Focus on…..How your practice is funded
October 2008

This guidance note has been produced by the General Practitioners Committee to help GPs, practice managers and LMC staff understand how individual practices receive funding under the GMS contract, and is one of a series of guidance notes on the GMS contract. This document only deals with income from the GMS contract, and does not include other income streams, such as training grants. We would advise all GPs to read the contract document and supporting documentation, which is available on the BMA website at www.bma.org.uk.

This guidance is relevant UK wide, although there are some differences in the way in which funding is allocated in different countries. Where applicable, these differences have been noted in the text. Readers should also note that, for simplicity, the guidance links primarily to English source documents.

Introduction
There was significant investment in primary care when the current GMS contract was introduced in April 2004. The new contract also introduced a completely new system for funding practices and GPs. This was intended to allocate resources according to the relative workload associated with each practice's specific patient population and give GP practices much greater flexibility and autonomy in how they deliver services, allowing them their own choices as to how they organise the care of their patients whilst partly rewarding them on the quality and outcomes of the care they provide.

Almost all funding is practice based, which means that it is a payment to the practice rather than individual GPs. Funding is allocated based on weighted patient populations rather than number of doctors. This guidance note explains how this funding is received by individual GMS practices. There are likely to be similarities between how GMS and PMS (Section 17C in Scotland) practices are funded as many of the features of the GMS contract have also been introduced into PMS contracts, for example the QOF and enhanced services. It is noted in this guidance where there may be significant differences.

Funding streams
In simple terms, the cash envelope distributed to practices is broken down into the following income streams, each of which will be covered in turn by this guidance:
- global sum and MPIG
- Quality and Outcomes Framework
- enhanced services
- PCO*-administered funds, including seniority
- premises
- IM&T
- dispensing/personal administration of drugs

Details of how pre-2004 Red Book income streams were mapped across to the global sum can be found in Appendix 1.

The global sum
The global sum is calculated using the global sum (Carr-Hill) allocation formula and was intended to provide for the delivery of:
- essential services
- additional services
- staff costs
- locum reimbursements (for appraisal, career development and protected time)
- the cost of GPs "employers superannuation" contributions for those funding allocations mapped across from the old red book contract.

* PCO is a generic term for Primary Care Organisations across the UK, encompassing Primary Care Trusts (PCTs) in England, Health Boards (HBs) in Scotland and Northern Ireland, and Local Health Boards (LHBs) in Wales.

The purpose of the global sum allocation formula is to share out a sum of money in proportion to perceived need. It represents practice, not GP, income. It is calculated quarterly and paid monthly. Payments will change dependent on patient turnover and demographies. Adjustments are made for age and gender, patients in nursing and residential homes, needs (morbidity and mortality), list turnover, unavoidable costs (staff market forces and rurality). These six indices are then applied simultaneously to the practice's unweighted registered list. A further detailed example can be found in the section 'Explaining your practice statement' of this guidance (appendix 1).

Deductions from the global sum are made from practices that have opted out of providing out-of-hours care and those that choose not to provide additional services. The global sum amount is reviewed at the start of each quarter (when the contractor may have a new weighted population for the quarter) or if there is a change to the practice's additional or out-of-hours services opt-outs. This explains why there is a likely to be a change in a practice's global sum payment at the start of each quarter (i.e. April, July, October and January).

Further details of the global sum allocation formula and how this is applied can be found in part 1 (paragraph 2) and annex B of the consolidated GMS Statement of Financial Entitlements: http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/GMS/DH_4133079

PMS and Section 17C practices do not receive a global sum to provide essential and additional services, but instead receive a baseline allocation. This is determined locally and is likely to include mechanisms for calculating the price of opting-out of out-of-hours and taking on additional patients. Further information for PMS practices can be found in the GPC guidance note 'PMS agreements,' on the BMA website: http://www.bma.org.uk/ap.nsf/Content/pmsagreements0904

In Scotland, the Scottish Allocation Formula (SAF) is used. There are some differences in the formula, but the underlying principles are the same (information about the SAF is available in annex B of the Scottish SFE: http://www.sehd.scot.nhs.uk/pca/PCA2008(M)09SFE.pdf). There are also some minor differences in the global sum formulas used in Wales and Northern Ireland but, again, the underlying principles remain the same.

