

Norfolk LMC Flyer

Special Edition September 2003 GMS2 – Update

Intro

In just over six months, all GPs will embark on a completely new system of organising and funding primary medical services provided by the NHS. Our hopes are that all the benefits will be fully and fairly available to GPs and patients alike across Norfolk from day one, but there will need to be a lot more preparatory work completed by practices and PCTs before this is realised. This flyer is intended to give you an update of where we are at nationally and locally, and what there is to do still. The GPC has produced a considerable amount of briefing and guidance and updates since the ballot, and GPs are urged to view this regularly on the GPC website. Go to <http://www.bma.org.uk> select “committee activities > General Practitioners” from the left hand menu, and the main items are “contract implementation news”, “contract guidance” and “contract questions and answers” on the right hand menu of the GPs’ page. Another useful website is the NHS Confederation www.nhsconfed.webhoster.co.uk/gmscontract/ which contains all of the contract documentation, letters from the Department and briefing notes.

Norfolk LMC – what are we doing ?

Over the brief summer recess, the Officers and the Executive have been concentrating almost exclusively on the New Contract (“GMS2”). We have to keep abreast of the latest GPC guidance, to familiarise ourselves with what the Department of Health is saying to PCTs, and above all, to make every effort to assist and collaborate with the PCTs of Norfolk as they roll this out locally. This flyer is an example, and others are the meetings with the PCTs this summer and regular correspondence with PCTs on the various important details of the contract, some of which are mentioned below. We have also ensured a LMC presence at the monthly PCT leads’ meeting with Eastern Support Services about the new contract starting in September. We are monitoring the situation as a whole to decide if and when to call a series of local meetings for GPs, but these may be best kept until the new year.

PCTs – what are they doing ?

Norfolk’s PCTs have all created their own GMS2 implementation groups, each chaired by a GMS2 lead. We have contacted these individuals already, and have attempted to ensure that they recognise the areas over which we have most concern. We will make sure that each group has a GP who can liaise with the LMC. Each PCT is supposed to have replied to the Strategic HA about details of their proposed minimum guaranteed future funding for Enhanced Services, and we are seeking copies of these replies. PCTs are canvassing GPs about their intentions for opting out of out-of-hours. We are working with PCTs to produce a questionnaire to all practices about what services they now offer which would become Enhanced Services, and whether or not they envisage continuing with them.

Practices – what should you be doing ?

In anticipation of the survey, practices should document all the areas work they do now in terms of whether it comes under “essential”, “additional”, or “enhanced”. Particular attention should be paid to what practice nurses are doing, such as assisting with minor ops, taking blood, seeing and treating minor injuries, giving vaccinations, giving contraception jabs, as these will either be additional or enhanced services in future. Practices should also look closely at the Quality and Outcomes scheme and attempt to audit what they do now to see what needs to be done to achieve as high payments as possible. A lot of this work will need computer searches and amending READ codes. This area of work may need extra staff drafted in and is what the Quality Preparation payments are intended to be used for. Practices should also remember that in future, individual GPs will find it difficult to “do their own thing” within a partnership; the balance will shift fundamentally to an arrangement between the practice and the PCT, and GPs and their staff must be prepared to work corporately as a practice unit.

PMS

Over a third of Norfolk’s GPs are in PMS, but GMS2 applies to them as much as those still within GMS. All the major gains from GMS2 will apply to PMS as well, such as out of hours, Enhanced Services, improved seniority and the Quality and Outcomes scheme. These will apply either in just the same way, or factored in to the contract price in a GMS-equivalent way. The Minister of Health has stressed that PMS practices will be treated fairly, and we assume that this applies equally to those practices moving to the GMS2 contract as to those remaining in PMS. The LMC will strive to ensure that this proves to be so.

