

LMC Secretariat Newsletter (April 2006)

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Practice Based Commissioning and use of Savings

The Secretariat has drawn the attention of TV SHA and PCTs to the PBC Q&As on the DOH website. This seems to have resulted in the clarification of use of PBC savings outlined below in an extract from the document "Principles for Implementation of the 2006/07 PBC DES in Thames Valley" which Chief Executives have agreed.

1. Where a practice spends less than its total indicative budget and so frees up resources that are greater than any reward payment due, irrespective of whether or not it meets the specific objectives agreed in its PBC-DES plan, the surplus resources (after deduction of any reward payment) should be split as follows:
 - 70% to be added to the practice indicative budget for 2007/08, and 30% to be retained by the PCT (and see point 2 below).
 - PCTs may wish to consider modifying these proportions for practices that have a total (historic) indicative budget that is significantly above or below their fair share based on weighted capitation allocation.
2. In the event that overspending or deficits management cannot be contained within the contingency fund and recovery plan arrangements, as a last resort, the 30% PCT share of the total resources freed up by a practice may be used to cover PCT overspends.

3. Where a practice achieves all its objectives under the PBC-DES plan, it shall be entitled to the reward payment of 95p/pt irrespective of its spend against its total indicative budget and whether or not it makes sufficient (or any) savings overall.
4. PCTs should agree with practices how the full reward payment of 95p/pt may be modified if a practice meets some objectives but not all.
5. PCTs may wish to adopt a "QOF-style" points scheme to enable practices to achieve partial reward payments for partial achievement of specific objectives - for example the scheme proposed by Mid and South Bucks PCTs.
6. The 95p/pt reward payment to practices

It lists objectives under 4 headings of Activity Reductions, Processes, Budget Performance and Prescribing. It allocates bits of the total 95p to increasing % reduction in activity or money spent.

LMC advises practices to avoid particularly objectives involving saving against a budget, for the following reasons:

- When historical activity is multiplied by the NHS tariff price, the total comes to more than any PCT could afford with their allocation
- The actual usable allocation has been further reduced by a 2.5 % top slice for a SHA contingency fund and the requirement to recover last year's deficits by end of 06/07.
- This means PCTs will normalise (or scale down) practice budgets based on historical data to affordable levels
- This will make savings more difficult if not impossible
- The tariff was recently withdrawn so that budget setting will be delayed. Practices should therefore not make commitments to save against an unknown and un-assessed budget.

It might, however, be reasonable to agree processes likely to contribute to demand management and saving such as:

- Peer review of all referrals prior to their leaving the practice
- Assessment of need for continued long term follow up in outpatients
- Analysis of all emergency admissions to learn preventive lessons
- Regular practice review of cost effective prescribing.

Whether activity reductions should be an objective contributing to end of year payment is a matter for individual judgement but is not without financial risk.

PCT reorganisation

The consultation on reorganisation ended on 21/03/06.

The configurations favoured by the SHA are:

- Five PCTs for Thames Valley
- Thames Valley, Hampshire and Isle of Wight SHA

A DOH decision is expected between the 8th and 31st May.

The new PCTs will probably exist from 1st October 2006 and the new SHA from 1st July. PCT Chairs and Chief Executives should be appointed between June and August 2006.

SFE changes

The new version of the SFE for April 2006 onwards (incorporating the new QOF) is now available for download from the DH web site at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4107508&chk=dc/lzz

Please note that the correct link to follow at the bottom of the DOH page is the one highlighted in red and bold below

> Download Consolidated SFE text as at 1 April 2006 - this is provided for information and is not a legal document (PDF, 1625K)

It seems it isn't a legal document because the relevant legislation hasn't yet been passed.

Changes to 28 Day Retirement

See <http://www.bma.org.uk/ap.nsf/Content/GPrettowrk>

The Department of Health has announced that GPs who wish to return to work after retirement are no longer required to take a one month break. This will provide greater flexibility for those GPs who wish to take their NHS pension and return to work in the NHS.