The formula as it applies in England and Wales was reviewed in 2006, and a consultation on the findings of the Formula Review Group (FRG) was held in 2007. Following the consultation, the joint negotiating forum that includes NHS Employers and the GPC, discussed the findings with the health departments in England and Wales. It must be stressed however that until and unless there is agreement between the negotiating parties on the need for change the current 2004 Formula will continue to operate. Northern Ireland also held a consultation on the review of the NI formula and NIGPC responded. Further details of the review can be found on the BMA website: http://www.bma.org.uk/ap.nsf/Content/GlobalsumconsultationFAQs.

Information on managing new registrations and how this may effect practice payments can be found in the GPC guidance note 'The financial implications of increasing list size,' which is available on the BMA website:
http://www.bma.org.uk/ap.nsf/Content/increaselistsize?OpenDocument&login&Highlight=2,financial,implications,increasing,list,size

The MPIG

To ensure that practice GMS income did not drop in the transition from the Red Book to the global sum, the GPC and NHS Employers negotiated a Minimum Practice Income Guarantee (MPIG).

In order to assess whether a practice would lose resources in the transition, it was necessary to determine a Global Sum Equivalent (GSE) against which the global sum delivered through the allocation formula could be measured. The GSE was the total of the global sum equivalent Red Book payments a practice received under the previous contract. If the formula yielded, for any given practice, a global sum that was lower than the GSE, then that practice became eligible for an MPIG as follows:

MPIG = global sum via formula + correction factor

If GS via formula < GSE then the correction factor = GSE - GS

If GS via formula > GSE then no MPIG is needed

The data used to determine the GSE, and hence the MPIG, was taken from the last three quarters of 2002/03 and the first quarter of 2003/04.

MPIG calculations were one-off calculations made in respect of contractor practices whose GMS contract began on or before 1st April 2004. Details of how the MPIG was calculated, including how adjustments were made for practice vacancies or practice mergers and splits, can be found in annex D of the 2004/05 SFE available at the following address: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069762

Correction factor payments remain constant at the 2004 level based on the initial calculation. The Correction Factor does not increase with expanding list size, nor does it decrease if there is a reduction in patient numbers. However, global sum payments, as noted previously, will change quarterly.

Completely new GMS practices established since 1st April 2004 are not eligible for the MPIG, as they did not exist before or during transition from the old to the new GMS contract. Although PMS practices which wish to revert to a GMS contract have no statutory right to an MPIG and there is no agreed method of calculating this, they should insist on an MPIG or equivalent, as a part of a fair and equitable return package. Section 96 of the 2006 NHS Act gives PCOs discretion to provide such funding. Practices should refer to the then Minister of State for Health John Hutton's October 2003 letter which provides more information on how MPIG would apply when returning to GMS: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4079439.pdf

Normalisation

One aspect of the global sum allocation formula that has caused considerable confusion is the concept of normalisation and the way in which it impacts on global sum payments. Normalisation applies in England, Wales and Northern Ireland, but not in Scotland where a different formula is used (the SAF).

Because the formula involves adding weightings to certain patient characteristics to produce a weighted patient list the net result is that across the country the total number of weighted patients will exceed the actual population. Normalisation involves scaling back the results of applying the global sum allocation formula to practice lists, so that the aggregated weighted lists always total the national registered population. This scaling back occurs at each stage of the global sum formula's calculation, so that no individual adjustment is allowed to dominate. This allows payments to be calculated based on each practice population's position relative to that of other practice populations in the rest of each country, rather than on absolute changes in a practice's weighted population. The formula by which global sum payments are normalised is outlined in annex B of the consolidated GMS Statement of Financial Entitlements (2007): http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/GMS/DH_4133079

Given changing demographies (for example, emigration versus immigration or death rates over birth rates) and the need to use relative assessments rather than absolute ones, there will always be some fluctuation in the quarterly global sum payments made to practices. At the extreme, such fluctuations will include some apparently unexpected changes, for example an increase in registered patients, but a decrease in weighted patients. It is important to be clear that this is and always has been a possibility because it is inherent in a relative-based, redistributive formula.

