NEW

North & South Essex Local Medical Committees

Volume 2 Issue 1

Special points of interest:

- Practice Based Commissioning
- Primary Medical Services Allocations
- Enhanced Services Spending by PCO
- QMAS & QOF review process
- Appraisals
- Referral Forms

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Welcome to first issue of the LMC 'TMI'

It is now over twelve months since the first issue of the LMCs' New Contract Update.

Hopefully the update has been a useful source of reference for practices.

The end of the first twelve months seemed a sensible time to review both the structure and frequency of the New Contract Updates. Feedback from practices has been positive and the idea of providing information to practices on a monthly basis, in a common format appears to have been of help to practices.

With this in mind and in an attempt to keep information sent to practices to a minimum the following has been agreed.

- From January 2005 issue onwards the New Contract Update will now become known as the 'TMI'.
- The change of title reflects the fact that the TMI will also include issues that would previously have formed part of the LMCs' quarterly Newsletters (now defunct!!)
- The main content will continue to be issues arising from the new GMS/PMS contractual arrangements and will appear in the same format as the New Contract Update.

Hopefully TMI will remain of interest and help to practices. Feedback from practices, either positive or negative is always welcome. If you feel that there is any other information that should be included in these regular bulletins then please do not hesitate to contact the LMC office.

Practice Based Commissioning

Main Proposals

Practice based commissioning is a new, currently England only, initiative. The Government's proposals set out that from April 2005, all practices/groups of practices will have the right to receive a firm indicative budget from the PCT at any stage in-year and thereafter.

The Department of Health's paper is intentionally non-prescriptive and states the Government's wish to see early experience of the scheme informing its later development. It would appear therefore that by putting forward ideas at a local level and negotiating around the practicalities, LMCs can be proactive in shaping the best practice models which will emerge in the future.

The Department's paper outlines a broad set of proposals – the main points are given below:

1. All practices will receive annual information on their use of health services, "including scheduled care, unscheduled care, and diagnostics". This will be one of the factors by which PCT competency in commissioning will be measured.
2. The indicative budget will in the first instance be based on historic practice utilisation of healthcare resources, with a move to a weighted capitation formula within 3 years.
3. PCTs will hold the budget and will be responsible for contracts with secondary care providers.
4. There will be initial flexibility for practices to choose for which services they wish to hold a budget, although there is an expectation that practices will move towards holding budgets "covering the entire scope of health care provision with the exception of a few highly specialised services".
5. Commissioning process: the practice(s), with support from their PCT, will identify the health needs of the local population and in conjunction with local stakeholders, identify the appropriate services to be provided. Decisions to be made within context of agreed Local Delivery Plan (LDP).
6. Practices must offer patients a choice – there should be no coercion for patients to use a practice based service.
7. One hundred percent of any savings made can be held at practice level, which must then be used for developing or providing services for patients.
8. Overspends will be paid for

Cont'd on page 2

IMPORTANT - PLEASE CIRCULATE TO ALL DRs IN THE PRACTICE

Practice Based Commissioning Cont'd….

"The GPC has expressed its willingness to work with government to develop more detailed proposals"

by the PCT. Practices can overspend in one year, but this will be carried forward and practices must achieve financial balance within 3 years to remain in the scheme (except in exceptional circumstances).

9. Groups other than practices will be able to hold indicative commissioning budgets, e.g. community based nursing teams (the legal mechanism for which would come through PMS contractual frameworks).
10. The quality of new services commissioned or provided by practices must be assured. PCTs will have a role in ensuring that proper clinical governance procedures and appropriate standards in respect of the services provided or commissioned by their constituent practices are in place.
11. Initial management costs will be provided to practices/groups of practices in advance by PCTs.

AREAS REQUIRING CONSIDERATION

1. **Right to hold an indicative budget: objectivity and equity**
   How can fairness be maintained throughout the process, avoiding the situation whereby some practices/groups of practices in the area are favoured over others by the PCT?
2. **Indicative budgets: historic budgets for April 2005**
   Possible inequities resulting from historic budget setting at practice level and subsequently inequitable achievement of savings?
3. **Management costs**
   Have PCTs agreed that they will make available resources for management costs in the preparatory period to gear up to practice based commissioning?
4. **PCT capacity**
   Has the PCT identified a practice based commissioning lead and has it made adequate provision within its staff for the management aspects involved?
5. **Commissioning decisions and practice discretion**
   How can a transparent process be implemented to ensure that practices/groups of practices are commissioning in accordance with the LDP?
6. **Savings and patient choice**
   How can practices/groups of practices achieve savings?

