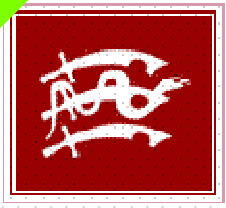


NEW



North & South Essex Local Medical Committees

Too Much Information ?

Volume 2 Issue 2

March 2005

Special points of interest:

- Practice Based Commissioning
- Enhanced Services
- Choose & Book
- Quality
- Appraisals
- PGEA
- Premium & National Rate Phone lines
- Freedom of Information Act

Inside this issue:

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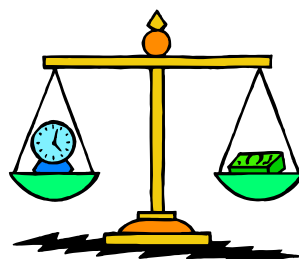
Practice Based Commissioning

Two seminars, involving PCO representatives and LMC Members and officers were held at the LMC office in February. The seminars were held with a view to developing a collaborative approach between the LMC's, PCOs and practices in progressing practice based commissioning (PBC) in Essex. Both meetings were well attended and generated an opportunity to consider where we are now, challenges attached to PBC and also the potential opportunities for both practices and PCOs.

Everyone agreed that there are real difficulties around the available referral data and validation of the data. The changing timetable for Payment by Results was also viewed as a lost opportunity this year. There is very little guidance in terms of PBC implementation and whilst it was hoped that the technical guidance, issued at the end of February would answer some of the questions on management costs and resources within both

practices and PCOs, this has not proved to be the case (more on that later)!

None the less, it was also acknowledged that there could be some real opportunities to be gained by PBC. The lack of rules could be seen as an advantage, providing an opportunity to develop local policies and



principles between the PCOs and LMC's.

Both meetings identified possible next steps:

1. O n g o i n g communication between the LMC and PCOs;
2. Supporting data collection and validation – looking at ways to resource practices to do this;
3. Identifying a short list of procedures where practices could make a difference;

4. Building on the principles of PBC to make it more tangible;

5. C o n s i d e r opportunities for an Essex wide approach.

Everyone who came to the seminars agreed that they had been useful in what will hopefully be the start of ongoing discussion towards the development and implementation of PBC in Essex.

Practice Based Commissioning – Technical Guidance

Technical Guidance on PBC finally arrived at the end of February and this can be accessed on our website at www.essexlmc.org.uk. As expressed by Dr Hamish Meldrum, the view generally is that the guidance is neither very technical nor does it give much guidance! It also explicitly links PBC with Choose and Book and this has caused concern at GPC, LMC and with doctors. There will be more on Choose and Book later in this

Cont'd on page 2

IMPORTANT - PLEASE CIRCULATE TO ALL DRs IN THE PRACTICE

Practice Based Commissioning Cont'd....

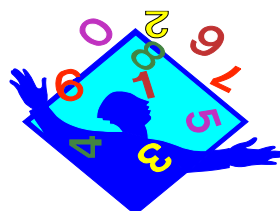


newsletter, but in connection with this, you are reminded that there is no contractual requirement for GMS or PMS practices to participate in Choose and Book.

The technical guidance covers budget setting and risk management, management costs, use of efficiency gains (savings) and governance. It should be noted that it also reinforces the principle that practices may

choose to work in groups or networks (localities) but that the utilisation of these localities for PBC cannot be imposed on practices.

We are now awaiting further guidance from the GPC on PBC, which should help GP's in deciding whether or not to take on this new commissioning role.



Global Sum—PGEA

Most people will by now have heard about the Islington GP who won his case against Islington PCT to claim a full year's PGEA following the start of the new contract. The whole crux of this matter rests on whether PGEA was paid in arrears or advance. Following further legal advice the view of the GPC is that the ruling cannot be applied generically to all GPs because:

It would not apply to PMS practices who have different arrangements. It would only apply to those who could present evidence themselves that they had been paid in arrears, and

The GPC is aware of other GPs who can provide evidence that they had not been paid in arrears.

Given the above, it is not possible for the GPC to take a legal or negotiating action on behalf of the whole profession at this stage. To take a class action would need a large group of GPs, all of whom could provide evidence that they had been paid annually, in arrears. It is also important to note that the summary judgement in favour of the claimant's case came about because the PCT could not provide evidence that the doctor

had not been paid in arrears. However, the GPC will be undertaking investigations to find out what further information they can about what happened in the past to see if there is anything further that can be done. In the meantime, GPC current advice is that only those who can provide evidence that they had been paid in arrears might have a case.

