GPC Newsletter

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Content

GPC meeting

The GPC held its meeting today and this newsletter provides a summary of the main items discussed.

Revisions to the unplanned admissions enhanced services guidance

Further to the negotiated contractual changes for 2014 / 15, some concerns had been expressed about confused wording in the guidance on unplanned admissions. Following pressure from GPC, the revised guidance clarifies that:

- Care plans for patients initially added to the case management register have to be in place by the end of September 2014, not June 2014 as was originally specified. This recognises the difficulty with producing care plans for these patients for the end of June and ensures consistency with the payment structure in place for the enhanced service - Please visit the BMA website.
- Patients initially added to the case management register have to be informed of their named accountable GP and care co-ordinator by the end of July 2014, not June 2014 as was originally specified. The July deadline for the named accountable GP applies only to patients

added to the register who are under the age of 75, as patients aged 75 and over will have been informed of their named GP by the end of June (existing patients) or within 21 days of registration (new patients), as per the requirements of the GMS and PMS regulations for a named GP aged 75 and over.

The changes are made on pages 7 and 15 of the guidance, which can be found on the BMA website.

Technical requirements guidance for 14/15 contract

Guidance on the technical requirements for the GMS contract for 2014/15, which includes clinical enhanced services, named GPs for patients over 75, and vaccinations and immunisations, has been published on the BMA website.

Guidance on PMS reviews and equitable funding for PMS practices

As part of the 2013-14 contract imposition, the government in England planned far-reaching changes to practice funding. From 1st April 2014, the wide variation in core funding per patient between practices will begin to reduce. This may have a profound effect on practice income.

Practices with above average levels of funding generally receive either large correction factor payments (as a result of the Minimum Practice Income Guarantee (MPIG) negotiated at the time of the new general medical services (GMS) contract) or above average personal medical services (PMS) funding.

NHS England's guidance puts the amount of 'premium' expenditure, (identified as the amount by which PMS expenditure exceeds the equivalent items of GMS expenditure) at £325m, which will reduce to £235m over the seven years to 2021-22 as GMS correction factor funding is phased out and global sum funding increases.

The guidance states that Area Teams should invest the premium funding according to the following criteria:

- reflect joint Area Team /CCG strategic plans for primary care
- secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises
- help reduce health inequalities
- give equality of opportunity to all GP practices
- support fairer distribution of funding at a locality level.

Area Teams will complete these reviews over a two year period starting in April 2014. NHS England has suggested that GP practices can expect local medical committees to be engaged in the local review process and GPC is issuing this checklist to assist LMCs in that process.

GPC guidance on PMS reviews and equitable funding for PMS practices is available on the BMA website.

NHS England's letter to Area Teams and accompanying presentation is available online.

13/14 QOF achievement payments

In early April, we had several reports from practices querying the calculations of the QOF achievement for 13/14 and a reduction in payments to many practices. Following pressure from GPC, NHS England confirmed that there had been an error in the calculations and on 9 and 14 April, HSCIC sent out communications confirming that the incorrect calculation for the QOF achievement and aspiration payments had been used. Instead of the national average practice list size as at January 2013 (6911) CQRS had used the average list size as at January 2014 (7052), which caused a deduction in payments for many practices. The HSCIC has now recalculated the figures and have informed the affected practices that they can re-declare achievement.

The re-calculation is expected to result in approximately a 1.95% increase in QOF 13/14 achievement on CQRS for most GP practices.

Further information about the re-calculation of QOF 2013/14 achievement and declaring achievement can be found in the FAQs listed on the HSCIC website.

NHS England has also responded to some of the queries in relation to this as outlined below:

Why is the index list size taken as it stood on 01 January 2013, when the year in question is 1 April 2013 to 31 March 2014?

Basing the actual national average practice list size on that at the start of the last quarter before the financial year in question ensures there is transparency going into the financial year.

On the whole, it appears that list sizes are increasing - why is the current list size not taken into account?

Contractors current list size is reflected in the CPI calculation which is the sum of Contractors Registered Population (generally that at the start of the final quarter in the financial year) divided by the actual national average list size as above.

CPI allows QOF payments to reflect comparative list size.

