local flexibility in the provision and management of services. This was confirmed by the findings of the focus group and is evidence by the year on year increase in the level of investment by PCTs in Enhanced Services (see later). PCTs report that the increased investment they have made in the scope and delivery of enhanced services has contributed in large measure to improvements in both the quality and choice available to patients accessing primary medical care services.

Feedback from the focus group highlighted that the 2008/09 award was perceived to impact adversely on GP morale and in some cases the relationship between practices and PCTs was made more difficult because of the mismatch between the award and the expectations of GMPs. The evidence would suggest that these cases were the exception rather than the norm.

2.5. General Medical Practitioners' net pay

Since the introduction of the new GMS contract in 2004, the net pay of independent contractor GMPs has benefited from a series of significant annual increases, i.e. a cumulative increase of some 50% over four years (based on the latest available figures).

Data taken from the 2006/07 GP Earnings and Expenses Enquiry¹ (published by the NHS Information Centre in October 2008) shows that the average income before tax for contractor GMPs across the UK, i.e. their net profit in 2006/07 was £107,667, a decrease of 2.1% over 2005/06. This reduction in net income was expected following the changes to the contract in 2006/07 that were agreed between NHS Employers and the GPC.

The following table, based on the NHS Information Centre publication, shows the increase in gross earnings and net income over the period 2002/03 (the financial year immediately prior to the introduction of the new GMS contract) through to 2006/07. It also shows the changes to expenses as a proportion of gross income over this period:

¹ The NHS Information Centre for Health and Social Care, Primary Care Statistics, GP earnings and Expenses Enquiry 2006/07, October 2008.

UK GPMS GMPs						
Financial Year	Gross Earnings	Total Expenses	Net Income (before tax)			Expenses to Gross Earnings Ratio
	£	£	£	% Annual Increase	% Cumulative Increase	%
2002/03 ⁽¹⁾	183,136	110,822	72,314	–	–	60.5%
2003/04	201,630	120,064	81,566	12.8	12.8	59.5%
2004/05	230,096	129,926	100,170	22.8	38.5	56.5%
2005/06	245,020	135,016	110,004	9.8	52.1	55.1%
2006/07	247,362	139,694	107,667	-2.1	48.9	56.5%

(1) Based on GB results and restated to equivalent UK basis

Note: Figures in the table above are averages and include the full range of general practitioner results. The figures also include income from all sources, including private.

3. NHS Employers

Based on the available evidence and the feedback received from the focus group, NHS Employers recommends an overall gross uplift of up to 1.5% be applied to GMS contract payments for 2009/10.

Due to the nature of the GMS contract, and in particular the likely opportunities GMPs will have in 2009/10 to earn additional income outside of GMS contract payments, NHS Employers believes that such an uplift in the gross GMS contract value will result in broadly a 2% increase in GMPs' net pay in 2009/10.

In making this recommendation, NHS Employers expects the uplift recommended by DDRB (and if accepted by Government) to be applied differentially across the contract (as per the agreement detailed in the attached Annex).

The differential application of an uplift of 1.5% will significantly reduce general practice reliance on correction factor payments.

Modelling suggests that some 17% of GMS practices would no longer require income protection payments under the Minimum Practice Income Guarantee (MPIG) arrangements. The proportion of GMS practices receiving correction factor payments would reduce from around the current 91% to an estimated 74%.

The same modelling forecasts a saving on total correction factor payments of some £125m, i.e. reducing from £285m to £160m. These savings would be reinvested into global sum payments, facilitating a fairer and more equitable distribution of resources across GMS practices.

3.1. Rationale

In making this recommendation, NHS Employers has taken into consideration the following factors:

- 3.1.1.** NHS Employers believe that independent contractor GMPs should receive an uplift to their net pay in line with that awarded to other healthcare professionals in 2009/10. In its evidence to the DDRB in September 2008, NHS Employers suggested that this should be 2%.

PCTs report that they would welcome some uplift to the GMS contract to help cultivate their working relationships with GMPs.

- 3.1.2.** The total spend by PCTs in England on primary medical care activities (excluding that which relates to the financial arrangements that support Dispensing Doctor and Out Of Hours activities) is around £7bn. This figure can be derived from the analysis of spend shown within the attached Annex.

The £7bn can be broadly split £4.2bn expenses (60%) and £2.8bn profit (40%).

