Gateway Ref: 14380

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To: SHA Directors of Commissioning
SHA Primary Care Leads

Copy: SHA Directors of Finance

8th June 2010

Dear Colleagues

DOCTORS' & DENTISTS' REVIEW BODY (DDRB): DISTRIBUTION OF THE AWARD FOR GENERAL MEDICAL SERVICES CONTRACTORS 2010-11

1. My letter of 29th March (Gateway reference 14090) set out the previous Government's response to DDRB's recommendations on General Medical Practitioners (GMPs).

2. In response to DDRB's recommendations, the Department proposed a level of gross uplift which will achieve the intended effect of no increase to GMP contractors' average net income, but after assuming an efficiency saving of 1% of practice expenses. We rounded the resulting uplift to one decimal point, which gave an overall gross uplift of 0.8% for GMS contractors.

3. DDRB recommended that the negotiating parties should have further discussions on the question of how to distribute the overall uplift between different types of contract payments. This letter sets out the final decisions on uplift following those discussions.

Distribution of award

4. The negotiating parties have agreed to apply the formula recommended by DDRB, namely:

   - half of the overall gross uplift to contract payments will be applied to the following five elements of the GMS contract, in proportion to their current relative spend: global sum; correction factor; Quality and Outcomes Framework; enhanced services; and locum payments;
   - the other half of the overall gross uplift will be applied only to global sum payments with no corresponding increase to correction factor payments;
   - released correction factor payments - through corresponding reductions in the Minimum Practice Income Guarantee (MPIG) - will be reinvested back into the global sum, further uplifting global sum funding and reducing the number of practices on MPIG;
   - there will be no uplift to seniority payments.

5. The GMS Statement of Financial Entitlements will now be updated accordingly, with the changes backdated to 1st April 2010.

6. The more detailed effect of these changes will be as follows:

    a. every GMS practice will receive a national minimum uplift of 0.41% to their Global Sum Equivalent (i.e. global sum payments including protected income levels under MPIG);

    b. a further 0.41% uplift will be applied to Global Sum payments. After also reinvesting savings in correction factor payments, the price per weighted patient used in the Global Sum calculation will increase from £63.21 in 2009-10 to £64.59 in 2010-11 (an increase of around 2.2%);

    c. the value of Quality & Outcome Framework points will increase by 0.41% from £126.77 in 2009-10 to £127.29 in 2010-11;

    d. there will be an increase of 0.41% in Enhanced Services payments.

Implications for PMS practices

7. Whilst the agreement applies to GMS contracts, we are committed to ensuring an equitable approach for PMS and other local Primary Medical Care contracts. While the PMS and APMS contracting arrangements provide PCTs with flexibility in commissioning services, PCTs need to be able to demonstrate that funding decisions between all primary medical care contractors are fair and equitable and represent value for money.

8. Given the differential effect of the DDRB award on GMS practices, as described above, PCTs will wish to consider the implications for PMS practices on a case-by-case basis, with specific reference to the contractual agreement the PCT has with that practice.

9. Most PMS practices have baseline funding that is based on historic GMS income. This is analogous to the effect of MPIG in GMS. In addition to this baseline funding, PMS practices often receive 'growth' funding.

10. For these reasons, applying an uplift to PMS practices (in an equitable way to that applied to GMS practices) may more typically result in PMS practices receiving a percentage uplift to their core funding that is comparable to the minimum uplift for GMS practices, as opposed to the higher uplifts for GMS practices with no MPIG or low levels of MPIG.

11. We anticipate that increases in payments in respect of QOF achievement and delivery of enhanced services are likely to mirror GMS arrangements.

Implications for Enhanced Services

12. There are three types of Enhanced Services:

    a. Directed Enhanced Services (DESs), where service specifications are agreed nationally;

b. Local Enhanced Services (LESs), which are commissioned by PCTs to meet local health needs; and

c. National Enhanced Services (NESs), which are commissioned by PCTs to national specifications and benchmark pricing to meet local needs.

13. The Department of Health will increase DES payments in Part 3 of the Statement of Financial Entitlements (SFE) by 0.41%. It is for PCTs to consider the implications of the DDRB recommendations for other Enhanced Services on a case by case basis. All other things being equal, we would anticipate that PCTs will wish to increase prices in line with the 0.41% increase being applied to DESs in Part 3 of the SFE. However, PCTs are responsible for ensuring value for money from the services they commission and will need to consider with local practices the pricing of individual commissioned services.

14. There are other payments, outside the scope of the SFE, for the Influenza and Pneumococcal Immunisation Scheme, Violent Patients Scheme and Minor Surgery Scheme which are set out in directions 10, 11 and 12 of the 2010 DES Directions. We would encourage PCTs to uprate payments under these particular Directions by 0.41% in line with the approach to the DESs in Part 3 of the SFE.

Conclusion

15. You may wish to share this letter with PCTs in your area, so that they can begin to take forward discussions with PMS practices and practices that provide locally commissioned Enhanced Services.

Yours sincerely

BEN DYSON
Director of Primary Care