Is the PMS QOF deduction also incorrectly based on the January 2014 CPI figure? The letter from NHS England to area teams sent on 4 April uses the average list size which is applicable for 2014/15, but the calculation is for the 2013/14 QOF. NHS England has provided the following briefing in response:

- The QOF PMS Points Deduction was set in 2004 as £13,050 for average PMS practice – that was a practice with a list size of 5,891 (the average in 2004). £2.22 is the deduction calculated as the price per patient when you divide the above price by the then average list size (£13,050/5891).
- The worked example in the letter has used an incorrect CPI figure, but it is just that a worked example, to demonstrate that the current CQRS calculation will undervalues the QOF PMS Points Deduction.

- The national average practice list size for use in CPI to calculate 2013/14 QOF achievement is being corrected to 1st January 2013, which is 6911, which is in line with the SFE. So to run the worked example again, a practice of 6,200 patients should have its deduction calculated as 6200/5891 x 13050 = £13,735 but CQRS will calculate as 13050 x 6200/6911 = £11,707. So CQRS remains to undervalue the deduction that needs to be made and in this example by £2,028.
- Another way of looking at is CQRS will calculate the deduction at £1.89 price per patient (£130505/6911) which is a difference of £0.33 price per patient (£2.22-£1.89). Using £0.33 might be a simpler basis to calculate the adjustment required.

14/15 QOF point value

During the QOF negotiations for 14/15, the negotiating team highlighted the issue that the QOF point value needed to increase comparatively along with any increase in the national practice list size to NHS England. Although there was a 16% rise in the value of QOF points for 13/14, we pointed out that this would be an ongoing problem every year if QOF was not adjusted accordingly every year. It was argued that due to the 16% increase in QOF point value, this change was meant to be cost-neutral. It clearly has not been, so we are continuing to put pressure on NHS England to sort it out.

Care.data – phased roll out

A six-month extension to the start of data collections from GP systems under the care.data initiative was announced in February. Representatives from the GPC and BMA have met regularly with NHS England to discuss the actions to be taken between now and the autumn.

The GPC is also represented on the recently established independent care.data advisory group. The purpose of the group is to make recommendations to the care.data programme board to help ensure the benefits of the programme are understood and articulated, as well as the risks, and that these risks are appropriately mitigated.

NHS England has issued a letter to stakeholders, which confirms that care.data will now proceed in the autumn with a phased roll out of the GP data extraction process. This will involve a cohort of between 100 and 500 GP practices to trial, test, evaluate and refine the collection process ahead of a national roll out. Further information on how the phased roll out will be implemented will be available soon.

Steps are also being taken to make changes to the law that will further increase protections around confidentiality and ensure greater transparency around the release of data by the Health and Social Care Information Centre (HSCIC). The HSCIC will provide additional assurances over the safety of data collected, stored and shared, including the option of accessing data from a controlled environment, sometimes referred to as a 'data-lab' or 'fume-cupboard', for use by organisations requesting data.

NHS England will be taking further action to ensure that patients have a clearer understanding of the care.data programme and will be working with stakeholders to produce additional supporting materials, such as a template letter for patients, as well as simplifying the opt-out process.

NHS England is keen to hear your views so that they can improve and build confidence in the programme. They will be engaging with GPs and patient groups through local and regional engagement events and they also welcome individual comments, which can be emailed to: england.cdo@nhs.net. We recommend that LMCs and practices feedback their concerns and suggestions.

Further updates will be provided in GPC News and on the BMA website.

CCGs - one year on

GPC noted that 1 April marked the first year of the Health and Social Care Act and CCGs.

To mark the first anniversary of CCGs in England, the GPC is conducting an online survey to assess GPs' views and experiences of CCGs. We are interested in hearing the views of all GPs, CCG clinical leads and board members. The survey closes on the 23 April and the findings of the survey will be used to help inform GPC policy on CCGs. All GPs are encouraged to contribute to the survey (available online). This work will be accompanied by a workshop which will build on the survey and explore how CCGs are operating in practice.

GPC task and finish groups

At January's GPC, members took part in a number of breakout sessions that debated key issues for the primary care. In preparation for this month's meeting volunteers were sought for three groups that would look at a particular topic and feed back their discussions.

The three groups were:

- Improving patient access
- On line patient record access
- Development of patient e-comms.

Work will continue in all these areas but below is a summary of the areas concerned so far:

Improving patient access

This group was asked to consider systems of improving access to GPs and practice nurses. This included opening hours, particularly extended hours and 7 day working.