Recent figures published by the NHS Information Centre report that the Expenses to Earnings Ratio (EER) for the year 2006/07 (a measure of the average profit taken by non-dispensing contractor GMPs) was 56.5:43.5, a step move closer to the traditional 60:40 ratio (from the EER in 2005/06 of 55.1:44.9). This means that the amount of profit taken by a GMP from each £1 spent with them in 2006/07 was 43.5 pence.

However, NHS Employers believes that the recommendations of the DDRB for 2007/08 and 2008/09 will have moved this ratio even closer to the traditional figure of 60:40. On this basis, NHS Employers is of the opinion that the amount of profit taken by an independent contractor GMP from each £1 spent with them in 2008/09 is around 40 pence. This is in line with the traditional figure.

The DDRB has considered in previous submissions the view point that the GMS contract agreed in 2004 was founded on an assumption that GMPs would continue to reinvest broadly some 60% of their gross earnings back into the practice and in the provision of an improved range of services. The corollary is that GMPs take some 40% as profit, i.e. net pay.

- 3.1.3.** NHS Employers estimates that included in the expense figure of £4.2bn is upwards of £0.8bn of either "pass through" costs that relate to premises, information technology and other similar types of straight reimbursement by PCTs of practice spend or, other spend that does not contribute directly to practice profits. Much of this spend (in excess of £0.5bn)

relates to the reimbursement by PCTs of costs associated with practice premises.

Feedback from a number of PCT finance directors indicates that they are planning for an expected growth in premises spend of some 5% in 2009/10. This takes into account the potential growth in rental costs.

Finance directors also report that they are providing for growth of between 2% to 3% on the balance of this spend.

Taken together this equates to an overall growth in this spend of broadly £32m.

- 3.1.4.** Independent forecasters suggest that the residual expenses figure of £3.4bn (the majority of which is made up of pay costs) would attract inflationary uplifts of between 2.5% and 3.5% (depending on the category of expense). This in the context of the Government's 2% inflation target (based on the Consumer Price Index). However, the current economic position means that inflation forecasts are liable to change.

With this caveat, NHS Employers estimates that practice expenditure will increase by around £85m to £95m as a consequence of pay and price inflation in 2009/10 (broadly 2.5% to 2.8%).

- 3.1.5.** GMPs have, over recent years, demonstrated their ability to manage their costs and maintain their profits, in particular through changing the skill mix of the practice primary care team, for example, increasing the workload undertaken by practice nurses, employment of salaried GPs etc.

Expecting practices to achieve efficiency savings is consistent with the approach taken to other providers within the NHS. The 2008/09 NHS Operating Framework highlighted an expectation that NHS providers achieve "value for money" savings of 3%.

It is recognised that GMPs have contributed to efficiency savings in past years, notably through improvements in the quality or level of services provided. However, there is little in the way of efficiency saving contained within the recently concluded agreement for 2009/10.

Given the above, NHS Employers believes GMPs should be expected to achieve cash releasing efficiency savings of at least 1% on this residual expense. This would equate to £34m (£3.4bn x 1%).

3.1.6. Locally Enhanced Services

Evidence presented below shows the considerable year on year increase in the investment made by PCTs in Locally Enhanced Services (LESs). Such investment will reflect the PCTs' response to both local priorities and

national initiatives, for example, the achievement of 18 weeks where PCTs may seek to increasingly manage patients within a primary care setting.

Based on the trend demonstrated below (see section 4), NHS Employers judges that it would not be unduly optimistic for GMPs to assume an increase of between £30m to £50m in 2009/10 in the level of investment made by PCTs in Local Enhanced Services.

3.1.7. National programmes

NHS Employers believes that in 2009/10 there will also be opportunities for GMPs to gain significant additional income through their involvement in national programmes, for example, cardio-vascular screening and care plans. It is likely that GMPs will be well positioned in 2009/10 to take this work forward. Whilst difficult to judge, NHS Employers estimates between £50m to £100m might possibly be made available by Government to progress these initiatives in 2009/10.

However, NHS Employers does recognise that such opportunities to earn additional income will be conditional on additional work being undertaken within general practice.

3.1.8. Application of any uplift recommended by the DDRB to the Personal Medical Services (PMS) investment is a local contractual matter. However, as was recognised in the 14 October letter sent by all parties to the Chair of the DDRB, "all Health Departments remain committed to ensuring an equitable approach for independent contractors operating under different contractual frameworks".

