RCN Policy and International Department
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Personal Medical Services – proposed contractual changes

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Introduction and background

The Department of Health is consulting on proposed changes to primary medical care contractual arrangements which will impact on Personal Medical Services (PMS) contractors from April 2013.

The PMS is a locally-agreed alternative to the General Medical Service (GMS) contract for providers of general practice. Legislation has allowed for PMS contracts since 1997. Unlike the GMS contract, they are directly negotiated between the responsible commissioning organisation and the individual contract holders, and are not subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the BMA. Responsibility for PMS contracts will move from PCTs to the NHS Commissioning Board (NHS CB) from April 2013 as part of the current NHS reforms.

The RCN has been formally approached by the Department of Health to comment on the proposed changes to the PMS contract in England because there are a number of PMS contract holders who are nurses. We welcome the opportunity to respond and to pass on our members' views. In our response we would also like to reflect the views of our members who work as practice nurses or work in primary care more widely.

The consultation will run until 26 February 2013, after which the Secretary of State will consider all responses and take a decision on the final content of the PMS and GMS contracts for 2013/14.

What are the proposed changes to the Personal Medical Services contract?

The Department of Health has stated that the proposed contract changes are intended to maintain current levels of investment in general practice, whilst promoting continuous improvement in the quality of services. Significantly the proposed changes to the PMS contact are taking place within at the same time as proposed wider changes to the GMS contract, and some changes affect both types of contract. However members should be aware that this consultation briefing relates to the PMS contact only. The key changes being proposed include the following:

1. Securing equitable funding: 2014/15 and beyond

The Department of Health would like to change the PMS and GMS payment structures so that all contract holders are paid for core GP services using the same system. This core funding is calculated based on the size and make up of practices' patient lists, and takes into account age, needs and factors like rurality, but different methods are currently used for GMS and PMS practices. The Department of Health is proposing to implement one funding formula to calculate the amount a practice receives per patient. This would be phased in over a seven-year period beginning in April 2014, to reduce the impact that this may have on those practices which will see a drop in income.

Key questions

- Do you believe that the core funding for practices is fairly distributed at the moment? Do you agree with the Department of Health's proposals?
- Do you think that the funding practices receive should be based primarily on the age profile of the populations they serve, or do you think that factors like deprivation and needs are more important?

2. Application of Contract Uplift: 2013/14

The increase in the value of payments made to contractors will be decided by the Department of Health, taking into account recommendations from the Doctors and Dentists Review Body (DDRB), and is not part of this consultation. The Department of Health has said that they are committed to treating independent GP contractors like other public-sector funded staff, so would like to deliver a 1% pay increase.

The Department of Health is consulting, however, on the way that the "extra" money from this annual contract uplift will be distributed between practices. If a 1% increase is given across the board, those practices which have higher funding levels per patients will receive more than those who receive less per patient, exacerbating any inequalities in the system. The Department therefore proposes to apply any uplift partly to all practices, but with a higher uplift to practices with lower core funding. This would narrow the existing funding gap between practices, while providing some uplift to all practices.

Key questions

- Do you support giving more of this year's contract uplift funds to practices with lower core funding levels, or do you think the funding should be distributed evenly?
- Are you concerned about the pay and grading of practice nurses in the current economic climate? How do you think that the proposed 1% uplift and its redistribution would affect this?

3. Changes to the Quality and Outcome Framework

The Department proposes to make a number of changes to the Quality and Outcomes Framework (QOF) in order to secure further health improvements for patients. In summary these are as follows:

- Implementing all the NICE recommendations for changes to QOF aimed at improving patient care.
- Raising the upper thresholds for existing indicators to reflect the current achievement of the 75th centile of practices. Since the introduction of QOF, the average achievement of practices has increased, and the Department of Health believes that increasing the upper threshold will encourage practices to improve patient care even more. In order to make sure that the workload for practices is manageable, a phased approach is proposed, with an increase to threshold levels applied to 20 indicators in 2013/14 and the remaining indicators in 2014/15.
- Setting up a public health domain within the QOF, as originally proposed in the 2010 Public Health White Paper. All the existing indicators relating to screening, case-finding, the prevention of disease and lifestyle interventions will be moved into this domain. In the future, any changes to these indicators will need to be agreed by both the NHS CB and Public Health England.
- Retaining for a further year the Quality and Productivity (QP) indicators that reward practices for work to reduce unnecessary emergency admissions, referrals and A&E attendances by improving care for patients.
- Removing the remaining organisational indicators (e.g. record keeping and staff training) that are not retained in QP or moved into the Public Health Domain. The Department of Health believes that these represent basic organisational standards that all practices should adhere to as part of their CQC registration (which is being introduced for GP

practices from April 2013), so are now inappropriate to include in QOF. The money released would be used partly to fund the NICE recommendations and partly to invest in a new Directed Enhanced Service that will be offered to all GP practices.

