

April/May  
2002

## ECMS

Since its launch on 18 March the system has thrown up a series of problems and the feedback received in this office has all been critical.

The project team that had LMC representation has been altered and I no longer sit on it. I am endeavouring to feedback the anxieties of GPs as I receive them. The project management of the pilot has passed to Sue Heatherington, Chief Executive of Wokingham PCT at Wokingham Hospital. I shall be writing to her with the concerns of GPs and pass on to her their first hand experiences. Evaluation forms are supposed to be sent out to 1: 10 users and every case where the patient has been admitted to an alternative hospital. This apparently isn't happening.

Among the complaints are:

- Extra telephone calls needed compared with the old system.
- Calls charged at national rates and often GPs asked to hold on for several minutes, 15 minutes on a mobile in one instance.
- Acute Trusts' failure to understand the system.
- The patient's home is used as the waiting room during which time the GP has clinical responsibility.
- GPs advised by ECMS to use 999 inappropriately.
- There is no improvement in the outcome just more effort required to admit the patient.

If the system is not working it is essential to have it altered to achieve the improvements it was expected to achieve.

With that in mind either let me or Ms Heatherington (or both) know of your concerns. The pilot is costing £3 million and clearly at present is not providing value for money.

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### INSERTS:

1 Classifieds

## MOTIONS TO CONFERENCE

A list of the Motions from both Berkshire and Buckinghamshire LMCs to this year's Annual Conference, and to the Special Conference, are included on page 5 of the Newsletter.

## FAREWELL TO LINDA

With regret the Secretariat has had to say farewell to Linda Butler, who finally called time on fighting the rush hour traffic!

Our grateful thanks go to Linda for all her hard work and support during her time with us, together with every best wish for the future.



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# Letter From The Secretary

Dear Colleague

So the cat's out of the bag!

On April 19<sup>th</sup> four of us from the two counties attended the special LMC meeting to unveil the proposed new contractual framework for GPs. It should be of interest both to GMS and PMS doctors for two reasons. Firstly, if what is on offer turns out to be acceptable PMS doctors may wish to cash in their return ticket and, secondly, because of the government's stated intention to have national standards, the new contract may be what we shall all be working to in the future.

As Julian Neale, Chairman of the Conference of LMCs, said at the special meeting the more you read the documents the more seems to appear. Much has been written in the medical press about the proposals and you will have received a copy of the contract, which I am sure you have all read carefully.

As with many situations of this nature much of the problem lies with what is not in the document and how the detail will impact on your working lives. Not surprisingly there is good and not so good and inevitably some GPs will benefit and others lose. **Don't forget you have a chance to question a member of the negotiating team on 21 May, Adams Park, Wycombe.**

The profession is being asked to approve the proposals in two stages:

- A vote on the framework as published. Although the ballot papers will be sent out before the Conference of LMCs in June the return deadline will be after the Conference, one day of which is dedicated to the New Contract Proposals.
- If the framework is approved there will be a second ballot after the contract is priced.

The action to be taken if the profession rejects the proposals at the first round is unclear.

I shall outline the main proposals:

- Move to a Practice based contract (this requires primary legislation). Individual lists will disappear which will mean all doctors will have to revisit their partnership agreements.

Before outlining the main proposals I will describe the funding streams. There are three:

1. **The Global Sum** which comes direct to the Practice according to the list size.
2. **The PCT Unified Budget** which pays for enhanced services and other things IT, etc.
3. **Quality Payment Fund** which is new money for the quality payments, untouchable by the PCT.

Services will fall into the following categories:

- Essential (must do) looking after ill people **global sum**.
- Additional (expected to do) Imm and Vacc, cervical cytology **global sum**. There are opting out arrangements, which may be invoked depending on the circumstances. This may take between 3 and 9 months.
- Enhanced:
  1. National (negotiated centrally) INR, specialist GP services **unified budget r/f**.
  2. Local (negotiated locally) Asylum seekers, homeless, violent patients **unified budget not r/f**.