NHS Employers interprets this statement to mean that PMS practices can expect to be treated in the same way as their GMS counter parts.

3.1.9. The following Table presents the financial effect of the various factors discussed above:

Paragraph Reference	Table		Gross Investment
		£m	£m
Growth in Gross Earnings			
3.1.3	"Pass Through Costs" etc (paid over by PCTs)		32
3.1.5	Cash Releasing Efficiency Savings of up to 1%		34
3.1.6	Additional Investment (LEs)		30
3.1.6	Additional Investment (National Initiatives)		50
	Recommended uplift of 1.5% (to gross GMS contract payments), i.e. 1.5% multiplied by £3bn		45
	Assessed impact of recommended gross uplift of 1.5% on PMS practices (based on a relationship that a 55% cost to GMS equates to a 45% cost to PMS, i.e. GMS cost of £45m divided by 0.55 multiplied by 0.45)		37
	Total Growth in Gross Earnings		228
Less Growth in Expenses			
3.1.3	"Pass Through Costs" etc	32	
3.1.4	Other Expenses (average)	90	
3.1.6	Associated with additional investment (60% of gross earnings, i.e. £80m multiplied by 60%)	48	
	Total Growth in Expenses		(170)
	Increase in Net Profit (GMPs Net Pay)		58
		£58m/£2.8bn	2%

If all of the above are factored in, including an uplift of 1.5% to gross GMS contract payments, then the average GMP could expect an increase of up to 2% in their net profit, i.e. pay in 2009/10. This assumes that GMPs operating under a PMS contractual framework will be treated in a similar way financially as their GMS counterparts.

NHS Employers recognises that these are broad based assumptions. However, NHS Employers has attempted not to over state income or under state costs in its analysis.

An uplift of 1.5% to gross GMS contract payments is broadly sufficient to fund the estimated growth in expenses that practices would be expected to manage in 2009/10, if the following assumptions are discounted:

- opportunities that will likely be available to GMPs during 2009/10 to gain significant additional income outside of GMS contract payments
- ability of independent contractor GMPs "to manage their costs and maintain their profits, in particular through changing the skill mix of the practice primary care team".

4. Opportunities to expand services/additional investment

As has been referred to above, there are significant opportunities for GMPs to secure additional funding, other than through the contract, by providing other services. The Table below provides year on year spend on Enhanced Services since the start of the new GMS contract:

Table	2004/05	2005/06	2006/07	2007/08	2008/09
	£000s	£000s	£000s	£000s	£000s
Directed Enhanced Services	155,987	151,795	263,706	225,944	276,000
National Enhanced Services	36,353	44,629	38,108	41,072	41,000
Local Enhanced Services	110,330	129,663	104,776	134,940	185,000
Total Enhanced Services	302,670	326,087	406,590	401,956	502,000

Note: The 2008/09 figure is an NHS Employers estimate based on the outcomes of the 2008/09 contract negotiations.

The analysis in the Table shows an increase in:

- total enhanced service spend of some £200m (66%) since the introduction of the new contract; and
- local enhanced services spend of £75m (68%).

4.1. Local Enhanced Services (LESs)

Some examples of how PCTs have invested in LESs are given below:

- Warwickshire PCT has invested £1.1m in additional rents to support co-location of services (one stop shops).
- NHS Walsall has invested £1.5m in enhanced services available to GPs in 08/09, including Choose and Book and Practice Based Commissioning (PBC) and the primary prevention of Cardiovascular disease (CVD).
- Bexley PCT funded a LES for Practice Based Commissioning in 07/08 equivalent to a 3% pay increase; the same LES has been re-commissioned in 08/09 along with a further LES for incentives relating to the achievement of PCT targets in primary care. The cumulative effect is an additional investment of over £1.2m in 08/09.

- Derbyshire County PCT uplifted all LESs by 2.3% in 08/09 (this includes ones such as smoking cessation, Chlamydia and International Normalised Ratio (INR) which are commissioned from pharmacy). The investment in GP-commissioned LESs for 08/09 is £8.3m.
- Derbyshire County PCT also continued the Booking and Referral Management LES (not choice) at £1.46 per patient. For an average sized practice of 7500 patients, this equates to an extra £10,950 income.
- West Hertfordshire PCT currently commissions three LESs - Practice Based Commissioning, Choice & Booking, smoking cessation, and plans to commission a fourth one for Atrial Fibrillation. The payments vary according to the type of LES, but as an indication, the PBC LES is worth approximately £1.6m at practice level with further payments for locality level input.

