February 2006

GPC

General Practitioners Committee

The financial implications of increasing list size

Guidance for GPs

BMA

The financial implications of increasing list size

This guidance is designed to advise practices facing the possibility of a large increase in list size. This may be voluntary, where, for example, there is a steady increase in the population in the practice area and where the practice agrees to planned growth in order to accommodate the increased population. In other cases it may be involuntary, for instance when the practice does not wish to expand but finds that there is no alternative provision within the Primary Care Organisation (PCO). The GPC is also aware of an increasing number of cases where small or PCO-run practices have been closed and large cohorts of patients allocated to neighbouring practices.

Whether it is voluntary or involuntary, an influx of new patients is likely to be a major strain for GPs and their staff in terms of workload. Existing resources are likely to be stretched and many practices are unclear about what extra funding to expect under the nGMS contract.

This paper is primarily intended to explain the funding streams which are available and to suggest ways in which funding may be increased. However it is impossible to do so without considering also the contractual context of list expansion, the pros and cons of a voluntary increase in list size, and the mechanisms for resisting an involuntary increase. Although this guidance focuses mainly on GMS practices, the same principles can be applied for PMS practices. This guidance is UK-wide.

GMS practices

What extra funding do new patients bring in?
It might be expected that each new patient would bring in a pro rata increase in practice income but this is no longer the case. Even under the old Red Book the situation was not straight-forward, as, whilst capitation and Item of Service (IOS) payments were based on the number of patients, other payments such as the Basic Practice Allowance were also based on the number of GP principals. Furthermore whilst some PCOs had developed capitation-based staff budgets, others stuck to approving individual posts so that staff funding did not always increase with a rising list.

Under the new GMS contract there are 4 main income streams:

(1) Global Sum
(2) Correction Factor
(3) Enhanced Services
(4) Quality and Outcomes Framework (QOF)

Further details are below.

Global Sum

The nGMS contract was intended to provide practices with a fairer method of funding as the myriad of fees and allowances which existed under the Red Book was replaced by a single Global Sum based on list size but weighted according to the practices' workload as calculated by the allocation formula (previously known as the Carr-Hill Formula).

As GPs will recall, when practice Global Sums were announced in March 2003 it became clear that, for the majority of practices, the calculated amounts were much less than existing, equivalent Red Book income and would have left many practices with a serious financial deficit. In part this was due to money being mapped to quality payments for the QOF.

Minimum Practice Income Guarantee and Correction Factor

The Minimum Practice Income Guarantee (MPIG) was designed to protect those practices which would have lost out from the redistributive effects of moving from the Red Book to the new contract. The MPIG is calculated by adding together the practice's calculated Global Sum payment and a correction factor. The Correction Factor was designed to bring the practice's global sum income back to where it would have been under the equivalent Red Book payments at 1 April 2004 - the day the new contract came into force.

Whilst the Global Sum should rise with each extra patient, any increase in list size after 1 April 2004 will have no effect on the size of the practice's Correction Factor which is fixed.

Under MPIG, practices across the country received an average of £62 (estimate) per patient. Even for practices with an allocation formula weighting of 1.0, the Global Sum base payment at £54.72 is considerably less, but as many practices have a weighting of less than 1.0 (i.e. are "Carr-Hill losers") the per capita Global Sum will be even further reduced.

The net effect is that as the list size rises total income will also rise, but per capita income from this income stream will fall.

Practices facing expansion may be able to do a "back of the envelope calculation" – one such example is detailed below – to assess the likely increase in Global Sum with each new patient. But it must be stressed that this method can only give a rough indication. The formula is dynamic and calculates the practice's relative share of income, rather than an absolute payment. As the list size increases then the age/sex weightings may alter. Furthermore the application of 'normalisation' at a local level has meant that practices in a PCO where other lists are rising may only get a very small increase in Global sum for three quarters of the year, although this should be rectified on 1st April each year. This adverse effect will be remedied from April 2006 when there is an agreement to move to national normalisation for each quarter.

Worked example:

Date	1 April 2004	1 January 2006
Practice patient list size	5000	7000
Carr-Hill weighting	0.80	0.80
Total global sum income*	£218,880	£306,432
Income from correction factor	£81,120	£81,120
Total funding	£300,000	£387,552
Per capita funding	£60.00	£55.36

*Calculated by multiplying list size by weighting by £54.72

The global sum increase between 1 April 2004 and 1 January 2006 in this example is £87,552. This amounts to a £43.48 increase per patient.

QOF payments

QOF payments must also be taken into consideration. These are based on the practice list size as at 1st January in each QOF year. As a guide, an example is set out below.

