



Department of

**Health, Social Services
and Public Safety**

www.dhsspsni.gov.uk

AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

GMS Global Sum Formula Review for Northern Ireland

Summary of Consultation

Northern Ireland GMS Working Group

January 2008

Introduction

The report and recommendations of the review of the Northern Ireland GMS global sum formula were published on 18th September 2007. This review was undertaken by the Northern Ireland GMS Working Group which included representatives of the Department of Health, Social Services and Public Safety (both statistical and policy), Finance and GMS Policy representatives of the four Health and Social Services (HSS) Boards, statistical representatives from the Central Services Agency and a representative of the N Ireland BMA's General Practitioners' Committee (NI GPC).

The review follows a commitment made by the UK negotiating parties (the British Medical Association's General Practitioners' Committee and the NHS Employers); that, as part of the original negotiations on the new GMS Contract, it was agreed that the global sum formula should be reviewed in light of the developing contract and the availability of new data.

The NI GMS Working Group asked key stakeholders for their views on the formula review findings and recommendations through a consultation exercise that ran from 18th September to 7th December 2007.

Consultation responses

In total 15 responses were received. Of these a response was received from each of the four HSS Boards (27%), one response (7%) from the NI General Practitioners' Committee (NI GPC) and the remaining ten responses (67%) were from individual GPs or GP practices.

In analysing the responses no weightings have been applied to reflect the varying levels of representation of the responding individual or organisation, therefore for the purpose of this paper, the submitted data and comments are divided into two categories, namely those received from:

- i. Health and Social Services Boards
- ii. GPs or GP practices and NI GPC.

Response to questions

Question 1: Should we seek to implement the proposed new formula?

	Yes	No	Don't know/ No answer	Total
HSSBs	100%	0%	0%	100%
GPs & GPC	18%	64%	18%	100%

The boards were unanimously in favour of implementation of the proposed new formula; however there were differing opinions among GP's. The main concerns were in relation to the Minimum Practice Income Guarantee (MPIG) adjustment and the financial stability of practices that would lose income.

Examples of comments:

"...as with any capitation formula it is appropriate that *(the proposed new formula is)* subject to regular review, in order to pay regard to emerging thinking and new information."

"We would first need a convincing argument that the revised formula was more equitable than before. We would then need to be shown figures demonstrating the actual impact on practice finances to enable an evaluation of the scale of redistribution."

"Practices will have expenditure patterns in terms of staff, premises and other overheads which cannot be easily adjusted without destabilising the practice and/or reducing the service to patients."

Question 2: Would you wish to see implementation of the new formula even if the resulting redistribution of the same overall global sum meant that some practices would lose income?

	Yes	No	Don't know/ No answer	Total
HSSBs	100%	0%	0%	100%
GPs & GPC	18%	64%	18%	100%

Examples of comments:

"...if there was a substantial loss to practices, *(we)* could only support implementation if a new MPIG was also implemented."

Question 3: Are you content that the FRG workload factor is not appropriate for application in Northern Ireland and that the current separate adjustments should instead be updated where possible?

	Yes	No	Don't know/ No answer	Total
HSSBs	100%	0%	0%	100%
GPs & GPC	36%	0%	64%	100%

Of those respondents who commented on this question, all were content that the FRG workload factor is not appropriate for application in Northern Ireland. One comment was made regarding the additional needs index of the current separate adjustments.

Examples of comments:

“Northern Ireland developed its own variation of the GMS formula at the commencement of the GMS contract, which proved to be more sensitive to local needs. It would be a retrograde step to move over to the FRG workload factor at this point.”

“Locally sensitive adjustments seem wise”

“(we have) concerns about what is measured by the Additional Needs Index. The index relies heavily on patient self-reporting and Northern Ireland tends to have a high level of self-reported morbidity. Many practices have reported that this is the factor that appears to have most effect on their weighted patient list (usually negatively) and in view of this, (we) question the use of this factor.”

Question 4: Should the revised global sum formula include an updated age/gender adjustment?

	Yes	No	Don't know/ No answer	Total
HSSBs	75%	0%	25%	100%
GPs & GPC	36%	0%	64%	100%

Of those respondents who commented on this question, all felt that the formula should contain an updated age/gender adjustment.

Examples of comments:

“Updated and ideally NI specific data should be included.”