4.2. Non-clinical activities

GPs are also remunerated for a number of non-clinical activities.

- In West Hertfordshire PCT there are a number of additional non-clinical activities for which some GPs are remunerated, for example:
 - £630 per Quality Outcomes Framework (QOF) visit for GP Assessors
 - £630 per appraisal for GP appraisers
 - £630 per Information Management and Technology (IM&T) Direct Enhanced Service practice accreditation visit
 - £75 per hour for attendance at PCT ad-hoc meetings.

5. Retention and recruitment

PCTs report no problems with GP recruitment and retention, which is perceived to be “buoyant”. PCTs report that there are a large number of applicants for each GP position. Therefore there would appear to be no requirement for a significant increase in pay to ensure positions can be filled.

6. Response to the British Medical Association’s comments on pay distribution

The DDRB has asked NHS Employers the following question:

Do NHS Employers agree with the British Medical Association's (BMAs) analysis in the second bullet point of paragraph 2.3 of their evidence about the distribution of GMP income in practices in the most deprived areas?

Paragraph 2.3 of the BMA's evidence is repeated below:

"The review body seemed to have been persuaded that there was undesirable inequity in the distribution of GMP income in that those practices in the most deprived areas were those which received the lowest amounts per weighted patient through global sum and correction factor combined. We would remind the review body that the GMS contract allocation formulae are related to relative workload and unavoidable cost differences and not to need as such. The most important determinants of workload are the number of patients and their distribution by age and gender. Indeed the researchers for both the original formula and its subsequent review could find no evidence for a relationship between workload and indices of relative deprivation.

That said, there would in any case appear to be little if any correlation between the extent of deprivation and income per weighted patient (Appendix 1). Indeed to the extent that the MPIG arrangements protected receipts from deprivation payments, the review body's recommendation on this occasion was likely to have perverse effects".

NHS Employers response

NHS Employers believes that the erosion of MPIG (through the mechanism described in the Annex and as agreed with the GPC) will start to address any issues in the distribution of funding to deprived areas. The changes to the prevalence adjustment which has also been agreed for 2009/10 will ensure that by April 2010 all practices will receive the same weighting per patient with a specific disease, irrelevant of list size. The move towards full prevalence will ensure fairer funding to practices based on their population's needs.

Although both of these changes will move toward a fairer distribution of funding, NHS Employers agree with the BMA that this will not address the problem as a whole. NHS Employers believe that application of a revised formula (as developed by the Formula Review Group) is essential in ensuring improved equity in funding.

Annex

Joint Letter to DDRB

Ron Amy, OBE
Chair
Doctors and Dentists Review Body
Kingsgate House
66 – 74 Victoria Street
London
SW1E 6SW

14 October 2008

Dear Ron,

General Medical Practitioners Pay Recommendation 2009-10

We are writing to report the outcome of discussions between the parties as to the DDRB's role in relation to recommendations on GMPs pay for 2009-10.

Background

In its last report (the thirty-seventh), the DDRB asked the parties *"jointly to consider our role for the future and either to agree a mechanism whereby we can make recommendations on GMPs' net incomes, or to remove independent contractor GMPs from our remit and settle future changes to the contract by negotiation"*.

We are pleased to report that considerable progress has been made in discussions between NHS Employers (for the four Health Departments) and the GPC and an agreement has been reached on the role of DDRB in recommending an uplift for 2009-10.

We have agreed that for 2009-10 there should be differential uplifts to the global sum and global sum equivalent in order to reduce general practice reliance on correction factor payments under the Minimum Practice Income Guarantee (MPIG). We have also agreed the principle that there should be a comparable process to achieve the same aim in future years, either through differential uplifts or through possible alternative models, and we will keep the DDRB informed.

For 2009-10, we have agreed a specific methodology, based on a pre-determined ratio formula, which will be used to distribute the overall uplift agreed for 2009/10 (on the basis of DDRB's recommendation) differentially across agreed components of the GMS contract. The overall purpose of the methodology is to reduce general practice reliance on correction factor payments through the application of differential uplifts to the global sum, global sum equivalent, QOF payments and other elements of the GMS contract. These arrangements are explained more fully below.