Calculating additional QOF income

A rough and ready guide, which does not take account of prevalence, can be given by using the simple calculation:

Total practice list size / 5891** x £124.60 x no. points
[**the Contractor Population Index (CPI) = 5891 in England]

Assuming the above practice achieves 950 points and expects to achieve the same this year, then this total calculation will be 7000/5891 x 124.60 x 950 = £139,677. Therefore the total amount can be divided by the patient list size (7000) to calculate the amount per patient of approximately £19.95.

It is important to note that this is a rough calculation and should be used only as a guide. A full calculation is detailed in paragraph 6.5 of the 2005 Statement of Financial Entitlements.

List Turnover Index

It is well documented that newly registered patients consult more frequently in their first year with the practice (in fact there is strong evidence to suggest that this effect continues into and beyond the second year). This resulted in extra weighting being given under the formula for patients registered within the previous 12 months. This is known as the List Turnover Index (LTI).

If a practice's patient turnover level remains fairly steady year on year then the LTI will remain fairly constant. There are problems, however, where practices take on a large cohort of new patients at one time, for example when another local practice's list has been dispersed. During the first year the receiving practice will benefit from a boost to the Global Sum, but, after 12 months, the increased effect of the LTI will be lost.

PMS practices

For PMS practices growth in list size is also an issue, especially for the later waves of PMS. Allowances for an increase in list size will be largely dependent on local contract and negotiation.

The value of what a PMS practice gains by taking on additional patients will need to be calculated by the individual practice. Therefore the practice will initially need to work out what their baseline per patient fee is, and also what this figure includes (e.g. staff funding). Practices then must assess, whether, at the price suggested, it would be economically prudent to take on the patients or not. As each PCO will fund PMS practices differently, it is largely dependent on practices to try to negotiate an acceptable solution, locally. PMS practices should also take into account additional funding they will receive from the QOF and other income streams.

Possible scenarios

Scenario 1 – Closure of a practice, then taken over in its entirety by one existing practice

This situation is most likely to occur when a single-handed practitioner retires and the contract is not offered to a replacement GP – who would continue to run the practice as a single-handed practice – but instead to an existing local practice to take over the list in its entirety. The PCO would need to advertise the practice, short-list, interview, then appoint. The appointment could be a direct replacement for the single-handed GP or a practice. The practice needs to be an 'open offer'.

In financial terms this is probably the most advantageous situation, provided the PCO agrees to treat it as a merger of practices as set out under paragraph 3.16 of the 2005 Statement of Financial Entitlements (England) and equivalent in Scotland, Wales and Northern Ireland.

In this case the MPIGs of the two practices should be added together to give a new MPIG for the enlarged practice. It is likely, however, that the PCO will simply wish to merge the entire patient list with the new practice in a way which does not involve re-registration and in this case there will be no LTI payable.

As part of the negotiation for taking over the list, practices should seek to be compensated for the lack of LTI because there is no doubt that there will be a great deal of extra work in the first year or two.

There is, however, one major potential pitfall in taking over an entire list in this way; it is likely that the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) will apply. This means that as well as taking over the patient list, the practice will have to take on the staff of the smaller practice with the same pay and terms as they enjoyed previously. Thought needs to be given as to how the newly acquired staff will fit in with the existing team and what effects this might have on the existing pay structure. Practices would also need to consider what they would do with any premises the closing practice may own.

In some circumstances, however, the PCO will not treat this scenario as a merger, but as the termination of an existing contract with a single-handed practitioner but with no creation of a new contract with the existing practice. In this case there will be no merging of MPIGs and the new practice will not inherit the Correction Factor of the practice which has been taken over. In fact, the Correction Factor would go into the unified budget of the PCO which gives a perverse incentive to PCOs not to treat the takeover as a merger. However, the LTI would apply, giving an enhanced Global Sum in the first year only because the patients would have to be re-registered. Practices would also have the advantage of TUPE not applying and would not inherit the premises of the closing practice for example. However the practice would first have to agree to take on another practice's list in its entirety. If a practice was unhappy with this scenario, similar arguments as set out under scenario 3 would apply.

Scenario 2 – Closure of a small practice and patients advised to re-register with local practices

There may be circumstances where a small practice is disbanded and a number of other practices, whilst not willing to take on the complete list, see this as an opportunity to increase their own list size and, subsequently, take on some of the displaced patients voluntarily.

In this case the receiving practices must be aware that, as explained in Section 1 of this paper, the new patients will bring an increase to both the Global Sum and payments for QOF and Enhanced Services, but there will be no additional element for the Correction Factor.