- Removing the current overlap of QOF years by reducing the time period for most indicators from 15 months to 12 months, or from 27 months to 24 months. These extra three month periods were added on when QOF was first introduced to allow practices more time to achieve their indicators, but now effectively allow practices to be paid twice for processes carried out between January and March, or to carry out annual health checks on patients less than once a year and still get paid the same. The Department of Health sees this as a loophole which a move to an annual time frame would remove.
- Changing the list size weighting (Contractor Population Index) which governs the amount given to each practice per QOF point based on the number of patients they have. At the moment this is based on the average practice list size from 2002. The Department of Health wants to update this so that each year from 2013/14 it will be based on an up-to-date figure, which they believe will make the way that QOF points are priced more transparent. This will be a cost neutral change in 2013/14.

Key questions

- Do you believe that the upper thresholds for QOF indicators should be increased? Do you think this will cause difficulties for practices with challenging patient populations, or do you think this will encourage better care? Are you concerned that this will result in a significant increase in workload?
- Do you think that organisational indicators should be removed from QOF? Are you concerned that this would have a detrimental impact on training, or would it make no difference?
- Do you think that a new public health domain within QOF is a good idea?

4. New Directed Enhanced Services

Directed Enhanced Services (DESs) are services that practices can “opt-in” to in addition to core general practice work. The responsibility for developing them will move to the NHS CB from April 2013. The Department of Health are consulting on four new DESs that will be offered to practices that would be developed by the NHS CB in detail in conjunction with stakeholder groups. It is proposed that the money to pay for these will come from savings made by ending the organisational indicators in the QOF. The four new DESs proposed are:

- **Risk profiling and care management** – encouraging practices to coordinate and manage the care of frail older people and other high-risk patients through identifying those at risk and instigating case management. The proportion of patients to be supported in this way by each practice would be agreed locally to take into account the needs of the their patients.
- **Case finding for patients with dementia** – rewarding practices for proactively assessing high-risk patients so that dementia can be diagnosed in the early stages.
- **Remote care monitoring** – encouraging practices to remotely monitor people with long-term conditions to reduce unnecessary attendances at the practice. The Department of

Health would like to focus on the care of those with hypothyroidism for the first year, and then extending this to other patient groups later based on local priorities.

- **Improving online patient** – rewarding practices that improve patients' online access to services, including booking appointments, ordering repeat prescriptions, medical records, and test results.

Key questions

- Do you agree that the proposed new DESs should be priority areas for primary care? Are there any other areas that you think should be a priority?
- Do you think that there are enough resources available to practices and community services to achieve the aims of the new DESs?

How does this consultation impact on nursing?

Many nurses will have an interest in the delivery of primary care, particularly those involved with commissioning primary care services and those working as nurses within individual PMS practices. Significantly nurses are permitted to become partners within a PMS practice or form their own limited company, as long as at least one GP is a signatory on the contract. As contract holders, these nurses will have an interest in all the proposed changes as they affect the ways that funds are distributed to practices and the way that they earn income.

Practice nurses provide specialist roles in the fulfilment of many aspects of the current general practice contracts (in both the GMS and the PMS contracts) as well as QOF (for example immunisation, cervical screening, minor illnesses and chronic disease management). The proposals to increase the thresholds for many QOF indicators and the introduction of the new DESs could increase the workload for practice nurses.

Tell us what you think?

This briefing is intended to provide a brief overview of the consultation, and the RCN would like to receive comments/feedback from as many members as possible on the PMS consultation. Please send your thoughts on the key questions in this document and any other wider comments to Stuart Abrahams, Policy Advisor on stuart.abrahams@rcn.org.uk by 12 February 2013.

We are particularly interested to hear from members working within PMS practices.

More information

- The changes to the GMS contract have been summarised on the Department of Health website: http://gp.dh.gov.uk/2012/10/30/gms-contract-proposals/
- Information on the existing PMS contract is available on the Department of Health website: www.dh.gov.uk/health/tag/pms-contract/