DDRB Role

The Health Departments, NHS Employers and GPC will look to DDRB to make a recommendation on the level of overall uplift to be applied to GMS contract payments for 2009-10.

DDRB will therefore be asked to recommend an overall gross uplift in GMS contract payments, taking into account its views on the average increase in net income that GMPs should receive and its views on movements in practice expenses. The gross uplift is to be expressed as a single percentage figure (if need be to two decimal places).

This single gross percentage uplift figure recommended by DDRB (and if accepted by each Government) will be used to determine a set of differential uplifts that will be applied to agreed components of the GMS contract at the start of 2009-10. The computation of these differential uplifts will be based on a methodology that has been agreed by all the parties.

Whilst we jointly request DDRB to recommend an uplift, we have agreed to submit separate evidence to guide and support DDRB in making its recommendation on the level of the gross percentage uplift. These sets of evidence will reflect the differing views of the individual parties.

The Methodology

Overview

Under the formula, new money put into the contract is split, with different proportions being added to agreed components that make up part of the GMS contract, so as to apply differential uplifts to the agreed components in a way that will diminish correction factor payments under the Minimum Practice Income Guarantee (MPIG).

Detail

The gross percentage uplift figure recommended by DDRB for 2009-10 (and if accepted by each Government) will be applied to the forecast 2008-09 spend for each of the following components of the GMS contract:

- Global Sum
- Correction Factor Payments
- Quality and Outcomes Framework payments
- Enhanced Services payments
- Locum payments
- Seniority payments

The aggregated uplift in investment produced by this calculation will then be redistributed using the agreed methodology, so as to create a ratio relationship between the percentage uplifts applied to each component of the GMS contract.

We have agreed that the methodology will use the following proportions to create this ratio relationship:

Component of GMS Contract	Ratio Relationship
Global Sum	7
Correction Factor	2
Quality Outcomes Framework	5
Enhanced Services	5
Locum Payments	0
Seniority Payments	0

The ratio relationship created through using the agreed methodology will produce the differential uplifts applied to the global sum and correction factor payments received by practices operating under the GMS contract. The ratio relationship will also produce a differential uplift for QOF payments and enhanced services payments.

To assist DDRB in understanding which components of the GMS contract are covered by the agreed methodology for 2009-10, an analysis of spend on the GP contract, based on the 2007-08 audited accounts for England, is attached at Annex 1. The analysis clearly identifies which components of the GP contract are covered by and are not covered by the agreed methodology, i.e. where any inflationary investment will be applied to different income streams and where it will not. Please note that although the annex is England only, the agreed methodology would be applied by each of the four Health Departments, using their own national spend figures.

The areas not covered by the methodology include those where later negotiations will take place about any application of an inflation increase (e.g. dispensing income) and those where levels of reimbursement are governed by existing contractual arrangements e.g. premises and IM&T reimbursements.

Application of the agreed differential investment methodology to PMS and the application of any recommended DDRB inflationary increase to the PMS investment stream are local contractual matters. However, all Health Departments remain committed to ensuring an equitable approach for independent contractors operating under different contractual frameworks. The Health Departments will issue guidance to Primary Care Organisations about the application of the DDRB recommendation to local PMS contract arrangements. Please note that the equivalent to PMS in Scotland is Section 17c.

We would expect any other component not covered by the agreement or mentioned above to be treated as would normally be the case following a DDRB recommendation.

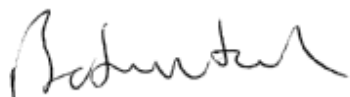
The agreed differential investment methodology will be used by each of the four Health Departments to create at an individual national level the differential uplifts applied to the components of the GMS contract identified as being covered by the methodology.

We will write to you again shortly with full details of this agreement including those changes we have agreed to the QOF, and agreed new arrangements for disease prevalence.

Whilst not covered within this agreement, we are continuing to discuss payments for dispensing doctors and possible changes to the mechanism for seniority payments.

Finally, if the DDRB Secretariat would find it helpful, we are happy for our respective experts to jointly meet with the Secretariat to discuss any outstanding questions.