Scenario 3 – Closure of a small practice and patients allocated to other local practices

PCOs have a legal responsibility to provide primary medical services to the population of their area. There is evidence that where a small practice has closed, some PCOs are seeking to discharge this responsibility by assigning (allocating) large cohorts of displaced patients onto the lists of other local practices.

This is the worst possible scenario as practices are forced to take on an increased number of patients with which they may well be unable to cope in terms of workload, space and so forth. It is unlikely that the extra Global Sum and QOF income will be sufficient to fund extra clinical staff, even if there is space for them to work in, and, as we have pointed out in section 1, the per capita increase income will not be pro rata with existing income.

It is essential that practices in areas where this might happen take as much preventative action as possible before they suddenly find themselves the unwilling recipients of a large number of extra patients. They should do so in conjunction with their LMC. Making the issue public and getting support of the existing patients of the practice (who will not wish to see their service deteriorate) will be helpful.

Practices may need to consider carefully the pros and cons of formally closing their lists. It is recognised that practices are often reluctant to do this as the process of list closure is complex. Additionally, there may be some disadvantage to the practice in that they are unlikely to be invited to provide any further Enhanced Services. However, practices should not have to accept a large influx of forced allocations without adequate funding. If LMCs take this stand, PCOs will be forced to resource practices appropriately or make different arrangements to disperse patients. Practices and LMCs should work together to ensure that the situation is resolved as best as possible for each practice in the area. The procedure and information about list closure can be found at appendix 1. Practices are also reminded of their right to refuse to register new patients provided it has reasonable and non-discriminatory grounds for doing so as detailed in the following guidance: www.bma.org.uk/ap.nsf/Content/focuspatientreg0404

LMCs should identify single-handed practitioners in their area who are approaching retirement and seek their cooperation in developing a strategy for the future of the practice and its patients. A single-handed practitioner can recruit a partner prior to retirement to ensure the continuation of the existing contract. However, the additional administrative burden and the cost to the single-handed GP would need to be weighed up. Provisions of how to do this are set out under part 25 of the Standard GMS contract.

In some cases, when a group of GPs has taken over a vacant practice list, the PCO has established a Local Enhanced Service (LES) – to assist the practice in note summarisation, appointing Health Care Assistants etc – to help practices to facilitate the movement of patients. However, this is not an avenue that we recommend because it funds new patients in a different way to existing ones, therefore complicating the process. Additionally, this would contribute to the Enhanced Services Floor, thus taking money away from other practices.

Scenario 4 – Large influxes of new population

There are many areas of the country, particularly in the South and East, where large scale expansion of housing and population is planned. Under the nGMS contract there is no analogue to the Type 1 and Type 2 Initial Practice Allowances which provided special financial recognition of the costs of providing for a wholesale rapid influx of new patients.

There is a major difference between taking on a handful of new patients and registering a great number. The latter can result in the overall per capita income of the practice becoming noticeably smaller. PCOs have the option to allocate patients to practices and often practices are happy to take on new patients, but subsequently discover that the resources that accompany them are not sufficient to meet requirements.

This is especially a problem in areas of rapidly growing population, and often the patients concerned are young and therefore carry a low Carr-Hill weighting. This is a situation which is becoming more common as new house building in a practice area encourages new, often very large, influxes of population.

Additionally the impact of normalisation – the practice weighted population adjusted to total the Office for National Statistics population estimate – often leaves the extra quarterly income for each new patient very small.

Scenario 4a – Expansion of Existing Practices

Existing practices may have the capacity to take on some of this influx or may even wish to expand in order to do so. It is important that such practices are aware of the funding implications and in particular the fact that, unless there is a major revision to the formula for calculating the Global Sum, overall “per capita income” of the practice is likely to fall. All

funding streams of the contract need to be considered when embarking on such a course of action, including the likely effect of additional patients upon QOF and Enhanced Services payments.

Whereas in the past such practices could look to the cost rent or notional rent schemes to finance any necessary expansion or re-development of practices, the funding for premises is now much more uncertain.

It is essential, therefore, that practices that are considering large scale expansion prepare a clear and comprehensive business plan and enter into negotiations with their PCO at an early stage rather than allow themselves to drift into expansion.

The business plan should set out the maximum number of patients the practice might be prepared to take on and the terms on which it will do so. The practice will be wise to seek cast iron guarantees from the PCO regarding funding of premises development and ongoing re-imbursement for rent and for the necessary expansion of the IT system.

GMS practices may well find that due to the factors mentioned in Section 1 the likely increased income from taking on a large number of new patients may not adequately cover the costs of providing a service.

PMS practices may find that the increase in income is more linear but will nevertheless wish to prepare a detailed business plan.