Payments from the global sum will be on a weighted capitation basis, which produces a notional list size. Various factors will be taken into account. e.g. deprivation. Thus an actual list size of 1950 patients could produce a notional list size of 2250 depending on the weighting factors. Previous staff reimbursement payments will be included in this sum which will be reviewed annually.

Out of Hours is defined as 8.00 am – 6.30 pm. Monday to Friday, yes Saturday morning disappears. The intention is to pass the responsibility for this service to PCTs. This will take time. There will be a transitional period when provision of the service will be on an opting out basis before it becomes an opting in service.

Quality payments are the one area where new money is identified. Quality will cover three main areas:

- Organisational Access, patient opinion, etc. **3 tiers**.
- Tiered Clinical which covers well defined clinical conditions including epilepsy, thyroid disease, menopause management, palliative care and upper GI disorders. **3 tiers**.
- Phased clinical which covers complex conditions including CHD, CCF, Hypertension and stroke. It is likely that diabetes will appear in this group. **5 tiers**.

You cannot cherry pick different tiers in the different categories but have to progress in stepwise fashion across the spectrum.

Payment for quality is broken down into three elements:

1. Infrastructure - to pay for staff etc needed to achieve the chosen tier. **Paid up front**.
2. Aspiration – you chose the level of quality you wish to achieve. **Paid up front**.
3. Achievement – this is paid when you have fulfilled the aspiration.


You have two years to achieve your aspiration. Once a level has been achieved it stays in place for two years. The tiers in the phased clinical group are organised so that most practices will easily achieve the first tier and only a small minority the 5<sup>th</sup>.

Certain payments will be in the gift of the PCT. Enhanced local services, Computer payments (100%), additional payments for Practice management and career development for GPs and their staff. This includes the current seniority payments, a commitment is given that those GPs in receipt of seniority payments will not be 'relatively' disadvantaged.

This is the briefest of summaries and there is much else in the detail.

There are many black holes. Pensions are the most prominent. There is still a considerable (11%+) chunk of GPs earning that are excluded from the dynamising calculations. There are still many areas not yet agreed and subject to further negotiation.

GPs will need to decide whether what is proposed offers an appropriate balance between flexibilities offered and the amount of control over GPs that will devolve to PCTs. GPs will also need to ask themselves whether or not it is appropriate to approve in principle an incomplete contractual framework and if it is sensible to vote on an unpriced model. Opinion is divided on all of these questions but every GP has a lot of thinking to do between now and putting a cross on the ballot paper in June. Make sure you put yourself in a position to make an informed choice.

A yes vote will mean a progression  as it is

# News

## ◆ TVHA

The Thames Valley Health Authority is just four weeks old and the county Health Authorities have disappeared, for the time being at any rate. In October the TVHA becomes the TVStHA when it receives the legislative backing to assume its new roles.

As LMCs still have to relate to a Health Authority, I have written to the TVHA to have the individual county LMCs recognised. The Local Reference Committees, as Sub-Committees of the county LMCs, will fulfil the representative role at PCT level. Although the legislation is not in place many of the roles previously fulfilled by HAs have been passed to the PCTs on an agency basis. The application was on TVHA Board agenda on 24 April.

## ◆ The Local Reference Committees

There have been meetings of seven out of the ten LRCs in the two counties. They are gradually feeling their feet and no doubt will become a useful mechanism for working with PCTs hopefully for the benefit of GPs and their patients.

In order to serve your interests well it is important that you let either your local reps, or the office, know of any burning issues so that they can be put on the agenda. They will only be as useful as you allow them to be.

In order to keep Practices involved it is our intention to send the Minutes of the meetings relevant to each Practice, preferably by e mail. This will not start until we are up to strength in the office as we have just lost a member of staff.

**NB: A list of the membership of the Local Reference Committees in each county appears on page 6 of this Newsletter for information.**

## ◆ County LMC Vacancies

Because of retirements we have vacancies in Wokingham, Newbury and Milton Keynes. The Office will be seeking nominations in these constituencies shortly.

## ◆ Allocations

GPs in parts both counties have been troubled by allocations. The TVPCA has a small working group to define all the issues and then GPs will be told how the system works.