Since April 2006, normalisation has been applied quarterly on a country specific level, in order to more accurately reflect relative changes across each country. This means that, in areas of increasing practice populations, growth will be reflected by an increase in practices' payments if their level of growth is greater than the average level of growth across the country.

Pensions
Deductions are made from the global sum directly by the PCO, before the funding reaches the practice, for both employer and employee superannuation contributions at 14% (7% in NI until 1 April 2008 and 15.7% thereafter) and 6% respectively. PCOs deduct the contributions from practices' global sums on a monthly basis and are responsible for paying that money to the Pensions Agency. In Scotland, NHS National Services Scotland undertake these processes on behalf of all PCOs and in Northern Ireland the function is carried out by the Central Services Agency on behalf of the HPSS Superannuation Branch.

Given that the actual amount of superannuation deductions due will not be known until after the end of the financial year, interim deductions will be made by the PCO. The percentage interim deduction should be negotiated and agreed between the PCO and the practice. Most PCOs base the calculation of interim monthly contributions on previous levels of contributions. This is in line with guidance from the NHS Pensions Agency (or its national equivalent).

Once a doctor's profits have been determined by an accountant and certified by the doctor, the actual level of contributions can be calculated. Depending on whether monthly contributions were under- or over-estimated, a balancing payment is either due to the Pensions Agency (or its national equivalent) via the PCO or to the doctor. Balancing payments are due on demand.

The changes to superannuation negotiated under the new GMS contract should apply equally to GMS and PMS practices.

Further information can be found in the GPC guidance note 'Focus on superannuation contributions', which is available on the BMA website: http://www.bma.org.uk/ap.nsf/Content/focuspension0704

Quality and Outcomes Framework (QOF)
QOF payments are divided into both aspiration and achievement payments.

Aspiration payments are a part payment in advance for expected achievement under the QOF. The payments are made monthly, throughout the year, and can be calculated using one of two methods:

- a calculation based on 70% (for 2008/09) of the contractor's previous year's achievement payment; or
- a calculation based on the total number of points that a contractor has agreed with a PCO that it is aspiring towards that financial year.

At the end of each year, practices' achievements against QOF targets are calculated. If an additional payment is required, it must be made by the end of the first quarter of the following financial year. If any money is to be clawed back, this will usually involve deducting one twelfth of the overpaid amount from each of the following year's monthly aspiration payments.

Further details of how both aspiration and achievement payments are calculated can be found in the BMA guidance note 'Focus on QOF payments':
http://www.bma.org.uk/ap.nsf/Content/FocusQOF0207

PMS and Section 17C practices receive 109 fewer QOF points than GMS practices, but the mechanism for their payment should be the same. Further information on how this "offset" is made can be found in the BMA Guidance note 'Personal medical services (PMS) agreements':
http://www.bma.org.uk/ap.nsf/Content/pmsagreements0904~pmsnewgms

Enhanced services
The contract sets out a national minimum expected expenditure (or "floor") for Enhanced Services for each PCO. More information on the Enhanced Services floor and the differences between Enhanced Services in England, Northern Ireland, Scotland and Wales can be found in the BMA Guidance note 'Enhanced services and floors from April 2007':
http://www.bma.org.uk/ap.nsf/Content/esanfloors0407

Enhanced services are optional. There are three different types:

- **Directed Enhanced Services (DES)** which PCOs *must* ensure are provided for patients within their area. The DESs available in each nation can vary depending on health priorities in each nation, but can include services such as choice and booking, flu immunisations, childhood immunisations and minor surgery. PCOs are legally obliged to commission all DESs, some from GP practices, others from a wider spread of primary care providers. Individual practices, however, do not have to agree to undertake this work. Practices receive direct payment for this work and national pricing, terms and conditions apply.