Question 5: Should the revised global sum formula include a Cost of Unavoidable Smallness adjustment?

	Yes	No	Don't know/ No answer	Total
HSSBs	100%	0%	0%	100%
GPs & GPC	36%	0%	64%	100%

Of those respondents who commented on this question, all agreed that the formula should include a Cost of Unavoidable Smallness adjustment. It was also mentioned that the CUS adjustment in part covers the added financial pressures faced by small practices based in rural areas.

Examples of comments:

“(An economies of scale adjustment) was originally considered but not included because of the perceived risk of providing a perverse incentive for practices to split in

order to benefit from such an adjustment. The proposed CUS adjustment appears to safeguard against this.”

“As this was a contentious deletion for Carr Hill, it should be included as genuinely smaller isolated practices have fixed costs for core practice activity that cannot be ‘diluted’ in a larger list size.

”The ‘scale of economy’ adjustment is absolutely essential (*but*) the ‘isolation criteria’ is a nonsense and should be removed. Proximity to another practice is not relevant. Small practices, even in urban areas, especially if ‘stand alone’, provide a specific and invaluable service to the local community. The ‘corner shop’, smaller and more personal provision is much preferred by patients and gives an invaluable service to e.g. elderly patients with limited mobility, single parents with no transport, patients with disability etc.”

Question 6a: Should a revised global sum formula continue to acknowledge in principle that a rurality adjustment is required?

	Yes	No	Don't know/ No answer	Total
HSSBs	100%	0%	0%	100%
GPs & GPC	18%	9%	73%	100%

Question 6b: If in principle a rurality adjustment should continue, should the current adjustment be retained or neutralised?

	Retained	Neutralised	Don't know/ No answer	Total
HSSBs	25%	75%	0%	100%
GPs & GPC	9%	27%	64%	100%

Responses to the rurality questions suggest that the majority of respondents agree that a rurality adjustment is required, but that the current adjustment should be neutralised pending further work into the additional costs incurred by rural practices.

Examples of comments:

“...further work should be commissioned in due course to establish an evidence base for a rurality factor, above the cost of unavoidable smallness factor...”

“...more work is needed to substantiate the degree to which rurality affects the viability of practices.”

“The introduction of the factor to be known as ‘Cost of Unavoidable Smallness Adjustment’ in part covers the added financial pressures faced by small practices based in rural areas.”

“...we favour expenses being used as a basis of analysis rather than payments in order that issues such as retained profit can be addressed, and ultimately, the factor of rurality is applied in a way in which truly rural practices benefit.”

“There is a need to acknowledge the additional costs related to providing services to rural communities, however with the current methods of allocation such funds do not target rural practices, rather the funding goes to practices with dispersed patient populations, including many urban practices. More work needs to be carried out to develop a means of allocating funds to genuinely rural practices.”

“Deletion of rurality would apply a bias (financially and legally) against rural patients and their doctors. It ought to be retained.”

“I do not believe that rural GP’s have a higher workload and so a rurality adjustment should be abolished. In fact I believe that rural patients consult less. Furthermore travelling time to do a home visit in a rural area may involve a greater distance but the time taken is often shorter compared to travelling relatively short distances in urban areas.”

Question 7: Should a revised global sum formula contain a neutralised staff market forces factor (that is, that there is no evidence of a differential MFF across N Ireland and so the index is set to 1.0 for all practices)?

	Yes	No	Don't know/ No answer	Total
HSSBs	100%	0%	0%	100%
GPs & GPC	36%	9%	55%	100%

Respondents generally considered that the staff market forces factor should be neutralised.

Examples of comments:

“I cannot see how a differential MFF can be justified in Northern Ireland given housing costs equalising throughout and the increased costs of transport in rural areas.”

“Several Trusts and four major hospitals exist within the greater Belfast area, and it is my experience that staff move more often as a result...the issue is not the current salary paid but the potential of greater staff turnover and the ensuing disruption during further training. I would submit that a differential should remain for Belfast practices.”

Question 8: Are you content that the new formula has been tested adequately against equality legislation and that any revisions meet equality obligations?