However, the process is not random and the TVPCA staff work hard to try and be even handed. It is unfortunate, therefore, when they receive verbal abuse from frustrated GPs who often think they are being singled out for allocations. The problems arise when GPs

close their lists even to patients in their core practice area. Patients are then allocated to neighbouring practices that return the compliment. The domino effect is serial list closing with counter intuitive allocations scattering patients when everyone is unhappy.

Occasionally problems have arisen when Practices have changed their boundaries. All Practices should remember that they have to get permission to change their boundaries from the TVHA through the primary care agencies after approval by the PCT after consultation with the LMC. Boundaries have to be published in practice leaflets. Unless permission has been obtained the boundaries will be those that were defined with all the changes in 1990.

In Vale of Aylesbury where the solution has been agreed among groups of practices allocations have fallen 165 per month to 13 per month. This simply resulted from practices agreeing to take patients in their 'core' practice area, which in turn was agreed both with Primary Care and each other. After all some one moving into a core area usually means somebody else is moving out.

There will always be the hard core of patients who for one reason or another (exclusive of cost or legitimate clinical demand) will be allocated on a rotational basis because no one wishes to look after them.

## ◆ Professional Executive GP Membership

Some areas in the two counties are finding it difficult to recruit GP members to their Professional Executive Committees. If you are canvassed do not rule the possibility out of hand.

In order for PCTs to work it is essential to have high quality GP membership on the PECs. GPs have the ability to bring a GP perspective to the difficult executive decisions PCTs have to take.

However remember you will not be a GP representative, that role falls to the LMC, and there will be times that the corporate decisions of the PCT may run counter to the wishes of your colleagues.

Nonetheless these are important functions in the workings of the PCTs and GPs need to be there. Should GP seats remain vacant then there is always the possibility that the PCT will consider giving them to other healthcare professionals.

## ◆ GP appraisal

Different PCTs are taking different

approaches; they all have difficulty in identifying funds.

Don't forget the guidance is specific that appraisal as a Terms and Conditions matter must be properly funded by the PCT for both appraiser and appraisee. This means either providing or paying for locum cover for the process individually. Appraisal should not be attached to PGEA or any corporate clinical governance exercises.

## ◆ Practice Reports Buckinghamshire

Practices in Buckinghamshire are being asked to produce practice reports giving much more complex information than they are statutorily required to do. This is a countywide approach and needless to say the LMC was not consulted although it is covered in your Terms and Conditions of Service requiring consultation.

The additional information being requested is no doubt of use for the PCT's planning purposes and thought has no doubt been given to the areas covered so that only relevant data is requested.

However, no matter what words the PCT use in the letter about the Annual Report you are only obliged to comply with Schedule 2 paragraph 50 to the NHS Regulations. Extracting this extra information for the PCT will no doubt have resource implications for Practices, as the statistics sought are relatively complex.

It is not right that the request for this data should be bolted onto a statutory obligation particularly when there was no consultation. Practices must decide whether they wish to comply or negotiate extra payment for assisting in primary care planning.

### Your LMC Representatives Are There For You – Please Use Them

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

- ⇒ Queries
- ⇒ topics you would like raised at LMC meetings
- ⇒ your views.

Our grateful thanks go to Lloyds TSB for kindly agreeing to renew their sponsorship for another year and to Bayer for their continuing sponsorship.



## GPC Slot

*These views are a personal expression and not necessarily shared by the LMC*

In June all GPs can vote on the new contract proposals. Every GP should have received a copy. It is important to make sure that you have read the right document. The pamphlet from the GPC that dropped into your letterbox is called “*Your Contract Your Future*” and subtitled “*General practice contract and Explanatory notes from the GPC*”. The contract framework – the important bit – is actually the last document in it but should be read first.

GPs will want to make up their own minds about the proposals. Some questions may help clarify things.

*When the profession voted overwhelmingly last year to consider resignation, what was it that was making us so demoralised?*

Was it total workload, the intensity of work and the relentless demands of patients, managers and politicians? Was it pay? Did you have your own particular reason for the way you voted? Look carefully at the proposals. Do they sort things out?

