

Letter From The Secretary

Jan/Feb

A very Happy New Year to one and all.

It's all hotting up. We (LMC officials) are continually reassured that everything is on track and the big bang will happen on 1 April. With the legislative timetable and negotiations continuing it will go down to the wire. The reality of implementation has been far from the anticipated transparent and smooth transition that the profession had a right to expect. Some PCTs, either intentionally or through ignorance, disregard the Guidance and are certainly not putting General Practice at the centre of their agenda but are being driven, solely, by the political imperative to break even.

I sought election to the GPC in the implementation year in order to be "in the know" to the benefit of my constituents. I have to say that I have been sorely disappointed. The GPC staff have worked tirelessly, no responsibility can be laid at their door. Although a Task Group has been set up to review the communications between the Negotiating Team and the profession via the GPC, so far little has changed. GPC is awaiting the report of the Group with interest. However, there still persists an atmosphere of secrecy and a "need to know" philosophy which is not encouraging. If National Negotiations are set to continue there will have to be major changes.

The leap of faith taken by the profession in voting for an unpriced and incomplete package has taken on the form of an orbit of faith as there are still so many unknowns. What was advertised as a High Trust / Low Bureaucracy contract is looking somewhat different now.

The Draft Guidance, the SFE and related documentation, along with the draft contract, was published just before Christmas. All this amounts to several hundred pages. The draft contract has been trawled over by lawyers. General understanding is all that is necessary, in particular which paragraphs need practice specific entries. We are reassured there are no hidden cruise missiles.

The Statement of Financial Entitlement (SFE which replaces what will be lovingly remembered as the Red Book, the SFA!) needs careful studying. There is detailed information which everyone needs to understand, your mortgages and Ferraris depend on it. In January we are promised that every practice will receive a CD Rom with all the documentation on it. Practice Managers look out.

In the general part of the Newsletter you will find small, and hopefully concise, pieces of guidance about both nGMS and PMS after 1 April.

PMS practices will have seen the latest details governing PMS. It is all going to be permanent in April and all central funding has disappeared. There is to be freedom of movement between contractual arrangements.

In a previous Newsletter, certainly over a year ago, the point was made that all the current changes might be designed to increase PMS until such time that it became the majority contract, therefore kicking national negotiations



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INSERTS:

1 Classifieds



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➤ Global Sum

Now the Draft Guidance is published certain issues are becoming clearer.

All practices that are currently providing GMS have a right to a nGMS contract on the 1 April. After 1 April contracts can be awarded to new practices at the discretion of PCTs under certain rules. Practices after 1 April will be known as Contractors, which may either be a single hander or a partnership. In the case of a partnership at least one partner must be a doctor, on the local list, providing services.

If a partnership splits after 1 April, it is likely that PCTs will grant temporary contracts and will then decide what happens after some months. As there are no personal lists there are likely to be casualties after partnership splits under the new arrangements.

Draft contracts with provisional figures for GS/MPIG should be with practices by the end of the first week in February, to be agreed by the end of the same month. In the unlikely event of a dispute preventing such agreement a “default” contract will be put in place until such time as agreement is reached.

There will be cases where the GS/MPIG will not be agreed satisfactorily but the Guidance dictates that such situations must be resolved by the end of June in respect of the monthly payment to practices. Underpayment must be reinstated and overpayment clawed back by that date.

➤ Open/Closed Lists

At the outset the Negotiators were charged with getting a deal on Allocations. This was always going to be impossible as there is a fundamental capacity problem in primary care, with open access, but a finite resource.

If a practice currently closes its list it is not supported either contractually or legally, it simply means that the doctors don't accept patients other than allocations.

If under the new arrangements a practice, having gone through the extended and tortuous processes, closes its list, it is unable to accept any patients other than immediate family of someone already registered, or an enforced allocation. Yes, a contractor with a closed list may still have allocations made under certain circumstances!

A closed list may have an effect on the ability of the contractor

to provide Enhanced Services or Additional Services for patients registered with another contractor.

Therefore, it is important that practices have open lists by the 31 March so that they enter the nGMS contract without compromising their ability to provide Enhanced Services.

What is essential is to agree your practice boundaries with the PCT that will apply after 1 April, where you will agree to accept all comers.

This should not cause too many problems in stable areas; difficulties will continue in areas of rapid growth.

➤ Preferred Provider Status

The situation is now clear. Preferred provider status applies only to Essential, Additional Services and Childhood Imm and Vacc under the Directed Enhanced Services. The QUIP and Access Directed Enhanced Services must be offered to all Practices.

The PCT has discretion over where it commissions all other services, or whether it decides to provide them itself.

Already some PCTs are looking to save money by providing flu vaccinations with central purchasing of vaccine. Of course they may run into difficulties with organisation and infrastructure and premises for the provision of this service.

➤ Health Service Body Status

All contractors will be invited to become Health Service Bodies under nGMS. All parties to an NHS primary care contract which are Health Service Bodies are bound to use NHS dispute resolution mechanisms which ultimately involve the FHSAA.

If a contractor declines Health Service Body status then the contract is a Private Law Contract. This means that disputes would have to be resolved in the courts **unless** the contractor agrees to use the NHS disputes procedures.

So whether or not a Contractor decides to become a Health Service Body the NHS dispute resolution procedures may be invoked by mutual agreement.