In either case, but for those on GMS contracts in particular, the practice may want to consider negotiating a separate APMS (Alternative Provider of Medical Services) contract for the list expansion (see below).

Scenario 4b – Greenfield Sites

In the past where local practices could no long cater for a rapidly rising population then under certain circumstances a new practice could be set up with a Type 2 Initial Practice Allowance. This gave a guaranteed income to the first two doctors, but more importantly paid all practice expenses for up to 5 years.

The Type 2 IPA no longer exists but the expenses of setting up a new practice or even a new branch surgery are high. The surgery has to be provided with heat and light, with a phone system and with office and medical equipment. There need to be support staff and all of this needs to be in place before any patients arrive. Unless practices or individual GPs are prepared to invest large quantities of their own money against the (rather unlikely) possibility of recouping this investment in the long term then we feel that there is no way in which a new surgery can be set up under the present provisions of the GMS Contract.

The APMS (Alternative Provider of Medical Services) Regulations open up the way for commercial provision of GP services and there are already a number of companies in the field looking for opportunities. It is likely that other operators, such as major supermarkets and pharmacy chains, will also be looking for opportunities in new centres of population. This may be further influenced by the publication of the Government White Paper - Our health, our care, our say: a new direction for community services.

Under paragraph 7.20 of the GMS Contract *Investing in General Practice* (the Blue Book) the PCO must arrange tendering for such new developments in two stages. In the first stage it must be offered to existing GMS and PMS providers who have preferred provider status.

Practices should, however, be under no illusion that bidding for such opportunities will be easy. There is already anecdotal evidence that some PCOs are biased towards APMS providers as they feel that the introduction of a commercial element will somehow result in better (and perhaps cheaper) GP services.

The only way in which practices will succeed in this environment and avoid being swiftly eliminated is by competing on the same ground. This will necessitate painstaking preparation of a detailed business plan and a first class presentation for the selection panel. The GPC is currently in the process of producing detailed guidance to assist GPs who wish to go down the APMS route.

The issue of rapidly growing practices in generally will be discussed as part of the formula review of the GMS contract in 2006/07 for implementation in April 2007. It is hoped that more assistance will be provided, via this route, for those practices affected by this issue. Additionally, the GPC and NHS Employers have already agreed that normalisation will move to national rebasing on a quarterly basis from 2006/07, which may go some way towards addressing this particular problem in areas of rapidly growing populations.

We are pleased to note that, in response to repeated representations on this issue to the Department, the recently-published White paper in England has recommended the introduction of an Expanding Practice Allowance. The GPC will seek to enter into urgent negotiations on this development.

For all scenarios, LMCs should note paragraphs 7.19 – 7.20 of the GMS contract booklet 'Investing in General Practice':

7.19 When a single-handed GP resigns, the PCO would still have an obligation to ensure the provision of primary medical services to that former GP's patients. The PCO could discharge that duty by entering into a contract with existing or new providers, or deliver primary medical services itself. Whilst the concept of a statutory vacancy will disappear, the LMC (or its equivalent) will be consulted about all proposals in relation to the retirement of a single-

handed practitioner and Greenfield sites and any existing affected patients will be kept informed.

7.20 Significant increases in local population may justify a need for additional providers of essential and additional services in an area and the PCO has an obligation to ensure provision of primary medical services to its population. The PCO could advertise locally and/or nationally the need for a practice in the area and seek applications, through a two stage process: first, competition between GMS and PMS practices which would have preferred provider status, and then open competition. The PCO would normally contract for such services through a variation to a contract with an existing GMS or PMS provider which has a preferential right to provide such services if it so wishes. However, in stage two, the open competition stage, the PCO could commission it from another potential provider. The LMC (or its equivalent) will be consulted.

Appendix 1 – Closed lists

Under the new contract, General Medical Services (GMS) practices which do not wish to have patients assigned to their list by the Primary Care Organisation (PCO) must go through the list closure procedures set out in paragraphs 29- 31 of Part 2 of Schedule 6 of the National Health Service (General Medical Services Contracts) Regulations 2004 or their equivalents in the other three countries of the UK. If the PCO or the assessment panel approves the closure notice, the contractor's list is officially **closed to assignments.** The closure period will then be either for a maximum of 12 months or, if a range was specified in the closure notice, until such earlier time when the number of patients falls below the bottom figure of the range.

During the closure period the PCO may not then assign patients to that list, unless, on its application, it is able to persuade the assessment panel to permit assignments to closed lists for practices that have been notified of the application. In such cases, however, there is a further right of appeal that is available to practices and the final determination of the matter is made by the Secretary of State following the dispute resolution procedure in paragraph 36 of Schedule 6 (or the equivalent procedures in the other three countries).