The suggestions for demand management are about educating patients into better use of services. Do you believe this will be enough? Will the ability (which already exists) to opt out of services like cervical cytology, childhood vaccinations, chronic disease management and out of hours make a significant difference to your day-to-day workload? This is what the GPC Negotiators believe. Do you agree?

If poor remuneration was an issue for you when you voted last year, is it okay to be asked to vote on a framework that has not been priced? Do you believe that the government intends to pay GPs adequately for providing Essential and Additional services or do you think GPs will have to sign up to National and Local Enhanced services and the Quality and Outcomes framework to maintain their income? If so, is this acceptable?

*Is the profession protected against future unilateral changes to the contract by the government?*

The government has said that it will observe a twelve week consultation period in all but exceptional circumstances but will still be able to impose change unilaterally. Is this alright?

*What effect will the Quality and Outcomes framework have on the practice?*

Quality will be measured mainly by audits of GPs’ adherence to protocols. Do you agree that this is the correct way to assess quality of care? Do the proposals give enough weight to the more intangible elements of excellent medical care? Do you have concerns about the effect on the doctor-patient relationship of doctors being paid for having patients on certain treatments? Is the individuality of the patient sufficiently protected?

The GPC negotiators believe that the Quality and Outcomes framework is not bureaucratic. Do you agree? How will the collection of so much data affect you and your staff? Will the

recording of “exceptions”, patients who may be excluded from targets, be time-consuming or not? Do you think the PCT will accept your list of exceptions or will you have to justify some, most or all of them? Does the government have a good record on setting and paying for targets? Below quality level 4, staying on the same level for more than two years is not good enough and practices will lose income if they don’t steadily improve. Are you happy with this?

*Premises*

The section on premises promises support for GPs saddled with negative equity or large mortgages. Improving premises owned by GPs should be easier. However, there is nothing about PCTs having to provide suitable premises for GPs who do not want to buy or lease premises commercially. Some of what is proposed has not actually been agreed. Do you like the premises package?

*Will GPs’ independence be increased or decreased by the new contract proposals?*

Will PCT managers have more or less influence than before on the way your practice is run? PCTs will own all the practice computers. They may employ and provide practice managers, especially for smaller practices. Will this make GPs more dependent on PCTs? Might the taxman decide that some GP principals really aren’t self-employed any longer? Or will the move to a practice-based contract actually make our self-employed status more secure? What do you think?

*What will it be like at the coalface?*

Will general practice be what you want it to be? Will you enjoy your job? Practices will hold lists of patients – individual GP lists of patients will be no more. Will this affect the way patients see the doctors in the practice? Will it affect continuity of care?

*Are there principles at stake?*

The proposals have been presented as a necessary set of changes to which there is no alternative. It is all or nothing. GPs need to look at the proposals not as an unpriced contract that needs pricing before a decision can be made, but as a framework that needs to be accepted or rejected on the principles within it. If you think the framework leaves intact the underlying principles of general practice and that you would like to work under the conditions proposed, then you will want to ask the next question, “Do I like it enough to want to see the price”. However, if you think that the framework will alter the nature of general practice in a way which will harm the profession and the doctor-patient relationship, or that working in the way proposed would be unacceptable, then the question is, “Do I know enough already to conclude that I cannot support the framework and want the GPC negotiators to try again?”

# PMS Contracts

With the arrival of the draft GP contract many practices, which hitherto may have been considering taking on PMS status, will need to rethink their strategic direction. Practices will need to compare what is available under the GMS proposals as set against that which is provided by PMS. According to the draft proposal, the new contract offers significant improvements over PMS. Whatever choice you make, the Government states clearly that it wants to see a single contract for GPs within the next two to three years so whatever the choice the ultimate outcome is already written in the stars.