- **National Enhanced Services (NES)** which PCOs *may* seek to commission within their area, include anti-coagulant monitoring, intra partum care, minor injuries, IUCD fitting, drug and alcohol misuse. National pricing, terms and conditions are used as the basis for commissioning.

- **Local Enhanced Services (LES)** are commissioned by PCOs and are *locally negotiated* without national pay rates. They are intended to be services provided in response to specific local needs or innovations that are being piloted. LESs can be used to provide services which exceed those provided by a DES or NES, although the negotiated price should, of course, reflect the additional workload that this would require. They should not be used to provide 'cut-down' DES or NES replacements. In particular, we have become aware that, in an effort to reduce expenditure, some PCOs have sought to abandon all or some of the National Enhanced Services and instead redefine activities such as anticoagulant monitoring as Local Enhanced Services, invariably paid at a lower price. Practices need to be vigilant about this and should always seek help of their LMC in resisting such changes.

Payments for enhanced services are made monthly to practices at the rates determined either by national or local agreement depending on the type of service.

PCO administered funds

Arrangements for payment of the majority of PCO administered funds are outlined in Part 4 of the SFE. These include:

- Payments for locums covering maternity, paternity and adoption leave*
- Payments for locums covering sickness leave**
- Payments for locums to cover for suspended doctors*
- Payments in respect of prolonged study leave*
- Seniority payments
- Doctors' retainer scheme

One asterisk indicates that PCOs in England, Northern Ireland, Scotland and Wales have discretion in the amount payable, and two asterisks indicates that it applies in all UK countries excluding Wales. Note that PCOs are not permitted to have a "blanket policy" on these payments but are required to consider each application on a case by case basis.

Locum cover - Payments for locum cover are dependent on circumstances, practice specific and should be paid as set out in the SFE.

Seniority – Seniority is unusual in that it is earned by individual doctors (e.g. a partner, single-handed practitioner or a shareholder in a limited company that is a GMS contractor) but paid to the practice. The payments reward experience, encouraging senior GPs to remain in post, and are based on the GP's number of years of reckonable service and superannuable income. As seniority payments are made to the practice, the methodology for dividing such payments will ideally be set out in the partnership agreement. Further information can be found in the 'Focus on Seniority Payments' guidance note on the BMA website:
http://www.bma.org.uk/ap.nsf/Content/focussenioritypay

Flexible Careers scheme, retainer scheme and GP returners scheme – In England, direct central funding for new recruits to the FCS and returners schemes has ceased, although practices with such GPs already in post (and who have previous PCO approval and funding) should continue to be funded as per the SFE.

Some funding is available for new GP retainers. Both new and existing retainers should be funded as per the directions in the SFE.

Premises

Premises funding agreed after 1st April 2004 is based on "The National Health Service (General Medical Services – Premises Costs) (England) Directions 2004" (or equivalent). The amount of funding received and the manner by which it is paid varies, but will largely depend on individual agreements reached between practice and PCO within the framework of the Directions.

Further information on how Premises funding is calculated can be found in the BMA guidance note 'Focus on premises costs':
http://www.bma.org.uk/ap.nsf/Content/focusonpremisescosts0104

IM&T

Since April 2004 PCOs, rather than practices, have been responsible for funding the purchase, maintenance, upgrading, running and training costs of IM&T systems. In the past, these costs were reimbursed, rather than funded. Therefore there is no direct funding to the practice for IT purposes. Practices do however have the right to choose which system they use from within a list of approved systems. Practices are responsible for the consumables used in such systems for example toners and inks in printers.