The group also considered the political context including the recently announced Challenge Fund; consideration was given to how improved access could work (eg networks for practices), the implications of extended access, and the interface with out of hours services.

In addition, the group was asked to consider the following points:

- Bearing in mind the government's position is outright rejection or denial a realistic option?
- How do we address the agenda and have some control over it?
- What is an appropriate level of access?
- How do we manage demand and work within financial limits?

On line patient record access
This group was asked to consider what level of online access to patient records is appropriate and its implications.

Consideration has been given to:

- the recently negotiated IT-related changes that have now become part of the GP contract
- the NHS Mandate for 2014/15
- the RCGPs' Roadmap

This group will continue to examine the different types of online access (for example: viewing of demographic details/ viewing of online test results/ core information/scanned or attached documents/ all coded data and prospective free text data) and the implications of allowing this access.

Development of e-comms
The group has been tasked with considering the benefits and risks of patient electronic communications and in what circumstances could they could be useful, as well as the caveats and the legal implications.

Among other things, consideration is being given to the ways in which video links can be used to benefit primary care, both in terms of interacting with patients and with secondary care, as well as to the use of e-letters as an alternative to communication with patients and secondary care.

A balance between national guidance and practice-level flexibility is likely to be central to the effective future use of e-communications within primary care.

Workforce
April's GPC meeting considered a paper on the workforce crisis facing general practice in advance of a debate at the LMC Conference in May.

In summary, the paper emphasises the success of general practice but points out this has been undermined by years of underfunding. The commissioners of medical education and training have failed to prepare for the high volumes of continuing care that GPs now provide for complex patients, and the demands of running complex businesses in an ever competitive environment.

The fall in applications for general practice specialty training means it has become the one of the least popular specialities second only to psychiatry. Falling fill rates, low morale, increasing workload and resignations are reaching a tipping point. The paper calls for a renewed respect for GPs and for the government to back general practice in the run up to the next general election. It also calls on

GPC to prioritise the work stream on GP recruitment and commence a sustained campaign to increase public and political awareness of the issues. Clearly this will form a major part of the work of GPC in the coming year.

Public disclosure of clinical trials' data

In light of the Cochrane review of the effectiveness of antiviral influenza treatments, the GPC will request that NICE refrain from recommending a reduction to the current treatment threshold for primary prevention of cardiovascular disease with statin therapy unless this is supported by evidence derived from complete public disclosure of all clinical trials' data.

Pneumococcal vaccine arrangements

As part of the recently announced contract changes practices will now be able to offer pneumococcal vaccination both to patients who have achieved the age of 65 during the financial year 2014-2015 as well as to patients identified as at clinical risk as indicated in the Green Book. However, as the scheme will delivered alongside the seasonal influenza vaccination DES which does not start until 1 August 2014, LMCs should work with their area team to ensure local schemes are retained from April until August to bridge any gaps so that practices can vaccinate at-risk patients when appropriate.

NHS Property Services (NHSPS) guide for customers and tenants

New guidance for tenants has now been launched by NHSPS and this can be found here (under the general publications tab).

LMCs – change of details

If there are any changes to LMC personnel, addresses and other contact details please can you email Karen Day with the changes at kday@bma.org.uk.

The GPC next meets on 19 June 2014, and LMCs are invited to submit items for discussion. You may like to review these, beforehand, with the representatives in your area who serve on the GPC. The closing date for items is 10 June 2014. It would be helpful if items could be emailed to Christopher Scott at cscott@bma.org.uk. You may also like to use the GPC's listservers to exchange views and ideas.

GPC News

LMCs are reminded that their regional representatives can provide more detailed information about the issues covered in GPC News, and other matters. Other members of the GPC would also be pleased to accept invitations to LMC meetings wherever possible. Their names and addresses are in the GPC Yearbook. The secretariat can also provide a written background brief if required, but it would be helpful to have such requests well in advance of your meetings.

Finally, if LMCs require assistance on local issues, they can also contact the BMA's local offices: addresses are on page 3 of the GPC's yearbook.

This newsletter has been sent to:

Secretaries of LMCs and LMC offices
Members of the GPC
Members of the GP trainees subcommittee
Members of the sessional GPs subcommittee