At the same time, many 2nd Wave PMS practices will soon be looking at renewing their agreements with their PCT. Practices should be aware that PCTs will want to add additional performance criteria particularly in relation to 3rd Wave Agreements which were

more rigorous than 2nd Wave. Many of these performance criteria will be linked to NSF requirements and Access targets from which no practice is exempt, however under PMS, practices are actually signing up to delivering performance targets which their colleagues working under GMS are not required to do. One of the greatest causes for concern is additional workload and signing up to achieving more targets carries with it the inevitable increase in workload.

Our advice to PMS practices is, if it is not broke why mend it? In other words if you are happy with your current agreement why sign up to another one? In this ever changing world of NHS and primary care it won't be long before it is all change again and another set of performance targets will be imposed within the context of another core contract, and so the wheel turns ...

## MOTIONS TO CONFERENCE

### BERKSHIRE LMC MOTIONS TO CONFERENCE

- 1 That this Conference requires GPC to seek negotiations with the CPS or other appropriate Office to secure appropriate reimbursement of costs for GPs required to give evidence both as an ordinary or expert witness.
- 2 That this Conference deeply regrets that the stated intention of the Secretary of State of Health of Zero Tolerance of violence towards NHS staff is not being implemented in the spirit of HSC 2000/001 by the failure of many Health Authorities and their successors to provide secure premises for the treatment of violent patients and asks GPC to negotiate a national solution as a matter of urgency.
- 3 That this Conference believes in a Primary Care led NHS and requires GPC to inform Government that this aspiration is undeliverable without proper new ringfenced funding dedicated to Primary Care.
- 4 That this Conference understands that having responsibility for 75% of inadequate funding is putting PCTs in an impossible position and is another way for politicians to pass the buck of failure to deliver.
- 5 This Conference demands that the GPC pressurises the Government to honour its commitment that ALL locum income be pensionable from April 2001 and not accept any further delays in its implementation, thereby ensuring that Assistants and Principals who also do locum work are not disadvantaged.
- 6 This Conference believes the collaborative has not produced meaningful advances in 48 hour access but has managed to distort clinical priorities.

### BERKSHIRE LMC MOTION TO SPECIAL CONFERENCE

That Conference firmly believes that General Practitioners cannot make a reasoned judgement on the proposed new contract for GPs without:

- 1 pricing
- 2 having sight of other models for providing Primary Care outside traditional NHS contracts produced by the Special Advisory Group to GPC.

### BUCKINGHAMSHIRE LMC MOTIONS TO CONFERENCE

- 1 That this Conference, whilst reaffirming its support for greater skill-mix within Primary Care believes that proposals for the wholesale replacement of GPs as the first point of contact by nurse practitioners are:
  - i) not Evidence Based
  - ii) not properly thought out
  - iii) not feasible as an answer to the current workload crisis.

2 That this Conference deeply regrets that the stated intention of the Secretary of State of Zero Tolerance of violence towards NHS staff is not being implemented in the spirit of HSC 2000/001 by the failure of many Health Authorities and their successors to provide secure premises for the treatment of violent patients and asks GPC to negotiate a national solution as a matter of urgency.

3 That Conference is confused by the multiplicity of regulatory and supervisory bodies now able to take action against a GP and request GPC to try and negotiate a more manageable system.

4 That Conference asserts that the refusal of this government to allow locum work undertaken by assistant and part-time GP principals to be eligible for the NHS superannuation scheme confirms the current belief that this government has no real commitment to supporting general practice.

5 That Conference believes that the Health and Social Care Act 2001 breaches the Human Right Act and:

- 1) supports any action taken by the GP Defence Fund to test this belief in Court
- 2) supports the contention that this government has no genuine commitment to general practice.

### BUCKINGHAMSHIRE LMC MOTIONS TO SPECIAL CONFERENCE

1 That the proposed new contract is more likely to undermine than enhance the Independence of General Practitioners.

2 That Conference cannot recommend acceptance of the proposed new contract for GPs until all outstanding negotiating issues are satisfactorily completed.

3 That Conference cannot recommend acceptance of an unpriced contract.

4 That Conference believes that the proposed new contract will be unnecessarily bureaucratic particularly with regard to identifying and confirming "exclusions".

### YOUR SECRETARIAT TEAM

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