   How can practices/groups of practices promote in-house/locality services to patients at the same time as offering them a choice of providers?

   How can potential conflicts of interest as regards GP PEC members in the decision making process regarding the deployment of savings be avoided?
7. **Groups other than practices**
   Will information be forthcoming from PCTs when groups other than practices, such as community-based nursing teams, approach the PCT to hold an indicative budget?
8. **Arbitration**
   Possible mechanisms that could be set up in the event of disputes arising from practice based commissioning decisions?

BMA/GPC

The GPC has taken the pragmatic approach to the Government's proposals on practice based commissioning in the absence of more technical guidance, which the Department of Health intends to issue in the New Year. The GPC has expressed its willingness to work with government to develop more detailed proposals.

Further, more detailed, guidance to LMCs from the GPC will be issued in due course.

LMC/PCT Workshops

The LMCs have arranged two workshops for LMC Members and PCT representatives to discuss the implementation of Practice Based Commissioning in Essex.
The workshops will facilitate detailed discussions on the opportunities and implications of Practice Based Commissioning including how best to engage practices.

Feedback following the workshops will be included in the next issue

Funding Arrangements - Primary Medical Services Allocations 2005/06

PCO	Global Sum / MPIG	Appraisal	Premises (in baseline)	IT	Enhanced Services	PCO Administered Funds	PMS
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Basildon	6,472	60	759	75	1,650	258	722
BBW	5,728	50	720	68	1,710	198	3,957
CP&R	3,590	32	451	92	1,989	143	8,459
Chelmsford	6,534	52	945	59	1,516	248	2,302
Colchester	9,536	76	1,914	77	2,021	367	2,432
Epping Forest	3,621	32	1,861	41	1,430	247	5,102
Harlow	1,091	9	393	34	1,156	30	5,702
M&SC	4,185	33	428	38	941	319	1,972
Southend	788	8	354	334	2,338	35	13,536
Tendring	2,637	25	318	68	1,975	80	8,518
Thurrock	6,833	61	944	84	1,842	235	3,717
Uttlesford	5,336	41	707	55	818	253	0
WB&H	6,610	57	972	50	1,641	288	2,681

Global Sum

No news since - August 2004

From this issue onwards, any information regarding MPIG will be placed here under Global Sum.

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Enhanced Services

Basket payments for non-core services have now been agreed with most PCOs across Essex. The basket arrangements vary in terms of content and pricing, dependent on local need and historical transfer of work from secondary care into primary care.

PCOs have always been clear in agreeing baskets with the LMC that payment is in respect of non-core services currently being provided in practices and for current levels of activity. Payment is not dependent on practices providing all of the services included in a basket or for taking on new work!

The LMC has acknowledged that it is difficult for PCOs and practices to quantify current levels of activity, as this data has never been collected. For this reason a number of the basket agreements require practices to collect activity data in a form agreed with the PCO, with a view to informing commissioning of these non-core services in 2005/06.

Where agreements require collection of activity, practices are reminded to submit this information to PCOs in a timely fashion as non-submission may affect the PCOs ability to make the appropriate payment.

Practices are also reminded that if your PCO has not made any arrangements to financially recognise non-core services being provided in primary care there is no obligation on practices to continue to provide these services free of charge!

No Negotiation!
Strictly
No Money —No Work

ENHANCED SERVICES SPENDING BY PCOs in ESSEX

<table>
<tr><th>PCO</th><th>ACHIEVING FLOOR?</th><th>SIGNED OFF AS APPROPRIATE BY LMC?</th><th>EXPECTED TO BE SIGNED OFF BY LMC?</th><th>PCT / LMC DISCUSSIONS TO ADDRESS CONCERNS</th></tr>
<tr><td>TENDRING</td><td>✓</td><td>✓</td><td></td><td></td></tr>
<tr><td>COLCHESTER</td><td>✓</td><td>✓</td><td></td><td></td></tr>
<tr><td>WITHAM, BRAINTREE & HALSTEAD</td><td>✓</td><td>✓</td><td></td><td></td></tr>
<tr><td>MALDON & SOUTH CHELMSFORD</td><td>✓</td><td>x</td><td>✓</td><td>✓</td></tr>
<tr><td>CHELMSFORD</td><td colspan="3">REVISED PLAN AWAITED FOLLOWING CHANGE IN MANAGEMENT</td><td></td></tr>
<tr><td>UTTLESFORD</td><td>✓</td><td>x</td><td>✓</td><td>✓</td></tr>
<tr><td>EPPING FOREST</td><td>✓</td><td>✓</td><td></td><td></td></tr>
<tr><td>HARLOW</td><td>x</td><td>x</td><td>x</td><td>✓</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td>BILLERICAY, BRENTWOOD &</td><td>✓</td><td>x</td><td colspan="2">Formal dispute re inclusion of Saturday am surgeries and PRIMIS Facilitator</td></tr>
<tr><td>BASILDON</td><td>✓</td><td>x</td><td>✓</td><td>✓</td></tr>
<tr><td>THURROCK</td><td>✓</td><td>✓</td><td></td><td></td></tr>
<tr><td>CASTLE POINT & ROCHFORD</td><td>✓</td><td>x</td><td>✓</td><td>✓</td></tr>
<tr><td>SOUTHEND</td><td>✓</td><td>x</td><td>x</td><td>✓</td></tr>
</table>

