North Yorkshire County Council

Scrutiny of Health Committee

8 November 2013

Minimum Practice Income Guarantee

Purpose of Report

1. This report provides an opportunity for the Committee to be updated on how NHS North Yorkshire and Humber (NHS NY&H, the local area team of NHS England) will manage the withdrawal of the Minimum Practice Income Guarantee (MPIG) locally.

Introduction

2. MPIG was introduced to top up GP practices' core funding to match their basic income levels when the New General Medical Services (nGMS) contract was introduced in 2003/04. The Department of Health has announced it is phasing out MPIG over the next years 7 starting from April 2014.

3. Some rural practices in North Yorkshire have indicated that they may have to close surgeries because of the loss in income – in some cases calculated at £78,000pa.

4. A briefing paper on MPIG is attached as APPENDIX 1.

5. Withdrawal of the MPIG is part of wider proposals by NHS England to change the way that general practice services are commissioned and provided. The aim of NHS England is to enable general practice to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

6. As part of the wider "Call to Action" that NHS England launched in July 2013 each local area team of NHS England is leading a debate in local communities – amongst everyone who works in general practice (including partnered and sessional GPs, practice nurses and practice managers), Clinical Commissioning Groups, health and wellbeing boards and other community partners – as to how best to develop general practice services.

7. Dr Geoff Day (Head of Primary Care, NHS NY&H) will be attending the meeting to provide more information and to respond to Members' questions. Members will wish to explore with him how the specific problems of GPs and communities in rural areas will be taken into account in the planned changes.

8. It should be noted that County Councillor John Blackie as Leader of Richmondshire District Council was part of a delegation who met with the Rt. Hon. Jeremy Hunt MP and the Rt. Hon. William Hague MP on 23 October 2013 to discuss healthcare in the rural areas of North Yorkshire. From Councillor Blackie's report of that meeting Jeremy Hunt readily accepted the concerns expressed by rural GP practices over the planned withdrawal of MPIG and that the issue must be dealt with in the discussions his Department is having with the BMA over a new GP contract.

Recommendations

9. That Members offer comment and advice on how the withdrawal of MPIG should be managed as part of the wider review of GP contracts with a view to ensuring that the proposals improve access to GPs and primary care services as envisaged.

10. That Members seek an assurance that this Committee will receive regular updates on the development of the proposals and how the changes will be rolled-out.

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Scrutiny Team Leader
County Hall, NORTHALLERTON

30 October 2013

Background Documents: None

APPENDIX 1

Minimum Practice Income Guarantee (MPIG)

The minimum practice income guarantee (MPIG) was introduced in 2004 as part of the transition of General Medical Services (GMS) to new contractual arrangements and was introduced as a way of smoothing transition into new ways of working. The MPIG itself was developed through national negotiations between NHS employers, acting on behalf of the Department of Health and the British Medical Association, General Practitioners Committee.

Funding pre 1st April 2004

Prior to the introduction of the new General Medical Services (nGMS) contract in 2004 GPs practice income was determined through a large number of items of service payments and fees and allowance all set out within the "Red Book" as such a practice received elements of funding based on the number of GP partners they had, the number of patients on their list and the age profile of those patients, payments for patients living within deprived areas and allowances for patients living in rural areas. In addition to this they received items of service payments for a wide range of interventions including for example minor surgery procedures carried out, recalling patients on contraception for an annual review, running Chronic Disease management clinics and hitting vaccination and immunisation targets
In addition to the fees and allowances above they received reimbursement of staff salaries, usually up to 70% of the cost.

Therefore a practices income was determined by their ability to maintain and grow a registered list and their ability to accurately record and claim for a wide range of fees and allowances.

Practices had a responsibility for their registered patients 24 hours a day 7 days per week.

Funding post 1st April 2004

The basic premise of the new funding regime was that practices would be freed from the bureaucracy of form filling and be paid a Global Sum of money, based on the Carr-Hill formula which had been developed to take into account a wide range of demographic factors that affected demands on primary medical care. For a detailed explanation of the formula visit the NHS Employers website. The formula takes into account additional factors such as rurality and makes allowances for this with the global sum calculation.

In addition to the Global Sum practices can choose to deliver a range of additional services and take part in the Quality and Outcomes Framework (QOF) to generate additional revenue for the practice.

Practices can choose to opt out of providing out of hours services to their patients for which 6% deduction is made from the global sum. Practices opting out have responsibility for their patients from 8am to 6.30pm Monday to Friday excluding Bank Holidays.

Transition into the nGMS contract

As part of the negotiations around the move to the nGMS contract an agreement was reached that practices would receive MPIG to top up to their global sum payments to match their income levels before the nGMS contract was introduced. Payments made under MPIG are called correction factor payments.

In 2006/07 NHS Employers and the GPC agreed that any future uplifts to the global sum should aim to reduce practice reliance on correction factor payments, to ensure a fairer allocation of resources across practices.

Reductions in MPIG payments have been offset by an increase in Global Sum payments.

Moving Forward

The future of MPIG has been subject to discussion between the British Medical Association (BMA) and NHS Employers for some time. The intention is to move to a common capitation price based on current average expenditure on "global sum" payments, correction factor payments paid under the Minimum Practice Income Guarantee (MPIG) and comparison to the basic elements of PMS funding. This common capitation price would be applied to both core contract types, General Medical Services (GMS) and Personal Medical Services (PMS) over a seven year period.

It is intended that the funding formula would take into account the number of patients served, weighted for a range of demographic factors that affect patient need and practice workload.

The guidance on how this will be undertaken across the respective Area Teams within NHS England is in the process of being developed. However what is important to emphasise is that the proposal will include a specific undertaking to include GMS contractors where MPIG forms a significant proportion of practice income. To this effect the Area Team will be liaising closely with these practices over the coming months to ensure we have a full understanding of the financial position and likely impact for these practices and the services that they provide. This will be used to inform the disaggregation process to progress towards establishing equitable payments.

Whilst we recognise that over the 7 years the "MPIG" will no longer be a recognised element of funding for general practice the changes to the national capitation formula should ensure that the practice receives a level of funding that is equitable across the country for its patient numbers and demographics. The Area Team will be taking a pro-active role in shaping the revisions to the formula and will be seeking to ensure that the specific issues faced by rural practices are accurately reflected in the formula.