Further guidance on how IM&T systems are funded can be found in the guidance document 'Focus on funding for Information Management and Technology', on the BMA website:
http://www.bma.org.uk/ap.nsf/Content/focusfundingIMT0404

Dispensing

In England and Wales, the mechanism for payment to dispensing practices changed in April 2006. The on-cost and container allowances were abolished, and doctors now receive an enhanced professional fee for each item they dispense.

The Prescription Pricing Division in England calculates the amounts due to doctors in fees and allowances for dispensing and personal administration and these are then paid through the Exeter system. Similar arrangements apply in Scotland, Northern Ireland and Wales.

In Scotland, a mixture of payment arrangements are in place – on cost, where a percentage is added to the purchase price of drugs; a dispensing fee, which is made per item dispensed; and a container allowance, which works along similar lines to the dispensing fee but makes payment per container, rather than per item dispensed.

It is important to note that, from 1st April 2006, the Department of Health will not pay a VAT allowance on dispensed items. This means that dispensing practices must register for VAT purposes with HM Revenue and Customs (HMRC) if they require VAT reimbursements after 31 March 2006.

The exact mechanism for making dispensing payments is set out in Section 17 of the SFE (Section 18 of the Scottish SFE), and guidance on the new mechanism for payments to dispensing practices can be found on the BMA website in Chapter 4 of 'Revisions to the GMS contract, 2006/07: Changing the arrangements for dispensing doctors in England and Wales':
http://www.bma.org.uk/ap.nsf/Content/revisionnGMSFeb20062~chap4dispensing.

Appendix 1 - Explaining your practice statement

Payments in respect of the GMS contract can be confusing, particularly as certain payments can vary each month. The following is an example of a 'typical' monthly statement. As statements of payments to practices vary throughout the UK, this is intended only as a guide. This statement is based on a practice with five partners, a practice list size of 9724 and based in the South of England.

Medical services practice payment, October 2006			
Practice Number: xxxxx Practice Name: Dr A and partners Practice Address: GP surgery			
Payment type		**Payment for service**	**Total payments**
Global Sum Monthly Allocation (GSMA) Temporary Patient Adjustment (TPA)†		44, 503.18 73.22	
Global Sum Monthly Payment (Initial GSMP)			**44,576.40***
Opted-out services Our of Hours Services	Initial GSMP % 6.00	-2,674.59	
Payable GSMP			**41,901.81**
Minimum Practice Income Guarantee (MPIG) Correction Factor Monthly Payment		10,852.34	
			52,754.15
* Detailed information about how the global sum monthly payment is calculated can be found at the end of this statement			
Standard Payments			
Directed Enhanced Services			
Childhood Immunisation – higher rate		1,705.22	
Pre-School Booster – lower rate		200.84	
Minor Surgery		35.52	
			1,941.58
National Enhanced Services			
Drug Misuse – patient maintenance		3,915.77	
Drug Misuse – retainer		250.00	
Near Patient Testing – level 1		404.88	
			4,570.65

† The need for TPA arises because of GPs' obligations to provide emergency treatment to people who are not registered with their practice and to provide treatment to temporary residents. Annex C of the SFE shows how the TPA is calculated.

Local Enhanced Services			
Asylum Seekers		1,605.29	
			1,605.29
Quality Payments			
Aspirational Payment		10,516.91	
			10,516.91
Total Earnings			**71,388.58**
Other payments			
Seniority		4,395.91	
			4,395.91
Total Before Deductions			**75,784.49**
Deductions			
Local levies		73.51	
Employees 6% pension contribution		2156.26	
Employers 14% pension contribution		5031.27	
			7,261.04
Net payable			**68,523.45**
Analysis of SEPTEMBER 2006 Seniority Payment			
Practitioner		**Seniority**	
Dr A		1,130.32	
Dr B		509.61	
Dr C		2,317.80	
Dr D		152.79	
Dr E		285.39	
Practice total		**4,395.91**	

***New GMS practice global sum and correction factor details for quarter 01.10.2006**		
Capitation Data (GP practice)		
Main Surgery Post Code	XXXX XXX	
Raw Practice List Size	9724	
Count of patients registered in the past 12 months	1047	
Patients average distance to main surgery	2744.59643	
Practices population density	13.62275	
Practice count of patients in residential care	86	
Raw practice list size	9724	