Yours sincerely



Dr Barbara Hakin
Chief Negotiator
NHS Employers



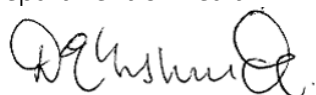
Dr Laurence Buckman
Chair
General Practitioners Committee



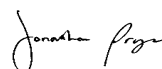
Richard Armstrong
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Christine Jendoubi
Director of Primary and Community Care
DH, Social Services and Public Safety - NI



Derek Fishwick
Head of General Medical Services
Welsh Assembly Government



Jonathan Pryce
Head of Primary Care Division
Scottish Government

Annex 1

	ENGLAND PCTs Audited Accounts
	2007/08
COVERED BY AGREED METHODOLOGY	£000s
General Medical Services items only	
Global Sum	1,535,244
MPIG (Correction Factor)/GSE	327,615
Quality Outcomes Framework	602,888
Enhanced Services	401,956
Seniority	79,446
*Locum Payments	20,010
Total	2,967,159
OUTSIDE (NOT COVERED BY) AGREED METHODOLOGY	
General Medical Services items only	
Premises	310,671
Information Management & Technology	45,270
Out of Hours	130,020
Sub-Total	485,961
OUTSIDE (NOT COVERED BY) AGREED METHODOLOGY	
All Other Contract Spend	
PMS	3,204,626
APMS	148,666
PCTMS	161,124
Dispensing	813,993
PCO administration (excluding Seniority, Locum payments)	85,682
Sub-Total	4,414,091
Grand Total	7,867,211
General Medical Services items only	2007/08
*locum payments consist of:	£000s
(a) Adoptive, paternity and maternity	9,491
(b) Sickness	3,728
(c) Suspended Doctors	4,232
(d) Other Locum payments (SFE paragraph 20.13	2,267
(e) Prolonged Study Leave	292
TOTAL	20,010



General Practitioners Committee

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2009-10 GMS Contract Negotiations - Agreement

This paper documents the 2009-10 changes that have been agreed between NHS Employers and the General Practitioners Committee.

There are broadly three main components to the changes we have agreed to apply for 2009-10:

- Progress towards reducing general practice reliance on correction factor payments under the MPIG
- Changes to the Quality and Outcomes Framework
- Changes to the current prevalence arrangements (that apply in the payment of QOF payments)

Progress towards reducing general practice reliance on correction factor payments under the Minimum Practice Income Guarantee (MPIG)

We have agreed that for 2009-10 there should be differential uplifts to the global sum and global sum equivalent in order to reduce general practice reliance on correction factor payments under the Minimum Practice Income Guarantee (MPIG). We have also agreed the principle that there should be a comparable process to achieve the same aim in future years, either through differential uplifts or through possible alternative models.

For 2009-10, we have agreed a specific methodology, based on a pre-determined ratio formula, which will be used to distribute the overall uplift agreed for 2009-10 (on the basis of DDRB's recommendation) differentially across agreed components of the GMS contract. The overall purpose of the methodology is to reduce general practice reliance on correction factor payments through the application of differential uplifts to the global sum, global sum equivalent, QOF payments and other elements of the GMS contract.

The agreed methodology is to apply for 2009-10. Both sides reserve the right to renegotiate how such a methodology might be developed or replaced in future years. However, all sides recognise the important precedent set for the future in agreeing this approach for 2009-10.

For 2009-10, we agree that we will jointly ask the DDRB to recommend an overall gross uplift in GMS contract payments for 2009-10, taking into account its views on the

average increase in net income that GMPs should receive and its views on movements in practice expenses. The gross uplift is to be expressed as a single percentage figure (if need be to two decimal places).

This single gross percentage uplift figure recommended by DDRB (and if accepted by each Government) will be used to determine a set of differential uplifts that will be applied to agreed components of the GMS contract at the start of 2009-10. The computation of these differential uplifts will be based on a methodology that has been agreed by all the parties.

Whilst we will jointly request DDRB to recommend an uplift, we have agreed to submit separate evidence to guide and support DDRB in making its recommendation on the level of the gross percentage uplift. These sets of evidence will reflect the differing views of the individual parties.

The agreed joint letter to DDRB is attached and is an integral part of this letter of agreement.

The Methodology - Overview

In summary, the agreed methodology involves the use of a formula to determine how the uplift arising from a DDRB recommendation (and if accepted by each Government) is to be applied across agreed components of the GMS contract, i.e. increasing payments not only to the global sum but also the correction factor, the QOF and enhanced services.

