Removal of the Minimum Practice Income Guarantee (MPIG)

1 Background

1.1 There has been much recent media coverage and some parliamentary debate about changes to the Minimum Practice Income Guarantee (MPIG) which could potentially have a significant impact (defined nationally as more than an average reduction greater than £3 per weighted patient population over each of the seven year transition programme) on around 98 GP practices across the country. 34 of these are in London, which equates to around 2% of the total number of practices in the capital.

1.2 This paper provides some background information about the changes, along with an outline of the steps we have taken thus far to support practices as the MPIG will be slowly phased out.

1.3 GPs are independent contractors and their practices are independent businesses. The NHS has no jurisdiction in terms of a decision to remain in business or to close the practice essentially for commercial reasons - that remains the concern of an individual practice. GP income derives from a number of different sources external to NHS England (which would typically include Local Authority, CCG).

1.4 General practice is the bedrock of the NHS in London and is crucial to wider plans to transform healthcare in the capital. We are committed to supporting the capital's family doctors through these changes.

2 What is the MPIG?

2.1 The introduction of the General Medical Services (GMS) contract in 2004 presented a significant change to the way GPs are funded. It moved GP funding away from payment tariffs for each individual item of treatment to a new funding formula based on a wide range of patient, environmental, workload and workforce characteristics. Under the GMS contract, practices receive a share of a total amount of money allocated towards primary care in GMS practices – known as the 'global sum'. The global sum makes up the majority of the money a practice receives. This amount is calculated based on a formula relating to the characteristics of a practice's patients and the subsequent workload created - which are based on numbers of patients and key determinants of practice workload, such as patient age, health needs and the unavoidable costs of rural practice (not an issue in London). This is known as the Carr-Hill formula.

2.2 The national contract changes made in 2004 meant that a number of practices would face a drop in income. In order to smooth the transition between the old and the new contracts, the Minimum Practice Income Guarantee (MPIG) was introduced as a measure to protect the previous income levels of those who were liable to lose money under the new system. It has been in payment for 10 years.

2.3 Practices that gained under the transition to the new contract in 2004 did not receive MPIG.

3 Phasing out the MPIG

3.1 The MPIG was always intended to be a temporary measure or 'stop-gap' funding, which would give practices time to adjust their finances to the new system. It was never intended to be a permanent feature of GP contract income as it was anticipated that it would phase out over time naturally as GP incomes rose.

3.2 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.

3.3 Two years ago, it was announced to GPs that MPIG would be phased out over a 7 year period. This change started in April 2014 - allowing time for practices to adjust to its gradual withdrawal.

3.4 The changes are part of a national policy to bring all practices into an equal financial position, which will ensure that all patients can expect the same high level of service from their GP wherever they live. At present, practices serving similar populations may be paid very different amounts of money per registered patient. In London's GMS practices based on 2012 list sizes, there was a significant range of funding per head of weighted capitation ranging from c£130 down to c£73 (after removal of the extreme outliers with very low lists). That is not equitable or sustainable.

3.5 There is a national review working group underway looking at the Car Hill formula with changes expected around deprivation factors, anticipated from April 2015. This is a major, complex piece of work and has already slipped from an expected operational date of April 2014. An explanation of the current construct of Carr Hill is available at the following site:

http://www.gpcwm.org.uk/wp-content/uploads/file/INVESTING%20IN%20GENERAL%20PRACTICE/Annex_D_Carr_Hill_resource_allocation_formula.pdf

4 Some other contractual issues

4.1 The culmination of a number of other contractual matters or changes is having a combined impact in some places in GP services. Aside from the MPIG removal, these other issues include:

- Changes in (Quality and Outcomes Framework (QOF) payments in 2013/14 resulting in an apparent drop in income last year
- Changes in QOF 2014/15 – retiring QOF indicators will be reinvested in global sum nationally not locally – (NHS England London Region said to be over target therefore the money will not be re-invested here)
- New 2014/15 DES schemes to be created as a result of changes in funding were not ready to start from April 1 2014 (they are now)
- An effective and on-going list maintenance programme is in place across London as part of the Quality, Innovation, Productivity and Prevention (QIPP) programme
- Reductions in all areas previously funded under the category 'discretionary funding' (e.g.
- locum payments through sickness)
- General trends in increasing workload/demand (although some of this may be funded through CCG developed local initiatives)
- Public health teams and Clinical Commissioning Groups putting the services, previously
- described as 'local enhanced services', out to tender or decommissioning them – reducing practice income and/or their ability to plan sensibly

4.2 However, related to the MPIG withdrawal, there are some issues where it could be argued that the Carr-Hill formula does not reflect the workload of London's GPs in some areas:

- Patients who attend the practice up to 12 times a year rather than for the 3.5 or 5.5 appointments per patient per year that are frequently used as a national benchmark figure
- Practices with a very high turnover and patients with no English or English as a second language which means generally booking double appointment slots

- Anecdotal reports of increased attendance of patients who are struggling to cope with the impact of national/Local Authority changes to benefits.

