

**TO:** West Gloucestershire Primary Care Trust Board  
**FROM:** Mike Theelke, Director of Finance  
**DATE:** 14<sup>th</sup> July 2005  
**SUBJECT: PROCESS FOR POTENTIAL TRANSFER OF PMS PRACTICES TO THE nGMS CONTRACT**

## **1.0 PURPOSE**

To provide a framework within which Personal Medical Service (PMS) practices in West Gloucestershire can exercise their right to transfer to the new GMS contract.

## **2.0 BACKGROUND**

In October 2002 11 practices became Personal Medical Service (PMS) Pilots and a further practice took up this option in April 2003. When the new GMS (nGMS) contract was implemented in April 2004 the PMS contract became permanent but a PMS practice can exercise its right to transfer to the nGMS contract under certain conditions. The PCT needs to provide a framework within which to do this. This process requires both a clear decision making process and timescales.

In West Gloucestershire there is very little difference in the way that GMS and PMS practices provide services.

This report was discussed and approved by the Professional Executive Committee (PEC) in May 2005 and shared with the PMS practices.

## **3.0 INTRODUCTION**

The Department of Health published revised guidance in 2004 on the new PMS arrangements. (Sustaining Innovation through New PMS Arrangements -18.3.04). This includes two relevant pieces of guidance on the financial aspects of a potential transfer.

- 1) 'A PMS practice that wishes to transfer to a GMS contract does not have entitlement to a Minimum Practice Income Guarantee (MPIG). However, where a PCT wishes to exercise its discretion a calculation of MPIG can be achieved using arrangements set out in the guidance'.
- 2) Where existing PMS Schemes have received growth, the reasons for receiving it should be examined – it may still be entirely legitimate for the provider to receive it within its GMS allocation or under a locally enhanced service agreement. Any growth that is not transferred is retained by the PCT for investment in Primary Care.

#### 4.0 DISCUSSION

4.1 As noted above, in West Gloucestershire there appears to be very little difference in the way that PMS and GMS practices provide services and a number of PMS practices would wish to transfer to GMS if there was no financial disadvantage in doing so. In addition the PCT administers the two different frameworks, which is implicitly more onerous than administering one.

4.2 A PMS contract does offer opportunities to a PCT to develop local approaches to meeting needs and raising standards of service. However it does need an investment of time by the PCT to achieve this and to date this has not been a priority area for the PCT given other demands on time.

#### 4.3 Growth Monies

When PMS practices applied for PMS status they received additional growth monies to provide additional clinical support to the practice. Practices were required to submit detailed plans for approval of how they would spend their growth monies before they could be released.

#### 5.0 OPTIONS FOR A FRAMEWORK TO TRANSFER FROM PMS TO NGMS

We believe that there are four options which the PCT could offer as a basis for practices to transfer to nGMS.

1. **To transfer the PMS baseline excluding growth monies to the practice without an MPIG.**
2. **To provide practices with an MPIG on the current PMS baseline excluding growth monies.** The pooled growth monies would remain part of primary care funding and former PMS practices would be entitled to offer to provide enhanced services with this funding. This would provide some protection to practice income in line with GMS and maintain the flexibility of organizations to continue to develop services local to practice populations. This fits well with culture that was intended to underpin PMS when the concept was developed.
3. **Not to provide an MPIG on PMS baseline funding excluding growth, and to pay practices the growth monies as a recurrent adjustment.** This would be based on plans being submitted to the PCT demonstrating that the money provides additional health gain to the practice population. This would enable practices to retain the growth monies on the assumption that the PCT is satisfied that they are used to deliver additional health gain to the local population.
4. **Practices are offered an MPIG on both the growth and baseline funding.** This does not fit well with the national guidance.

**6.0 RECOMMENDATION**

The PCT proposes that (2) is the most equitable option and fits best with national guidance and provides greatest equity across primary care.

**7.0 PROCESS**

- 7.1 Where practices request a transfer from PMS to GMS the practice will be asked to formally request a comparative value under the new GMS contract. The practice will be responsible for taking the necessary financial advice in reviewing the information and coming to a decision.
- 7.2 The PCT will commit to providing the analysis and meeting with the practice within one month of receipt of the request.
- 7.3 The practice will formally notify the PCT within 1 month of meeting with the Practice to review comparative figures whether it wishes to proceed with the transfer.
- 7.4 The PCT will review the financial impact of the change and agree a transfer date based upon the ability to agree any additional funding within the financial planning envelope. The PCT will provide a final decision and transfer date, if appropriate, to the practice within 1 month of receiving formal notification that the practice wishes to proceed with the transfer.
- 7.5 There will be a separate process for reviewing the potential to provide a Locally Enhanced Service.

**8.0 RECOMMENDATION**

The Board is asked to:

- Adopt option 2 above as a basis for practices transferring from a PMS contract to a nGMS contract
- Agree the process for transferring from the PMS to nGMS contract.