Essex Contractor Services has assured the LMC that Essex GPs were paid in 1990 and that no further payments are due.

'..it is not possible for the GPC to take a legal or negotiating action on behalf of the whole profession at this stage. To take a class action would need a large group of GPs, all of whom could provide evidence that they had been paid annually, in arrears.'

Enhanced Services

Agreeing Enhanced Services Floors— GPC Guidance for LMCs

The GPC has recently drawn up a list that reflects the result of local negotiations between LMCs and PCOs on Enhanced Services across the UK in 2004/5.

The list has been divided into three broad

categories: services that are enhanced services that can legitimately count towards the enhanced services floor (ESF), services that either are or are not enhanced services, but cannot count towards the ESF and services that, depending on local arrangements, their inclusion in the ESF varies.

The *varies* section exists as a result of an example

where historical, local factors mean that what in most areas would not count towards the enhanced services floor, in some areas does.



Enhanced services that can count towards the ESF

- | | |
|--|--|
| <p>1. All Directed Enhanced Services & National Enhanced Services</p> <p>2. Nursing/residential homes
Includes the enhanced element of care only</p> <p>3. Refugees & asylum seekers</p> <p>4. Prescribing and monitoring drugs not mentioned in the 'near patient testing' NES
Includes amiodarone, gold and sulphasalazine, lithium etc.</p> <p>5. Initiation of secondary care drugs
Includes insulin and initial monitoring under shared care agreements such as depot psychotropics, Ritalin and alcohol dependency prescribing
Note that "shared care" must be genuine and not merely on the instruction of a Consultant</p> <p>6. Suture removals
Note where there is a specific LES</p> | <p>7. Dressings post operation/leg ulcers
Note where there is a specific LES</p> <p>8. Minor/moderate surgery
Includes vasectomy, sigmoidoscopy, carpal tunnel release, in-growing toenails etc.</p> <p>9. GPwSI (community)
Includes dermatology, psychosexual counselling, allergy, genetic counselling, joint injections, vasectomy, urology, heart failure, gynaecology, podiatry
Why? If the GPwSI is working in the community and providing enhanced community GMS, this can count towards the ESF. In addition, to count towards the ESF, the referral pathway should be GP to GPwSI and not via secondary care.</p> <p>10. Contraceptive implants/fittings
Includes Prostat, Implanon, etc.
Why? These implants are not part of ordinary primary medical services as they require special training and technique.</p> <p>11. Other implants/injections
Includes Zoladex</p> |
|--|--|



- depo-provera etc.
12. Information collecting for PCO
Includes waiting list validation
 13. Unscheduled immunisations/vaccinations
Includes MMR to students, Hepatitis B for occupational health reasons etc.
 14. Early morning/evening/weekend surgeries if done by practices at PCO request and funded by same
Does not include emergency work
 26. ECGs upon external-initiation
Includes routine ECG for hypertension, palpitations or chest pain
 27. Ring pessary insertion and changes
 28. Patients with learning disabilities
 29. Hospital transport/ambulance organisation



15. More specialised chronic disease care schemes (GPwSI type)
16. Pre-operative assessments requested by the hospital
Includes MRSA screening
17. Phlebotomy that is not an essential part of GMS
Includes blood tests as requested by the hospital and/or out-patients department



18. 24 hour blood pressure monitoring
19. Cardiac event monitoring (24 hour ECGs)

20. Routine neonatal checks following early discharge or home birth

21. Audiology screening

22. Glaucoma screening

23. Teenage sexual health drop-in clinics



24. Obesity/weight management service

25. Counselling
Includes contestable service provided either by an independent organisation in the community and available to all GP patients and/or provided within surgeries

- Services that either are or are not enhanced services, but cannot count towards the ESF**
1. GPwSI (hospital)
Why not? If a GPwSI is working as a clinical assistant/staff grade in a routine out-patient clinic, this cannot count towards the ESF which includes a GPwSI service based in the community
 2. Therapies
Such as physiotherapy etc.
Why not? In most cases, this is the re-provision of secondary care in GP surgeries or community health settings and is therefore not an enhanced service (and cannot count towards the ESF). However, where a new, additional service for patients, which can be tendered for by GMS and PMS contractors, is established, this would be an enhanced service.