Under the formula, new money put into the contract is split, with different proportions being added to agreed components that make up part of the GMS contract, so as to apply differential uplifts to the agreed components in a way that will diminish correction factor payments under the Minimum Practice Income Guarantee (MPIG).

In essence the percentage uplift applied to each part of the contract identified in the table below will be in the ratio as described in the table below.

The Methodology - Detail

The detailed methodology for calculating the differential uplifts is as follows:

Step 1

The component proportion uplift is first determined.

We have agreed that the following proportions of the GMS contract will be used in the creation of the ratio of percentage uplifts that will determine the differential uplifts:

Component of GMS Contract	Proportion
Global Sum	7
Global Sum + Correction Factor	2
Quality Outcomes Framework	5
Enhanced Services	5
Locum Payments	0
Seniority Payments	0

[Technical Note: We have agreed to use the aggregation of the global sum and correction factor budgets as a surrogate for a Global Sum Equivalent figure]

Step 2

Each component of the agreed GMS contract budget is then adjusted to create a 'revised' budget. This involves multiplying the agreed budget by the agreed proportion to give a revised budget.

The adjustment in Step 2 is shown in the table below (which for illustrative purposes uses the 2007-08 audited accounts spend for England):

[Note that although the illustrative table is England only, the agreed methodology would be applied by each of the four Health Departments, using their own national spend figures].

GMS Component	Agreed GMS Budget £millions*	Agreed Ratio (of % uplifts) Relationship (see Step 1)	Revised Budget £millions
Global Sum	1,535	7	10,745
Global Sum + Correction Factor	1,863	2	3,726
QOF	603	5	3,015
Enhanced Services	402	5	2,010
Locum Payments	20	0	0
Seniority Payments	80	0	0
Total	4,503		19,496

* based on 2007-08 audited outturn

In arriving at the differential uplifts that will actually be used for 2009-10, the agreed methodology will use the 2008-09 Quarter 3 forecast spend for these components. These figures will be signed-off by the Technical Steering Committee.

Step 3

We agree to use the single gross percentage uplift figure recommended by DDRB (if accepted by each Government) as the basis for computing a set of differential uplifts that will be applied to the agreed components of the GMS contract at the start of 2009-10.

For illustrative purposes the amount of new money going into the contract is taken to be £59 million (assuming - without prejudice – a DDRB recommendation of 2% which would then be applied to the £2,967 million). Calculation of the aggregated uplift is illustrated in the following table:

	ENGLAND PCTs Audited Accounts	Recommended Uplift	
	2007/08		
SPEND COVERED BY AGREED METHODOLOGY	£m		£m
General Medical Services items only			
Global Sum	1,535		
Correction Factor	328		
Quality and Outcomes Framework	603		
Enhanced Services	402		
Locum Payments	20		
Seniority	80		
Total	2,967	Total multiplied by 2%	= 59

This new funding of £59m is divided by the revised budget produced through Step 2. This gives a factor as follows:

$$59 / 19,496 = 0.00307755437$$

The revised budget for each component (determined in Step 2) is multiplied by this factor (the results are shown below).

GMS Component	Revised Budget £millions	Increase as an amount £millions	Share of increase %	Increase as %
Global Sum	10,745	33	56%	2.13%
Global Sum + Correction Factor	3,726	11	19%	0.61%
QOF	3,015	9	15%	1.52%
Enhanced Services	2,010	6	10%	1.52%
Locum Payments	0	0	0	0
Seniority Payments	0	0	0	0
Total	19,496	59	100%	

The second column shows where the uplift in cash terms is initially invested into each of the components, before taking into account the 'iterative effect' of recycling savings on correction factor payments back into global sum.

The third column in the table shows how much of the £59 million, as a proportion, would be added to each component. Just over half of the increase is being used to

increase global sum (and reduce MPIG payments), with just under half funding a minimum uplift and uplifts to the QOF and enhanced services.

The ratio relationship created through using the agreed methodology will produce the differential uplifts applied to the global sum and correction factor payments received by practices operating under the GMS contract. The ratio relationship will also produce a differential uplift for the QOF and enhanced services.

To assist our mutual understanding of which components of the GMS contract are covered by the agreed methodology for 2009-10, we analysed spend on the GMS contract, based on the 2007-08 audited accounts for England. The analysis clearly identifies which components of the GMS contract were covered by and were not covered by the agreed methodology, i.e. where any inflationary investment will be applied to different income streams and where it will not.