Divided by		
PCO raw population current quarter	186265	
Multiplied by		
PCO normalised weighted population current quarter	198381.46225	
Equals		
Practice Normalised List Size	10356.54223	
Multiplied by		
Practice Weighted Index Values (for each of the six criteria)		
Age/Sex Weighted Index	0.96864	
Practice Additional Needs Index	0.95291	
Practice List Turnover Index	1.00734	
Practice Market Forces Index	1.00000	
Practice Rurality Index	1.00309	
Practice Nursing Homes Index	0.99823	
Equals		
Practice Weighted List Size	9642.17907	
Multiplied by		
PCO normalised weighted population current quarter	198381.46225	
Divided by		
PCO weighted list size	197872.86521	
Equals		
Practice Normalised Weighted List Size	9666.96	
Global Sum Annual Payment (based on practice normalised weighted list size of 9666.96)	528,976.19	
Temporary Residents Adjustment	5940.56	
Total Global Sum Annual Payment		**534,916.75**
Divided by 12 equals		
Global Sum Monthly Payment (GSMP)		**44,576.40**

Appendix 2 - Mapping of payments to new contract income streams

1. Basic Practice Allowance 2. Capitation Fees 3. Health Promotion Payments (excluding Chronic Disease Management) 4. Night Visit Fees 5. Night Allowance 6. Contraceptive Services Fees (except Intrauterine Device Fees) 7. Maternity Medical Services Fees (excluding Intra Partum Care) 8. Temporary Residents Fees 9. Deprivation Payments 10. Registrations Fees 11. Minor Surgery Fees (part) 12. Child Health Surveillance Fees 13. Emergency Treatment Fees 14. Immediately Necessary Treatment 15. Anaesthetic Administration Fees 16. Arrest of Dental Haemorrhage Fees 17. Rural Practice Payments 18. Chapter 10.5 Payments 19. Inducement Payments 20. Practice Staff Reimbursements 21. Telephone Fees 22. Vaccination and Immunisation Payments (except Target Payments) 23. Cervical Cytology Payments (part) 24. Primary Care Workforce Review (part) 25. Post-graduate Education Allowance 26. Appraisal and other protected time 27. Employers' and practitioners' superannuation	**To → Global Sum**
1. Designated Area Allowance 2. Initial Practice Allowance 3. Seniority Allowance 4. Assistant's Allowance 5. Associate Allowance 6. Doctors' Retainer Scheme Payments 7. Locum Allowances • Single-Handed Rural GPs • Sickness • Confinement • Prolonged Study Leave • Other 8. Supply of Syringes and Needles and other payments outside the DDRB mechanism 9. Recruitment and Retention 10. Prolonged Study Leave Educational Allowance	**To → PCO Administered Funds**
1. Primary Care Modernisation Fund • Access • Improving Primary Care Incentive Scheme 2. Changing Patterns of Services Delivery 3. Local Development Schemes	**To → Enhanced Services**

4. Maternity Medical Services Intra Partum Care Fees 5. Intrauterine Device Fees 6. Influenza Immunisation Payments 7. Minor Surgery Fees (part) 8. Childhood Immunisation Payments 9. Pre-School Booster Payments	
1. Chronic Disease Management Allowances 2. Sustained Quality Allowance 3. Cervical Cytology Payments (part)	**To → Quality**
1. Rent Payments (includes Rent, Notional Rent, Rent Allowance and Cost Rents) 2. Rates 3. Health Centre Rent and Rates 4. Improvement Grants 5. Premises Expenditure (historical spend)	**To → Premises**
1. Computer Costs • Purchases • Leasing • Upgrading • Maintenance • Training 2. Initial Staff Costs	**To → IM&T**
1. Dispensing Payments 2. Personally Administered Items Payments	**To → Dispensing**