Out of Hours

Most observers agree that this single factor was the most decisive when GPs considered how to vote in June. Yet, this will not be finally handed over to PCTs until the end of December next year, such is the amount of work needed to be done. The LMC has consistently urged all Norfolk PCTs to work together on this issue above all, so that out of hours cover is organised on county-wide basis and provided as a uniform level of service across our practices. We sincerely hope that all the Norfolk PCTs share this vision, and that the PCTs have taken sufficient initiative to plan a totally new service as opposed to tinkering with the current patchwork of co-ops and deputising services. We have urged PCTs to be bold, assume a 100% GP opt-out, and to think outside the box. However, GPs may not be able to definitively give their answers to the opt-out question before they know for sure exactly how much it will cost them. The “£6000” figure is based on a possible answer to this equation :- List size x £61 x CH number x 6%. This would be true of a list of 1640 with a Carr-Hill (CH) number of 1. PCTs are also considering aiming for an interim arrangement for opting-out by April 04, but this would depend on co-ops continuing much as at present. Our principal concerns are to do with the knock-on effect on admission rates or patients attending surgeries the following day, rather than being “sorted” by the out of hours provider as they are now.

Enhanced services

Successful adoption of Enhanced Services is our main concern, because history tells us that it is very difficult to separate “core” services from “non-core” services, especially when the latter should be paid for additionally. For Local Enhanced Services read Local Development Schemes. As mentioned above, many activities currently done by GPs and practice nurses as a matter of course come under Enhanced Services but are not properly paid for if at all – such as minor surgery, minor injuries, INR testing, visiting nursing homes, phlebotomy, counselling, drug and alcohol abuse management. That’s why we want practices to carefully note what they do in these and the other Enhanced Services areas, and we will support and encourage practices to firmly decline this work if PCTs do not fund them as Enhanced Services and at nationally-agreed rates. And remember that *ALL* Enhanced Services will be optional. The LMC will be a vital player in this area, and so please involve us early. Already we read in the Comics that books are being fiddled and PCTs are being creative in what they say is being spent on Enhanced Services areas at the moment. From April, No money = No work.

Quality Payments

The first monies for the QOF will be in the form of Quality Preparation Payments, which are technically a Directed Enhanced Service. The money is supposed to arrive in September, but we have heard of a delay until the DDRB has recommended the 2003-04 pay award which, at the time of writing, was being delayed because the NHS Confederation had yet to submit its evidence to the Review; we hope these fears are groundless. The payments should be spent on additional time and staff needed to uprate clinical notes to the standards aspired to in the framework. A definitive guide to the correct READ codes is in preparation, we understand.

Global Sum

Despite all the protests after “black Wednesday”, the Carr-Hill (CH) formula is alive and well, although the calculations for individual practices will all be revised. It looks as if the workings for the calculations will not be available, which will make it difficult to challenge, but there is the MPIG to protect practices whose red book read-across income falls under CH. But don’t forget that Enhanced Services, Quality payments, seniority and IT funding are all on top of the Global Sum. The GPC has suggested that the new CH formulae for each practice may not be published until the new year 2004.

Partnership agreements

Possibly the biggest “sea change” for practices will be the shift of the contractual axis from individual practitioners to practice, or provider, units. Even under PMS, GPs still had individual contracts and could “take their lists” elsewhere. This won’t happen under GMS2, and practice partners must act corporately, and ensure that practice agreements take this into account in the event of disagreements and disputes. Partnerships may well take on non-GP members, and practices will not need to apply for permission to recruit new doctors or to vary the hours of availability.

IT

This issue is currently the most ambiguous, and there appears to be a gulf between reassuring speeches from GPC luminaries about how there is limitless cash from the Modernisation Fund for new computers for all, and the reality that PCTs haven't had any extra funding. This is in the context of the idea that under GMS2, new computers and software will be 100% paid for (and owned by) PCTs. The current view from PCTs is that they would fund any necessary upgrades in order for practice systems to satisfy RFA99 v1.1, but of course some systems may just manage to make the grade but be creaky and always crash. A side issue is the ownership / responsibility for third party software which GPs load onto their PCT-funded systems. These are areas of debate we are currently having with the PCTs.

Other Issues

There are some other very important areas which remain somewhat vague following the publication of the GMS2 documentation. We will raise them with PCTs and ESS, and also via the GPC. Examples are seniority and how it applies to GPs who have been or are currently "non principals", (particularly those with NHS Pension "gaps"), protected time for professional development, the rules on superannuable earnings, maternity and sick leave arrangements, and the possibility of PCTs introducing home visiting services during the day.

Conclusion

As the goalposts are moved, and the music stops and starts, we will try and keep up with the latest, and when there is sufficient "new" news, we will do another flyer. Meanwhile, make sure you read anything your PCT or the GPC sends you as well, and keep an eye on the two websites mentioned above

Peter Harvey
LMC secretary August 2003