✓ = Yes   x = No

Quality

QMAS – Getting ready for the end of the year

NPfIT has issued guidance for PCOs and practices on QMAS getting ready for the end of the year. In December 2004 QMAS was updated to include functionality to allow practices to enter aspiration data and for PCOs to agree the aspiration for a practice. SHAs were given access to view SHA level QOF summary reports and PCT level QOF achievement reports within their Authority.

From April 2005 a practice will receive QOF achievement payments based on practice list size, achievement data and aspiration data held on QMAS. Correct clinical, organisational, achievement and aspiration data for a practice needs to be on QMAS before the end of the QOF period, i.e. 31st March 2005.

The Exeter system will take a practice list size count on 1st January 2005 from individual GP clinical systems. This list size will be used to calculate Global Sum and QOF achievement payments.

National prevalence day is the 14th February 2005. A snapshot of all QOF disease registers will be taken on 14th February and used to calculate the national disease prevalence.

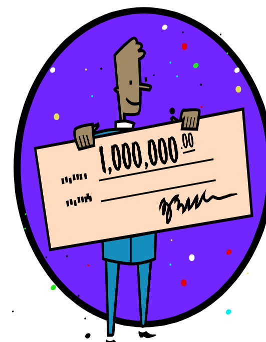
QOF Review Process – Random Counter Fraud Check

PCOs have received guidance on random counter fraud checks.

PCOs will be required to carry out a random counter fraud check on 5% of their contractors following QOF payment. The selection should be truly random and PCOs **may** wish to involve the LMC in the picking process, to reassure contractors that this is the case. Contractors and PCOs should both bear in mind that being picked for a counter fraud check does not imply any suspicion. If a PCO does have suspicions of fraud about a particular contractor, it should pursue these through the normal procedures.

It is recommended that random checks should take place annually and early in the financial year to avoid clashing with the QOF review visit during the second half of the year. It must not be combined with the QOF review visit.
The random check might look in more detail at the issues covered by the pre-payment verification check and so will necessitate at least a brief visit to the contractor. Areas that might be looked at as part of the pre-payment verification check are:

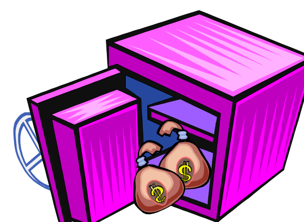
- Very high or low prevalence rates, compared to PCT or national average;
- Very high or low levels of exception reporting;
- Very high or low levels of achievement, compared to the contractor's aspiration or PCT or national average;
- Any sudden large changes in the figures;
- Any substantial discrepancies between the annual QOF review report and the achievement claim;
- In later years, disproportionate amounts of data entry at certain times of the year (although PCOs will be aware that contractors can choose to spread their workload as they wish and may concentrate QOF activity at certain times of the year).



"From April 2005 a practice will receive QOF achievement payments based on practice list size, achievement data and aspiration data held on QMAS"

PCO Administered Funds

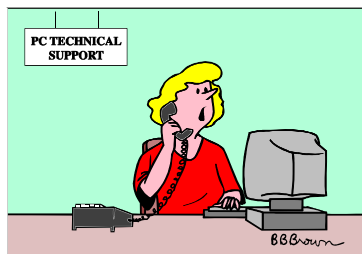
No news since - August 2004



Premises

No news since - August 2004

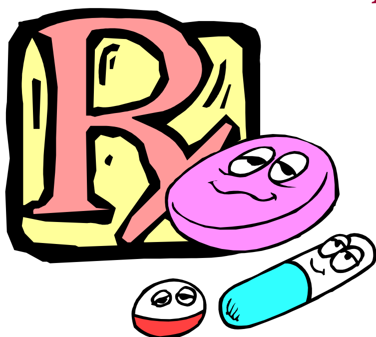
Information Management & Technology



"For that problem, sir, you need to contact the wizard of DOS."