3. Pharmacy work
Such as pharmacy advisors

4. Dental work



5. Secondary care carried out in the community
Such as work done by consultants and specialist nurses

6. Community Hospital current contacts

Unless there is for example a new minor injury unit

- 7. Normal OOH work
- 8. Prescribing incentive schemes
Why not? They are not medical or patient services; they are not contestable; they are not provided to patients and the schemes have never been funded by GMS money (or hospital money), but from completely separate prescribing budgets.
- 9. PRIMIS facilitator
- 10. Citizens Advice workers (practice based)
Why not? This is not an enhanced service as it is a social, not clinical service nor is it the provision of patient care.
- 11. Evercare nursing model and community matrons
- 12. Medical certificates for patients who have been in hospital



Services that, depending on local arrangements, the inclusion of in the ESF varies

- 1. Mental Health workers



Funding Arrangements

No news since - January 2005



ENHANCED SERVICES SPENDING BY PCOs in ESSEX

PCO	ACHIEVING FLOOR?	SIGNED OFF AS APPROPRIATE BY LMC?	EXPECTED TO BE SIGNED OFF BY LMC?	PCT / LMC DISCUSSIONS TO ADDRESS CONCERNS
TENDRING	✓	✓		
COLCHESTER	✓	✓		
WITHAM, BRAINTREE & HALSTEAD	✓	✓		
MALDON & SOUTH CHELMSFORD	✓	x	✓	✓
CHELMSFORD	x	x	✓	✓
UTTLESFORD	✓	✓		
EPPING FOREST	✓	✓		
HARLOW	✓	x	✓	✓
BILLERICAY, BRENTWOOD &	✓	x	Formal dispute re inclusion of Saturday am surgeries and PRIMIS Facilitator	
BASILDON	✓	✓		
THURROCK	✓	✓		
CASTLE POINT & ROCHFORD	✓	✓		
SOUTHEND	✓	x	Formal dispute re inclusion of PMS Greenfield Sites and EX GPFH	



✓ = Yes

x = No

Quality—QUALITY ACHIEVEMENT PAYMENTS

This is a brief reminder to practices about the timetable, process and calculation method for achievement payments under the Quality and Outcomes Framework.

Timetable:

- On 2 April, QMAS calculates the practice's final clinical achievement payment based on the regular report submitted automatically at the end of March 2005. Non-clinical achievement is based on the most recent non-clinical data submission by the practice on QMAS.
- On the same day, the practice should examine the final achievement report on QMAS (Current and Forecast Achievement) and submit their Achievement Declaration.

The calculation of final payments

Final achievement payments are calculated as follows.

A full worked example is given in section 3.63 of the Department of Health guidance *Delivering Investment In General Practice*. The method is also set out in part 2 and annex F of *The Statement of Financial Entitlements*. It is briefly explained below.

- In the clinical domain, the pounds per point in each disease area are adjusted by a separate Adjusted Practice Disease Factor (APDF) for each area. (This factor is based on the prevalence of that disease amongst the

practice population compared with national prevalence figures. All the practice's prevalence figures are subjected to a square root transformation. This compresses the range of prevalence distribution across practices and is done to protect those with the lowest prevalence, which would be at risk of financial disadvantage without this measure).

- In the additional services domain, the pounds per point are adjusted by the relative size of the contractor's target population.
- In the remaining domains (organisational and patient experience) the pounds per point are multiplied by the points scored, including points for the holistic care and quality practice payments and access bonus
- The points and pounds in all domains are added up to give a total raw achievement. For PMS practices, a points deduction is made (168 for 2004/05, 109 for 2005/06) to account for quality payments already in PMS baselines. The reasons for this deduction are explained in more detail in section 4.2 of the Department of Health guidance - *Sustaining Innovation Through New PMS Arrangements*.
- This figure (in pounds) is then adjusted by relative list size (i.e. multiplied by the Contractor Population Index).

- The practice's aspiration payment is then deducted from this to give a final net achievement for the year.

Disputes

If the practice or PCT does not agree with the practice's achievement value

If either the practice and/or the PCT disagree with the practice's achievement payment value then they will need to enter into a negotiation in order to agree on whether an adjustment to the payment value is appropriate.