5 The Impact on London's GMS Practices

5.1 NHS England has chosen not to identify specific practices and the associated impact of these changes. Some practices have chosen to identify themselves through their efforts to lobby for change. That is their prerogative.

5.2 Amongst the 34 significant outliers in London 4 of these are in City & Hackney - but 2 of these have a list lower than 1000 weighted population.

5.3 It is not possible to find a generalization as to why the impact should be more significant in some areas rather than others. The construct of Carr Hill is very likely to have an impact in some places because of demographics, deprivation etc. It is important to remember that MPIG was introduced as a bridge between an old, fee for service contract to one funded on a capitation based system. Typically it was more difficult for practices to drive high income in a more deprived population under the construct of the old fee for service GP contract – and, in managing the succession of practices after April 2004 where the MPIG is not payable, it may have made the financial sustainability of succeeding practices more problematic although nationally procured practices must be offered an APMS contract.

6 Action so far

6.1 A small working group with the LMCs and the Office of London CCGs (as a first stage means of engaging with CCGs) has been convened to consider what support arrangements might be put in place to support the changes practices will need to make. There has been some analysis of the impact/spread across London. Two separate letters about MPIG have been sent to practices and two separate letters about the 2014/15 contract changes and the impact on each individual practice sent by Finance colleagues. Practices have been advised to:

- Calculate the likely impact on their practice (via Open Exeter)
- Assess the impact on their practice
- Think about the pace and scale of the reduction
- Commit to the need to plan for change
- Examine income and expenditure critically
- Consider future options for the practice
- Consider technological possibilities

6.2 The support offered to practices thus far is:

- offer of 1:1 conversations with practices with NHS England/LMC/CCG (CCG if so
- wishes) where impact greater than a £3 per weighted patient average year on year loss; 1:1 for others if requested (but no overt offer to meet)
- conduct an examination/review of income and expenditure including pensionable income
- understanding the exceptional workload directly attributed to the specific and unique demographics of the practice population that might be delivered in a different way
- discuss practical changes that might be made
- discuss future options for the practice, which might include merger of all/some functions, federations and networks, technological possibilities and retirement if so desired
- some limited organisational development input to plan delivery of changes.

6.3 Discussions with the LMCs did not make any promise of any further financial help from NHS England.

6.4 It is noted that in City & Hackney, c£8m CCG investment is made into local practices for delivery of a range of local services.

7 Moving forward - options

7.1 While the majority of practices in London will be better off financially in their global sum payments as a result of these changes, it is recognised that there is a small number (2%) which may be significantly affected. Having offered to meet with each of the 34 most affected practices to discuss their unique financial challenges and how they can be supported on a case by case basis, there has not been significant take up of this. **None of the City & Hackney practices have taken up the offer to meet with NHS England.**

7.2 In a number of instances, there may be special circumstances where the national funding formula may not be sufficiently sensitive to very local practice issues. For instance, the funding formula will not take into account certain factors, such as:

- Practices with a significant number of patients who attend the practice up to 12 times a year rather than the 3.5 or 5.5 appointments per patient per year that are frequently used as a national benchmark figure
- Practices with a very high turnover and significant numbers of patients who do not speak English

7.3 Additionally, there may be workload implications from increased attendance of patients who are struggling to cope with the impact of changes to the benefits systems.

7.4 There are a number of options for financial support being considered.

7.5 Internal discussions and dialogue with national colleagues continue and are expected to conclude during the course of week ending Friday 10 July.

8 Conclusion

8.1 NHS England has reflected on the needs and concerns of local practices that have been raised either by the practices themselves or as a consequence of their lobbying. There is some merit to an argument that Carr Hill may not adequately reflect the workload of some inner city practices where there are local population specific peculiarities. The London Region will shortly reach a view as to whether a short term financial support arrangement and on what terms, should be made available.

8.2 NHS England is also mindful that this does not and should not replace national primary care funding policy that is designed to ensure equitable funding in GMS practices across England.

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