No news since - August 2004

Dispensing



No news since - August 2004

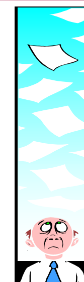
Out of Hours - Development Fund

There appears to have been confusion amongst some PCOs regarding payment of this year's Out of Hours Development Fund to practices. The LMC has been trying to seek clarification with the PCOs concerned who have maintained the view that the OOH development fund no longer exists and is within practice global sum!

Clarification was sought from the Strategic Health Authority, who confirmed that the above is incorrect. PCOs did receive an allocation for OOH development fund for 2004/05. However, some PCOs are still reluctant to acknowledge this and to pass the money onto practices. Clearly, where the PCO has now assumed responsibility for Out of Hours the payment will need to be pro-rated. If you are a practice affected by this the LMC would advise you to contact your PCO for clarification on how to claim a back-dated payment. Please let the LMC know should you have any difficulty.

PMS Issues

No news since - Oct/Nov 2004



General Help & Support for Practices

	Milestone	Activities
37	14th February 2005	QOF national prevalence day, at which point, relative recorded practice prevalence is measured. This will have taken place automatically for practices using QMAS
38	21st February 2005	Contractors not using QMAS will have submitted data for the prevalence calculation to their PCT

Appraisals

It would appear that in the region of 250 GPs have still to be appraised in 2004/5 GPs are reminded that this is a contractual requirement and at the present time appraisals will assist in complying with future revalidation requirements.

GPs wishing to arrange their appraisal should contact Madeline Kenny on 01245 380695. This does not apply to GPs in Tendring and Uttlesford who should contact their PCT

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We're on the Web
www.essexlmc.org.uk

LMC Position letter re referral forms (courtesy of East Yorkshire LMC)

The principles

- The needs of the patient are paramount
- The purpose of the referral letter is to provide information to assist the secondary provider to deliver appropriate medical care to the individual patient

All care providers are responsible for their own administrative systems

The problems

Over recent years more and more departments are designing forms that they expect GPs to use when referring patients to consultants or GPsWSIs.

The quality of information on the forms is less informative for its primary purpose than a good quality traditional referral.

The forms do not integrate with GP IT systems, and so are lengthy to complete, prone to illegibility, and less likely to pass on accurate past medical history or current medication. Easily forgotten details such as allergies are also easily omitted. There is no record of the details of the referral on the GP system for medicolegal purposes.

The large numbers of departments with differing requirements have resulted in a large number of forms for secretaries to keep, find, and photocopy when they run out.

GPs referring using a traditional letter often find their referral rejected.

Tick-box forms trivialise the complexities of referral decisions, obscure nuances of the English language, degrade personal GP/consultant relationships, and de-professionalize general practice.

Individual referral forms will be incompatible with any 'Choose and Book' initiative.

Reasons for the forms

On discussion with secondary care managers the first reason given for the forms is to allow the collection of data for audit purposes.

Occasionally it is mentioned that some GPs write poor quality letters and the forms encourage certain important details to be provided.

Some GPs, particularly those with low levels of IT use, find them convenient.

Discussion

It appears that managers in the secondary sector have firmly placed the cart before the horse, and subjugated the clinical needs to the administrative.

If audit needs to be done it is the responsibility of the secondary provider to collect the data, general practice has enough audit requirements of its own.

If letters from GPs are of poor quality, this should be addressed through clinical governance channels rather than by blanket measures such as standardized referral forms.

We would expect referral letters, in addition to demographic data, to contain an assessment of urgency, description of the clinical problem and examination findings, relevant test results, past medical history, drug history, allergies, and details of treatments already tried.

Secondary care providers have a duty of care to patients referred to them, and this starts from the moment that they are made aware of the referral. For a provider to refuse to see a patient on the grounds that the referral was not made on a particular form is ethically unacceptable.

Recommendation

- That Secondary care providers are welcome to distribute standardized referral forms if they wish.
- GPs are encouraged to use whichever method of referral they feel will best provide an exchange of clinical information and ideas between the consulting doctors.
- Patients being referred on traditional referral letters must on no occasions be discriminated against.
- The collection of audit data remains the responsibility of the organisation carrying out the audit.
- GPs consistently providing inadequate referral letters or inappropriate referrals should be helped improve their practice through clinical governance procedures.

Local Management of Complaints

The article in the September 2004 Newsletter **incorrectly stated** that GPs in Southend and Thurrock were included in the arrangement provided by Essex Consumer Services Team (ECST).

Southend and Thurrock PCTs will be writing to all GPs in their area advising them of the support that is available in dealing with complaints.

Apologies for any confusion the article may have caused.

NEXT ISSUE MARCH 2005!