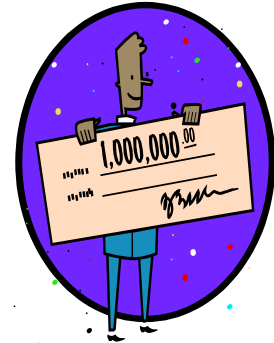
In the first instance it will be necessary for the practice and/or the PCT to assemble evidence in support of the disagreement before entering into discussions with the other party.

After assembling the evidence the practice and/or the PCT will need to contact the other party in order to review the evidence and negotiate an adjustment.

Adjustment where there is agreement following the PCT-practice review

Where agreement is reached, the PCT can adjust the practice's clinical/non-clinical achievement data. When this adjustment is made, then a new achievement report is generated that must go through the full approval process.

If, after negotiations, it is agreed that no adjustment is required, the process returns to the activity which triggered the need for the negotiation:



"If either the practice and/or the PCT disagree with the practice's achievement payment value then they will need to enter into a negotiation in order to agree on whether an adjustment to the payment value is appropriate."



Quality—Cont'd...



- If the practice disagreed with the payment then it will now need to agree its achievement payment report on QMAS and submit its 'Achievement Declaration'.
- If the PCT disagreed with payment then it will now need to approve the achievement payment report on QMAS and initiate actual payment.

Dispute Resolution where there is no agreement following the PCT-practice review

Where no agreement can be reached then it will be necessary to invoke local dispute resolution processes. If these do not resolve the situation then the formal dispute resolution processes should be initiated. A description of these processes can be found in the paragraphs 6.33 – 6.38 of the Department of Health December 2003 guidance 'Delivering Investment in General Practice – Implementing the new GMS contract'.

The detailed process for dispute resolution is also set out in the 2004 GMS and PMS regulations

Role of LMCs

The dispute resolution procedure is a complex and expensive procedure. Where possible the LMCs will assist practices in resolving disagreements locally with the PCT before referring the matter for dispute.

'Some practices are currently being invited to be involved in Choose and Book pilots. Before agreeing to be involved the GPC strongly suggests that LMCs and practices consider the following:'

Choose & Book

The GPC produced guidance on Choose and Book in November 2004. The guidance explains what it is, how it is proposed that practices should be involved and how it will work. There is also a section on 'Issues for LMCs and Practices to consider' and these are set out below:

Some practices are currently being invited to be involved in Choose and Book pilots. Before agreeing to be involved the GPC strongly suggests that LMCs and practices consider the following:

Workload

- The GPC are very concerned about the workload implications of Choose and Book. The GPC has worked to find ways of reducing

the workload of GPs. Choose and Book is in danger of counteracting these efforts and will place a further burden on practices.

Time Constraints

- It will be difficult for GPs to complete a Choose and Book appointment within the confines of a ten minute consultation, and we are concerned about the consequent effect on the quality of those and subsequent consultations.

Additional Resources

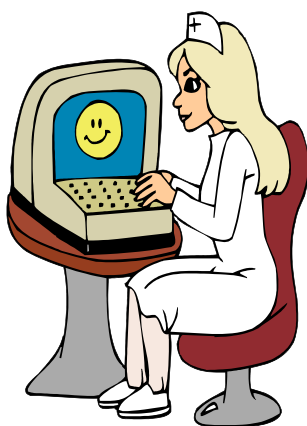
- Choose and Book is not a requirement of the new GMS contract and therefore resources are not included in present funding flows to enable GPs to take on this additional work. The GPC will be working

with the Department of Health to address this issue but until an agreement is reached, practices should be aware that legitimate additional resources are unlikely to be made available to them.

- All hospital trusts invest a significant amount in managing referrals and booking appointments. Choose and Book moves a lot of current activity into primary care without an equivalent shift in resources.

