FOCUS ON…
PERSONAL MEDICAL SERVICES

This guidance note has been produced by the General Practitioners Committee to help GPs and Local Medical Committees react to the effects on PMS practices of the new GMS contract, and is one of a series of guidance notes on the new contract. The guidance will be updated as a result of any changes made throughout the implementation process. We would advise all GPs, including those in PMS practices, to read the contract document and supporting documentation, available on the BMA website at www.bma.org.uk. The GPC has produced a list of frequently asked questions and answers which can also be found at the website address.

Subject to legislative change, PMS schemes will cease to be pilots from 1 April 2004 and PMS will become a permanent contractual option. Wave 5 B is therefore the last pilot. From 1 April 2004 there will be no national deadlines for PMS applications. Instead practices will deal directly with their PCT or SHA. There will be no further central growth money funding for PMS initiatives. Any growth money, whether it be for PMS or GMS, will have to be found locally.

The Department of Health has produced detailed guidance for providers, PCTs and StHAs on changes in PMS – *Sustaining Innovation through New PMS Arrangements*. It is available at

http://www.doh.gov.uk/pmsdevelopment/guidance.htm

References to the relevant sections of this guidance are given in the text below.

NEW GMS AGREEMENTS THAT WILL APPLY TO PMS

- PMS and GMS GPs will have **comparable access to the increase in investment in primary care** of 33% by 2005/06. This level of investment is guaranteed by the Gross Investment Guarantee. (Sustaining Innovation – page 4)
- PMS GPs will be eligible for the **same improvements to pensions** as GMS GPs. (Sustaining Innovation - pages 20-23)
- **Out-of-hours opt-out** will apply to PMS. The price will be calculated on the basis of £6,000 per average GP, adjusted for list size (Sustaining Innovation, page 18)
- They will also receive the **same increases in seniority pay.** This was included in the 3.225% DDRB increase. (Sustaining Innovation – page 20)
- PMS GPs will receive **the same changes in HR improvements, IM&T and premises flexibilities** as GMS GPs (Sustaining Innovation – pages 23-29). See also GPC guidance Focus on funding for IM&T and Focus on Practice Premises.
- PMS practices will have **access to equivalent funds for improving quality.** (Sustaining Innovation – pages 30 to 67)
- PMS practices will have access to **enhanced services funding** on a equitable basis to GMS practices (Sustaining Innovation – page 73)

QUALITY

PMS practices will be able to use the new GMS Quality and Outcomes Framework (QOF) to achieve their quality payments, but local variations to address local circumstances will be possible. Any locally agreed changes must be evidence-based and offer equivalent value for money as the QOF. We would advise that, initially, to access their fair share of the QOF money, it is likely to be easier for PMS practices to follow the GMS QOF. Furthermore, software suppliers are producing IT programmes to support the new GMS QOF and it will be simpler to use this rather than having to adapt it to deal with local variations.

PMS practices will have access to the same level of new investment in quality as GMS practices. However, in order to avoid double payment, this will mean that an allowance has to be made for money that, in GMS practices, has been carried forward from SFA to the GMS quality framework, such as the Sustained Quality Allowance and Chronic Disease Management payment.

The DoH guidance, *Sustaining Innovation through New PMS Arrangements*, devotes an entire chapter to the application of the GMS QOF to PMS. It is too lengthy to reproduce here. Practices should consult that guidance. However, below are some important points of principle for PMS practices to be aware of:

- All PMS quality schemes should use a points system, totalling 1050 points, to ensure comparability with GMS quality achievement as measured by the QOF.
- There will be a reduction of points from PMS practices overall quality points scores to reflect quality payments already in PMS baselines. Based on existing financial information, the Department of Health has assessed this to be approximately **196 points** (in 2004/05). (This figure may change after the latest PMS baseline financial information has been analysed and will reduce to about 122 points in 2005/06).
- Variations from the national framework to reflect local priorities should be possible. Some forms of local variation are suggested in section 4.3 (page 36) of the DoH guidance.
- If PMS practices take part in the national QOF, their quality payments will be adjusted by prevalence as in GMS. The methodology is described in sections 4.17 to 4.19 of the DoH guidance.
- The Interim Aspiration Utility used by GMS practices to prepare for participation in the QOF is being made available to PMS practices also participating in the national framework.

FINANCE

Growth money

- Existing PMS baselines, including any growth monies awarded during the piloting process, will be retained. That growth money will no longer be tied to personnel and practices will be able to use it flexibly.
- From 1 April 2004, there will be no central fund for PMS growth money. Any additional funding, including for premises flexibilities, will have to be delivered through the unified budget.

Allocations to PCTs

- The PMS element of the PMS/GMS allocation to PCTs will be based on the 2003-2004 allocations for waves up to and including 5b and uplifted to 2004-2005 prices.
- Unspent PMS allocations will no longer be clawed back in year.

MOVEMENT BETWEEN GMS AND PMS

PMS practices will retain their right of return to GMS, but after 1 April 2004 this will be changed to a right of transfer between PMS and GMS on a whole practice basis rather than as a right for individual doctors.

There is a commitment to fair financial arrangements on transfer to GMS and so there will be protection of aspects of PMS practice's income. However, it may not be possible to calculate an Minimum Practice Income Guarantee (MPIG) for PMS practices in the same way as for GMS GPs, as

GMS MPIG is based on former Red Book payments, which PMS practices no longer receive. The greater the length of time since a practice transferred to PMS, the more difficult this will be.

However, the English Department of Health has suggested that PMS practices can make a case to the PCT for an MPIG equivalent. It suggests that this could be based on local data (which the practice would be expected to provide) on payments for global sum equivalent items that they may have available for the pilot and a national average calculation based on PMS earnings and global sum equivalents. The national average will be used as a benchmark to establish an MPIG. The DoH guidance provides different benchmark prices per patient for different list-size ranges because "current global sum equivalent income per patient is not linear with respect to list size".

PMS growth monies will not automatically form part of global sum equivalent calculations for practices moving to GMS. PCTs may be able to retain this money to spend on PMS or GMS depending on where they see the priorities. However, we have obtained agreement that, where practices can demonstrate that growth monies have been used to fund the equivalent of essential or additional services, PMS practices should be able to retain some or all of these funds.

SPECIALIST PMS

From 1 April 2004, PCTs can agree specialist PMS contracts with providers. Specialist PMS will be directed primarily at vulnerable groups whose health needs are not adequately met by GMS and PMS. It could also be used to extend the range of services delivered in primary care and to provide out-of-hours services.

Examples of specialist PMS providers could be existing or new PMS practices, groups of clinical practitioners from secondary and/or primary care or any GPs providing specialist care to patients that are not registered with their practices.

Examples of vulnerable groups with unmet needs could be older people living in care homes, people with learning disabilities, the homeless and children in care.

More detailed guidance on specialist PMS will follow.

A further innovation in PMS will be practice-led commissioning. DoH guidance on this will be published shortly.