	Yes	No	Don't know/ No answer	Total
HSSBs	100%	0%	0%	100%
GPs & GPC	27%	0%	73%	100%

Although all respondents who commented on this question considered that the new formula had been adequately tested against equality legislation, several comments were made about the possible inclusion of an adjustment for ethnicity and/or non English speaking patients.

Examples of comments:

“...we consider that more work is required to assess the impact on workload of patients who speak a different language to their GP (or healthcare professional) and also of the impact of providing GMS services to the Travelling Community. Based on our local knowledge, we consider that there should be an adjustment for ethnicity.”

“There should be an adjustment for patients speaking a different language and/or adjustment for ethnicity. These consultations take at least twice as long.”

“Further work is needed in terms of a potential adjustment to reflect any increase in workload practices may face because of the number of patients speaking a language other than English.”

Question 9: Should any caveats be applied prior to any implementation of a revised formula?

	Yes	No	Don't know/ No answer	Total
HSSBs	75%	25%	0%	100%
GPs & GPC	82%	9%	9%	100%

Caveats mentioned were mainly in relation to regular review of the Global Sum formula and resulting distribution, the retention of the Minimum Practice Income Guarantee (MPIG) and the level of overall global sum funding.

“As with all capitation formulae, it would not be unreasonable to state that this GMS formula will be subject to review in the medium term, as new research emerges.”

“It is our view that the existence of MPIG prevents the equitable distribution of resources between practices and we consider that a strategy should be negotiated to phase out MPIG over time.”

“In view of the fact that the Minimum Practice Income Guarantee adjustment has the explicit purpose of providing financial stability to practices, it is important for consideration to be given to whether this inequity should or should not be embedded in the distribution of HPSS resources to local populations in the future.”

“The continuation of the MPIG brings into question the applicability of the formula. We acknowledge that some practices may be affected to a greater extent than others through the application of the capitation formula. We would not want to destabilise GMS services (especially equity in terms of geographical access), but if the formula is applicable and sustainable at the level of small populations based on evidence then there is an argument that the MPIG should be phased out in line with an agreed timeframe.”

“The main caveat is that any implementation of the new formula should either be based on an adequate amount of resources in Global Sum to allow for a true redistribution of GMS funds on the basis of workload or the promise of a Minimum Practice Income Guarantee in perpetuity must be honoured for those practices that will lose funding”

“we would request a guarantee that MPIG will not be touched as without MPIG the validity of this practice and many others would be seriously undermined by the existing and proposed formula.”

“Whilst recognising that the global sum was originally a fixed allocation, we consider that points should be agreed at which the totality of resources is reviewed in order to reflect overall changes in the population of Northern Ireland.”

“(we are) also concerned that no additional funding has been added to Global Sum to take account of the increasing population of Northern Ireland since implementation of the new GMS contract.”

“The effects of current Global Sum distribution have been further amplified with recent increases in population in Northern Ireland without any additional funding being put into the Global Sum pot.”

“The review which is currently on-going is focusing on minor components of the formula rather than addressing the issue of differences in payment per patient...we believe that a comparative study of workload in practices should be carried out to test the validity of the resource distribution rather than making changes to the existing formula.”

“Efforts should be made to demonstrate that those practices that are receiving twice as much per patient as other practices through the Global Sum, are actually justifying that payment in terms of workload.”

Conclusions and next steps

The review findings, recommendations and consultation responses provide a number of parameters within which the GMS global sum formula may be improved. In GB, the GPC and the NHS Employers are continuing to negotiate Contract changes for 2008/09 including what, if any, changes should be made to the global sum formula. Northern Ireland will await the outcome of these national discussions before taking a final decision on global sum changes.

What can be concluded from the review and the subsequent consultation exercise is that, in the event of the recommendations being adopted; the NI GMS Working Group acknowledge that further work would be required on the rurality adjustment and the inclusion of an adjustment for ethnicity and/or non English speaking patients should be considered. It is also acknowledged that the formula should continue to be subject to regular review in light of new data and to take account of developments in primary care.

The main issues raised by responses to the consultation were:

- Practice financial stability and the need for a continued income protection mechanism.
- Equity of resource distribution and comparative workload in practices.

Another issue which was raised was the need to review the total Global Sum resource. However, it was not the remit of the review to identify the resource envelope which would be required to fund global sum budgets across all general practices; but rather the formula and therefore the review was concerned with ‘relative’ costs of one practice compared to another.