A Health Service Body may be bound to all sorts of directions in future as yet unseen so maybe the sensible course is to wait

➤ OOH

Much is written in the medical press about the ability of PCTs to not permit practices to opt out. This is only in exceptional circumstances and would apply only to the most rural or isolated communities. Any renegeing on this part of the contract I have no doubt at all would be a deal breaker.

Most PCTs in Bucks and Berks are looking to take over their responsibility for OOH provision well before the deadline of January 1st 2005.

Some Practices are still considering whether to retain responsibility rather than opt out. There are several things to consider:

- ** Once opted out it will be unlikely to be able to opt back in and only at the discretion of the PCT
- ** The decision will be taken by the time the contract is signed by the end of March at the latest
- ** If responsibility is retained by the practice then so will be the 6% of Global Sum
- ** There will be no right of access to the OOH Quality Fund (the old OOH Development Fund)
- ** All the Quality Criteria of Carson must be met after 1 January 2005
- ** If it is the intention of the practice to retain responsibility but to sub contract the work then careful analysis of the likely costs is essential and the arrangements will have to be approved by the PCT.
- ** Your superannuation is dependent on the profits (not income) of your practice, so if the cost is likely in the long term to be greater than 6% you will be a net loser.

➤ Prevalence

After the Special Conference of LMCs in May 2003 the profession instructed the Negotiators to revisit with the NHSC the way that the Q and O framework rewarded practices. This should achieve a workload sensitive result so that those practices with larger numbers of patients would be rewarded appropriately. A practice that achieves well with 200 diabetic

patients should get more than one of the same size with 100 patients. Prevalence only affects the clinical domains.

This is, of course, a redistributive process producing winners and losers. The prevalence is measured separately in each of the four home countries which goes against the philosophy of a UK contract. Mind you, a coach and horses has already been driven through that principle as the Celtic fringes have, on the whole, done better in the implementation phase.

It is essential to have complete disease registers to do well. Below is the principle on which calculations are based. However, the national raw prevalence is adjusted by removing the lowest 5% to protect low prevalence practices, then taking the square root of all the results to compress the graph against which individual prevalence will be measured.

$$\frac{\text{Practice Prevalence}}{\text{National Prevalence}} \times \frac{\text{Practice List Size}}{5891} \times \text{points} \times \text{£75} = \text{the prize}$$

This exercise will have to be done for each clinical domain. Thus £/point will vary considerably both above and below £75 (£120 2005/06). Well organised practices with high morbidities should do well.

➤ Superannuation Contributions

Your superannuable earnings will not be known until the first set of Partnership Accounts are agreed under nGMS. Each practitioner's share of the profits will equate to their superannuable income.

Related to this will be the amount of seniority entitlement. National (UK) average earnings will be taken after Accounts have been agreed and signed off. This will not only dictate the dynamising factor for pensions but also be the yardstick for seniority.

Any earnings above 2/3 of average will trigger a full seniority payment. Earnings of between 1/3 and 2/3 of average earnings will trigger a payment of 60% seniority payment. Any earnings below 1/3 of average earnings will not attract any seniority payment.

Your LMC Representatives Are There For You – Please Use Them

They are there to help and advise you and can be contacted with:

⇒ queries;

nGMS Snippets (Continued)

➤ PMS

John Hutton has written to all PMS practices about how the new arrangements affect them. All pilots become permanent arrangements after 1 April. All central funding stops, so in future preparation and/or growth money will have to come from the PCT's Unified Budget.

The Guidance states that PMS practices will be able to take part in the Q and O initiative but will be subject to a 200 point premium because of payments already included in their PMS contracts.

PMS practices, as mentioned in the editorial, will be waiting with interest for the Guidance to be published later this month concerning "Practice based commissioning". Fundholding again most likely. From the way this Government functions, there are bound to be incentives for this type of contract. It will be interesting to see how the arrangements will interlock with PCTs' commissioning arrangement, or whether it will be an agency arrangement. However, if it is attractive there will no doubt be nGMS practices that will be tempted to cross the divide. The following benefits for nGMS practices will also be available to PMS:

- ** OOH opt out
- ** Enhanced Services

- ** Pensions
- ** Seniority
- ** IM and T
- ** Premises.

➤ Strategy

Times of great change offer opportunities and present risk. GPs and practices may well see great benefit in negotiating with PCTs as a federation, thus achieving the greatest benefit for the greatest number. The contract is fragmentary, offering services to some and not to others. GPs should work together to ensure that as much of the service is retained in General Practice as possible. GPs have huge collective knowledge, experience and infrastructure, which, in the long run, will serve patient care best.

PCTs, on the other hand, are driven by the bottom line. Some Managers may see an opportunity to make their name by "innovative" movement of services to other providers, or becoming providers through their organisation.

The negotiating strength of historic provision, and the experience associated, with it will be short lived. Now is the time for GPs to act in unison to take advantage of the opportunities offered.

SECRETARIAT LIST SERVER

160+ GPs and Practice Managers have now signed up to our List Server, established to facilitate the exchange of information, views and ideas, across the two counties.

If you would like to join them, you can do so via our web site, or by emailing your preferred email address to:

GPC REGIONAL REPRESENTATIVE

Dr Eric Rose is the GPC Regional Representative for both counties.

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