Confidentiality

- The GPC are concerned that the Choose and Book procedure cannot be completed until the GP has sent an electronic referral. The GPC has not yet been shown



Choose & Book Cont'd...

how this will work. We understand that the system is supposed to automatically extract data from the patient's GP computer record. This is an area of enormous complexity and will require close examination. The automatic extraction of data from GP computer records is fraught with all sorts of difficulties. This process may have to be overseen by the referring GP because no other clinician will know what information needs to be sent. It is also possible that this process may result in relevant (and or irrelevant) patient data being passed to the "spine" of the NHS Care Record Service and therefore raises all the issues and anxieties reflected in the 2004 LMC and ARM motions on the Care Records Service. These motions advised that GPs should not, at the moment, allow patient identifiable data to be sent to the spine. GPs that use Choose and Book and have sent e-referrals should be aware of LMC Conference policy. The GPC will be raising this as a matter of urgency with the Department of Health.

Security

- The GPC has not seen the technical specifications for Choose and Book and cannot vouch for its security. We are

unaware of any technological provisions to protect privacy and confidentiality. We are also raising this with the Department of Health.

Limitations when referring

- When using Choose and Book, practices can only request a booking for a service commissioned by the local PCT. The PCT will determine the list a GP can choose from.

Rejections of bookings

- The hospital can accept or reject a booking request. We understand that the hospital's response to the booking request is not subject to any nationally applicable targets. Apparently best practice is to be agreed locally. It is not clear what is expected of a GP if a request to book is rejected.

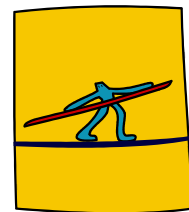
Performance of PCTs

- The PCT's performance indicator is only whether or not the system is 'available' to GPs. There is no performance measure made of the PCT based on actual usage.

Whilst the GPC welcomes any development that improves patient care and the working practices of GP's, they are very concerned that there are a number of unresolved issues relating to Choose and

Book, which could jeopardise the confidentiality and security of patient records. The GPC is also concerned about the workload and resource implications and is willing to work with the Department of Health and NPfIT to resolve these issues. In the meantime, we are aware that some PCOs are contacting practices for information with a view to implementation. Practices are advised to carefully consider the implications of being involved in Choose and Book. Choose and Book is not part of a GP's contractual obligations and therefore practices can decline to be involved and the LMC and GPC will support any practices that refuse to participate in this initiative. The full GPC guidance is available on our website at www.essexlmc.org.uk

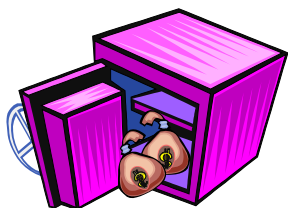
P.S. On a lighter note we understand that in some parts of the county this is now known as "Cheese and Book"!!!



ON LINE

'Choose and Book is not part of a GP's contractual obligations and therefore practices can decline to be involved and the LMC and GPC will support any practices that refuse to participate in this initiative'





PCO Administered Funds

No news since - August 2004

Premises



In addition to their allocations to fund the cost of premises already approved as at 1st September 2003, PCOs in Essex have received an additional revenue allocation of £1,127,000 for 2004/5 and £2,010,000 for 2005/6.

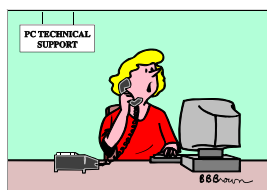
Whilst Colchester PCT

remains the lead PCT it has been agreed that for 2004/5 this additional allocation should be devolved to individual PCOs on a capitation basis.

The LMC has written to all PCOs seeking confirmation of their individual allocations and requesting details of any

plans for spending the allocated monies. The PCOs have been reminded of the need to consult with the LMCs and the LMCs have offered to nominate representatives to attend meetings of any premises sub-groups established by PCOs.

Information Management & Technology



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

Health Minister John Hutton last week announced plans for GPs across England to be able to select a wider range of computer systems as part of the National Programme for IT.

Family doctors will have the option of using a wider variety of systems, provided the system supplier has signed a distribution contract with one of the five Local Service Providers.

Eligible suppliers will now include EMIS, which has recently signed a contract

with CSC, the Local Service Provider for the North West and Midlands.

Mr Hutton said:

'Throughout the development of new IT systems for the NHS we have listened carefully to what front-line clinicians want from them. GPs have told us they want a wider choice of systems to use and I am pleased we can deliver this.'

Suppliers of GP systems will be offered to practices nationwide

provided they have a contract with a Local Service Provider, can demonstrate the required level of inter-operability with NPfIT systems, and can make a sound business case. The systems will also have to be hosted in a data centre to facilitate nationwide services such as GP-to-GP data transfer, electronic transmission of prescriptions and Choose and Book electronic appointment booking.