The methodology will not apply to those areas where later negotiations will take place about any application of an inflation increase (e.g. dispensing income), nor to those areas where reimbursement is governed by existing contractual arrangements (e.g. premises and IM&T reimbursements).

Application of the agreed differential investment methodology to PMS and the application of any recommended DDRB inflationary increase to the PMS investment stream are local contractual matters. However, all Health Departments remain committed to ensuring an equitable approach for independent contractors operating under different contractual frameworks. The Health Departments will issue guidance to Primary Care Organisations about the application of the DDRB recommendation to local PMS contract arrangements. We note that the equivalent to PMS in Scotland is Section 17c.

We would expect any other component not covered by the agreement or mentioned above to be treated as would normally be the case following a DDRB recommendation.

Finally, both sides have agreed to work jointly in examining other ways to resolve the issue of those practices who remain heavily reliant on correction factor payments.

We also agree the principle that there should be no additional increase in the level of payments made by practices that have opted out, as a consequence of this agreement, i.e. the differential uplift to the Global Sum payment. We also agree that the arrangement detailed in the 2008/09 SFE may prove to be the most appropriate mechanism for 2009/10 that enables us to achieve this principle. However, the actual mechanism will only be finalised once the parties are satisfied that it will in fact do so.

Changes to the Quality and Outcomes Framework

In summary, we have agreed to reallocate 72 points within the QOF. The reallocated points are to be invested in the following clinical areas:

- advice on long term contraception
- cardiovascular disease primary prevention
- new depression indicator on assessment of severity
- beta blockers for heart failure
- improvement to chronic kidney disease indicators
- improvement to diabetes indicators

- improvement to chronic lung disease indicators

All of the new indicators relating to the above will be reviewed prior to the start of 2011/12, in the light of changing priorities for health and healthcare.

More detail on the agreed changes to the 2009/10 QOF are shown in the attached paper referenced QOF 348_7 - FINAL.

Such changes are to apply to all four countries across the UK.

Prevalence

We agree that the current prevalence arrangements (used to determine QOF payments) will be amended over two financial years in the following way:

- on 1 April 2009, the square rooting component of the current arrangements will be discontinued
- on 1 April 2010, true prevalence will be used to determine QOF payments, i.e. the current cut off arrangements will be discontinued.

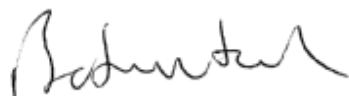
The overall effects of these changes are broadly cash neutral as they will largely redistribute QOF resources between GP practices. However, it is recognised that a small number of practices may experience a significant loss in their current QOF income. As a consequence, the following guidance will be issued by Health Departments to their PCOs:

"PCOs should work with practices which identify themselves as experiencing a significant loss in their income to understand the impact of the changed arrangements on their current service provision.

PCOs will also wish to use the opportunity to consider the local health needs of populations and, working with LMCs and practices to identify whether new services or improvements in care should be commissioned to address these local needs."

Whilst not covered within this agreement, we are continuing to discuss payments for dispensing doctors and possible changes to the mechanism for seniority payments.

Finally, both parties acknowledge and record thanks for all the hard work and considerable effort that has been put in by both teams over the Summer and in recent weeks to achieve what we both agree is a 'wise agreement' that will benefit all sides, not least patients.



Dr Barbara Hakin
Chief Negotiator
NHS Employers



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12 November 2008

Dear Keith

To avoid any doubt we thought it would be helpful to clarify one small part of the process described in the 14th October 2008 letter addressed to the Chair of DDRB.

In the Table at the top of page 3 – the label “Correction Factor” should read “Global Sum + Correction Factor”. We would also like to add a clarifying sentence at the end of the paragraph that immediately follows this amended table that reads:

“The differential uplift to correction factor payments is based on a global sum equivalent calculation and is before account is taken of the effect of recycling savings on correction factor payments.”

The above does not materially change the content of the letter you received on 14th October. It clarifies the agreed position and ensures a consistency of language across the 14th October letter and that used in our letter of agreement.

Yours

A handwritten signature in black ink that reads 'Andrew Clapperton'.

Andrew Clapperton
Head of Primary Care Workforce & Contracting
Employers

A handwritten signature in black ink that reads 'Chris Finlan'.

Chris Finlan
Joint Head of NHS GPs Division NHS
General Practitioners Committee

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