There are still conditions which must be met in order for GPs to receive their NHS pension:

- You must take a break of, at least, one day from all NHS posts; and
- You must not work more than an aggregate of 16 hours a week in the NHS in the month following retirement. The NHS Pensions Agency states that the onus is on the GP to prove that this condition has been met.

GPs should note that they do not need to come off the Medical Performers List in order to access their NHS pension. They simply have to retire from pensionable employment.

The NHS Pensions Agency intends to issue further information in the near future. Please note that this announcement applies to England and Wales only.

The Secretariat has subsequently sent the following email to the GPC:

Will there be formal announcement of the alteration to 28 day retirement, together with a start date? To which the reply was: Probably not but we'll deal with that in our guidance. I think the start date is 6 April 2006.

There is little information on www.nhs.gov.uk but by phone they tell me a new booklet is being printed.

nGMS Changes 2006/07

<http://www.bma.org.uk/ap.nsf/Content/revisionnGMSFeb20062>

The Revisions to nGMS for 2006/07 were emailed to every practice on 20.2.06, (together with a Secretariat explanation of how it was structured)

The DOH has now mailed two hard copies to every GP practice.

This document is intended to give practices and PCOs an overview of the changes to the contract (including the QOF) and the detailed information that will be needed to implement the changes.

It also details the four new DES specifications; IM&T, TPBC, Choice and Booking, and Access.

eGFR

The Secretariat is aware that many labs across the Thames Valley (TV) are currently not providing eGFR results required to produce a CKD disease register for indicator CK1 in the revised QOF.

On 9.3.06 TV SHA were asked by Adrian Jacobs (NHS Employers, Chair of QOF review) to confirm that all "local NHS pathology labs will be reporting eGFR from April 2006"

John Derry (TV SHA Primary Care Medical Advisor) then wrote to all TV PCTs on 15.3.06. seeking assurance that PCTs have commissioned eGFR from lab providers. LMC CEO has not heard of any formal response from PCTs so the Secretariat has now (10.4.06) written to the Chief Executives of all TV Acute Trusts asking the question:

Can you or will you soon be providing practices with eGFR results?

Pensions

In December 2005 the Department suggested they might not fully implement the pension deal agreed as part of nGMS.

Concern has been expressed that GPs have still not heard what the final dynamising factor will be for 2003-2004 despite the Technical Steering Committee having collected all relevant information on GP earnings.

The GPC reiterated its position on 31.3.06.

Pensions issue is of crucial importance and one on which the GPC has taken, and continues to take, a firm position with the Department of Health.

The GPC have taken every opportunity to state their position both publicly and privately to the NHSE, the Department of Health and to ministers. GPC have made it very clear to the Department that they are not prepared to accept anything less than the full implementation of the agreement on the dynamising factor and maintain their view that any renegeing on the 2003-06 deal would be completely unacceptable.

The GPC are yet to receive a response. At present the GPC believe that no news is good news. They have informed NHS Employers that they have taken and will continue to take legal advice.

GPs who were planning on retiring on or shortly after 1 April 2006 to seek maximum benefit from the predicted increase in the dynamising factor, can still do so. Pension payments, as well as the lump sum, will be based on the 2003-06 interim dynamising factors. Any increase in these dynamising factors, once announced, above the interim will then be adjusted, and backdated, in both the GP pension payments and lump sum to ensure that these GPs receive the correct payments.

GPC have also received requests from GPs for the interim dynamising factor for 2006/07. This has not been officially published yet but GPC hope that it will be in the not too distant future. It should be noted however that due to the fact that there are not likely to be significant pay rises for 2006-07, the interim dynamising factor is not likely to be as generous as the previous three years and we are expecting a figure closer to 1.0.

For BMA Pension Section see: <http://www.bma.org.uk/ap.nsf/Content/Hubaskpensions>

Patient Experience Survey Project Board

GPC representatives now attend the new monthly Patient Experience Survey Project Board, responsible for devising and implementing the survey to support the Access and Choice & Booking DESs.

The group has discussed a number of issues including confidentiality, IT systems to support the implementation and sampling methods. It is intended that a pilot is run in late summer to before decisions are made about the final survey.