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!

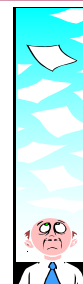
Clarification was sought from the Strategic Health Authority, who confirmed that the above is incorrect. PCOs did receive an allocation for OOH development fund for 2004/05. However 3 Essex PCTs have to date refused to pay practices their share of the OOH Development Fund. These are [BBW, Thurrock & Basildon](#)

The LMC will continue to pursue this matter via the SHA.



PMS Issues

No news since - Oct/Nov 2004



General Help & Support for Practices

	Milestone	Activities
39	14th March 2005	Contractors that have not submitted data but are participating in a particular clinical area are treated by QMAS as being at the bottom of the prevalence range for that clinical area
40	31st March 2005	QOF national achievement day. QMAS will have calculated payment levels for 2004/5, using the latest list size and with clinical payments adjusted for prevalence as at 14th February
41	By the end of April 2005	PCTs will have made 2004/05 achievement payments as a lump sum on the basis of QMAS calculations. If any quality remedial plans were not achieved, PCTs may have delayed payments

Appraisals

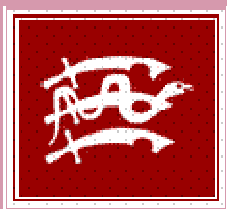


The LMC in conjunction with Wyeth Pharmaceuticals is running a training afternoon for all GP appraisers on 4th May 2005 from 12noon—4pm at the LMC offices in Hatfield

Peverel. If you are interested in attending this course or wish to know further information please contact Sarah Bell on 01245 383430 or Sarah@essexlmc.org.uk.

Please note: There is a maximum of 10 places available so please book early to avoid disappointment!





5 Whitelands,
Terling Road,
Hatfield Peverel
CM3 2AG

Phone: 01245 383430

Fax: 01245 383439

Email: info@essexlmc.org.uk

Web: www.essexlmc.org.uk

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



Freedom of Information Act (FOIA)

From January 2005 the FOIA obliges all practices to respond to requests about the information they hold and have recorded in any form and creates a right of access to that information. Practices are reminded that they must:

- Have a publication scheme in place – the

deadline for this was 21st October 2003;

- Respond to individuals' requests for information from 1st January 2005.

Essex Public Health Resource Unit have produced a really helpful document titled "Freedom of Information Act – The Simple Facts". Practices

may find the advice contained in this document helpful when dealing with requests for information and it can be accessed via a link on the LMC website or direct from

<http://www.ephru.nhs.uk/resources/publications.htm>.

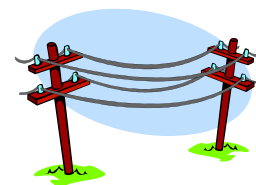
Premium and National Rate Phone Lines

Following the Department of Health's announcement banning the use of higher rate telephone numbers within the NHS, GPC discussions with the department to agree directions covering transitional arrangements are ongoing. The Department has identified NEG PLC as the main supplier of the premium and national rate lines and has agreed with NEG PLC that they will convert GP surgeries using these lines to 0845 numbers at a cost of £500 per line. Although it is the Department's intention to treat all

practices in the same way as NEG customers and make the same funding available, the GPC is not prepared to sign up to transitional arrangements until they have more information about the contracts practices have with suppliers other than NEG. The main concern is that these contracts may contain stricter financial penalties that those contained in the agreement reached with NEG PLC.

In order to inform the GPC discussions, if you are a practice affected by this and using a supplier other than NEG PLC, please let the

LMC have as much information as you can about these agreements, including actual contracts if possible and we will pass the relevant information to the GPC. The more information the GPC has the more likely that they can ensure that no practices are left financially disadvantaged by this policy.



GP PENSION NIGHT

Enclosed with this months Issue is a Flyer for a Pensions Evening the LMC has arranged for the 11th May 2005 at Furze Hill, Margaretting, Buffet Supper available from 7.00pm.

Dr Andrew Dearden will be speaking from 8.00pm about the changes to the GP pension scheme which will include an opportunity for questions.

If you have any concerns about GP pensions then this is not to be missed. **Book your place NOW!** on Tel: 01245 383430 or Email info@essexlmc.org.uk

NEXT ISSUE MAY 2005!