Referral management schemes (GPC view)

The GPC defines these as schemes which intervene in the patient's care pathway between GP and hospital treatment.

They stress that they are not against referral management in principle and describe the hallmarks of a good referral management scheme. These are where clinicians have been involved right from the start in setting the parameters, where there is full information about the options for both doctors and their patients thus allowing informed choice, and where there is good feedback to allow people to learn and improve the service that's offered.

The GPC also recognise that all GPs want to ensure good quality referrals and make the most cost-effective use of the NHS to provide the best possible service for patients.

However, in some parts of the country, the new processes seem more like mis-management schemes, primarily designed to save money by delaying treatment and riding roughshod over the concept of patient choice.

A key feature of some schemes has been to delay referrals to the next financial year in order to try to balance the books.

Sometimes this is overt but insidious bureaucracy has been used to delay referrals into another financial year.

Schemes have also been used to try to promote the use of an ISTC.

In lots of areas the local clinicians believe that their professionalism and patient choice are being significantly undermined.

The GPC are well aware of the financial difficulties in many parts of the country, but expect Trusts to be open and honest with their doctors and patients and not to introduce what is essentially rationing under the guise of a referral management scheme and make it clear that the prime function of referral management should be to improve the quality of service, not to cut costs.

BMA Website: GP Section

www.bma.org.uk contains many documents practices will find valuable

The selection is limited unless you register with the site using either a BMA or GMC number

Use the registration link on the home page (top right, blue text on white)

Low down on the list along the left of the home page (in blue text on grey) is the link for GP subjects which brings up a comprehensive list of GP subjects.

The GPC has recently issued the following guidance:

- Referral Management FAQ
- NHS LIFT
- Dispensing Doctors/Contractors and VAT registration
- Referrals to Complementary Therapists
- Focus all 4 new DESs
- The Financial implications of increasing list size
- Overseas Visitors
- Focus on... SFE Changes 06/07
- The new QOF Business Rules/Read Codes.

Flu Pandemic Planning on BMA Website

BMA now have a flu pandemic section available on their website:

<http://www.bma.org.uk/ap.nsf/Content/Hubflupandemicpreparations>

It contains a Service Continuity Plan and relevant guidance on creating an individual one for any practice.

GP Systems of Choice (GPSoC)

<http://www.connectingforhealth.nhs.uk/gpsoc>

On 20 March 2006 the Department of Health announced its intention to implement a new initiative for the provision of GP Clinical IT Systems (GPSoC).

Under GPSoC, GPs may:

- a. move to the GP clinical system(s) offered by their LSP
- b. keep their existing GP clinical system, undergoing upgrades as they become available under GPSoC
- c. move to another existing GP supplier's clinical system.

A key paragraph is hidden in the documentation:

"GPSoC funding will only apply to GpSoC compliant systems and will only include the cost of migration for options a and b above. The cost of migration from one existing supplier system to another existing supplier system will not be funded by GpSoC".

DDRB report

<http://www.bma.org.uk/ap.nsf/Content/DDRB2006>

The 35th report of the Review Body on Doctors' and Dentists' Remuneration (DDRB), dealing with pay recommendations for the financial year 2006-07, was published in late March.

The government has accepted all the DDRB's recommendations (except those for consultants) including a 2.2% pay rise for GP trainers, GP educators, salaried GPs and GPs in training. The GPC is disappointed as it is significantly less than they called for and does little to attract and train the doctors for general practice

The DDRB report did not make any recommendations for GP principals due to the separate negotiations although there was a disappointing freeze placed on seniority payments.

Owing to what GPC described as an internal "cock-up" GPC evidence on community hospitals did not get to the DDRB. GPC are urgently investigating how this happened and why the DDRB did not alert GPC to the fact that they had not received it.

Although it may have had little bearing on the DDRB's eventual conclusions, this is not the way GPC want to be seen to be doing business and urgent steps are being taken to try to ensure that such a problem will not happen in the future.

GPC regional election for Bucks and Berks.

Congratulations to Eric Rose on his re-election.