**Worcester VTS Residential**

# The Business Side Of General Practice

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## *Aims*

- Create a group conducive to effective learning during the term
- Develop a better understanding of the business side of General practice
- Considered dysfunctional and challenging consultations
- Finish planning the term
- Have fun

## *Objectives*

By the end of the residential we would hope that individual members:

- will have got to know each other;
- have explored and deepened their understanding of practice based commissioning, practice finance, personal medical services, general medical services and alternative providers of medical services and Quality Outcome Framework
- Used a Balint approach to exploring the doctor patient relationship
- Explored ways of dealing with dysfunctional consultations
- Enjoyed themselves

## *Time Table*

**9.00** Coffee/ Tea
Over Coffee write a 10 word caption about yourself
**9.30** Session 1
Intro
Who are we? What are we about?

**10.45** Coffee/ Tea break

**11.00** Session 1 Continued

**11.45** Session 2
Introduction to the business side of general practice

- Practice Based Commissioning
- Practice Finance
- Personal Medical Services, General Medical Services and Alternative Providers of Medical Services
- Quality Outcome Framework

Divide into 4 teams

Task

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You have 1 hour 30 mins before lunch and 30 mins after lunch to prepare a presentation using resources brought by PCME's to allow groups to gain understanding of each topic and produce a Flip chart poster, a poem / haiku / rap about the topic and a leaflet for their group to take away that we will type up and put on web/ produce the following week.

**12.45** Lunch

**14.00** Continue preparation for presentation
Allow 30 minutes per group to include poster, poem and question and answer session

**16.00** Practice Finance -opoly
Your chance to play general practice, win a fortune and take over the world or end up penniless?

**17.00** Team Building

**20.00** Dinner

Thursday 6th September

**9.0** Session1
**9.30** Planning the term

**11.00** Coffee

**11.30** Balint/ Case Discussions

**1.00** Lunch

**14.00** Dysfunctional Consultations

**17.00 Close**

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# Quiz

1. Definition of Terms. What do the following terms stand for?

PMS

APMS

GMS

DES

QOF

LMC

2. Place the following 5 things in value order in terms of revenue from QOF

Cancer
Diabetes
AF
Obesity
COPD

3. GPs earn the same amount of money whether they fully immunise 75 or 80% of their two year olds?

**Yes / No**

4. In terms of the QOF the amount of money GPs earn with regard to providing depends on the satisfaction of their patients?

**Yes / No**

5. All GP's must take part in "Choose and Book"?

**Yes / No**

6. Doctors who are not dispensing can claim for administering drugs?

**Yes / No**

7. Practices get help from the PCT to fund the premises they work from?

**Yes/No**

8. Partners may claim a mileage allowance for their work from the PCT?

**Yes / No**

9. Choose and Book will enable patients to choose which consultant they see?
**Yes / No**

10. PCT's may commission services from the following

| | |
|---|---|
| Private Contractors | **T/F** |
| GP's | **T/F** |
| Secondary Care | **T/F** |
| Drug Companies | **T/F** |
| Voluntary Services | **T/F** |

11. Which of the following is the most expensive for a practice?

Premises Rent
Staff Wages
Telephone

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# GP Finance

GP's may be either self employed partners or salaried. Practices may either have a Personal Medical Services Contract, a General Medical Services Contract or an Alternative Personal Medical Services Contract.

Partnerships are paid for the services they provide. The bulk of their money comes from their work for the NHS but some money is gained for the partnership by private work such as insurance medicals, H.G.V. medicals, Insurance Reports for life assurance, critical illness cover etc. As a registrar it is important to remember that only NHS work is provided free of charge to the patients, holiday cancellations forms, letters saying little Johnny can't play games and letters for housing etc may be charged for. This is usually a helpful tool in helping the patient decide if it is really necessary.

The NHS structure of payment has changed radically with the new contract. It is a form of performance related pay. The main thrusts of the payment are list size, organisation within the practice, and the Quality and Outcome Framework (QOF) indicators. Their was also a modifying factor called the MPIG (minimum practice income guarantee), designed to help practices move from the old "item of service payments" to the new without getting into major financial difficulties. General Practice has more than ever become a small business and each practice will flourish or wither on the vine according to the financial acumen of the partnership

An example of practice accounts follows
Serene Practice
Financially Sound Lane
Utopia

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Serene Practice
Financially Sound Lane
Utopia

Partners
Dr Brains
Dr Well Organised – WORKS PART TIME
Dr Politically Astute
Dr Caring
Dr Financially astute

Practice Manager
Mrs Belbin

Salaried Partners

Dr Enthusiastic
Dr Portfolio

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## Accounts for year ending June 2005

Income

| | |
|---|---|
| NHS fees | £754,630.00 |
| Reimbursements | £136,775.00 |
| Appointments | £15,000.00 |
| Other Fees | £49,000.00 |
| Other income | 0 |
| Total Income | £95,5405.00 |

Expenditure

| | |
|---|---|
| Practice expenses | £10,5501.50 |
| Premises expenses | £63,500.00 |
| Staff expenses | £380,250.00 |
| Administration expenses | £23,400.00 |
| Depreciation | £1,500.00 |
| Total expenditure | £574,151.50 |
| Investment Income | £2,500.00 |
| Net Partners Income | £381,253.50 |

Balance Sheet

**Fixed assets** **£60,000**

Tangible assets – Depreciation is provided at a set annual rate in order to write off each asset over its useful estimated life e.g. £500 p.a.

**Current Assets:** **£5,000**

Stock (e.g. drugs held by Doctors and nurses, equipment such as gloves, disposable speculae etc)

| | |
|---|---|
| Debtors (i.e. money owed to the practice e.g. injections administered by the doctors or nurses) | £25,000.00 |
| Money in bank accounts | £40,000.00 |
| Cash in hand ( ie this is petty cash) | £100.00 |

**Current Liabilities**

Trade Creditors- This what the practice owes ie un-cashed cheques paid to locums , stock bought but not yet paid for etc £29,000.00

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Net Current Assets £101,000.00

Net Assets £106,000.00
This is current assets plus stock in practice which has been paid for

The balance sheet must be financed by a set amount ring fenced in the current account to cover this.

NHS Fees £754,630.00

Golden Hello – for new partner £5000
Trainee supervision Grant £5130
Advance Access £5000

Targets Childhood Immunisation £12000

Minor Surgery £2000

New GMS £532,000
Global Sum-Depends on number of patients and also covers such things as staff reimbursement, and all the old item of service fees such as contraception, maternity pay cervical smears etc.

MPIG factor (this reduces over a x year period to 0) £100,000

Basket of services £3,500
This is a Worcestershire Locally Enhanced Service LES
It was negotiated by the LMC tocover things GPs now expected to do that were outside the contract for example work generated by early discharge of patients

Clinical Governance £7,000

Seniority £25,000
This may either be given to the partner personally or pooled and shared by the practice depending on practice ethos

Dispensing Fees and drug reimbursements £40,000
This figure is huge if you are a dispensing practice or
small if you just claim for personally administered items. These are injections given by the doctor or nurse e.g. depo provera, intra articular steroids stemetil etc. GP's have to purchase the drugs , they then write a prescription and label FP34D send it Newcastle who reimburse us for the prescription +dispensing fee. Basic cost of drug + 10.5% on costs + 3.8 p container allowance

Enhanced Services £10,000

Flu Vaccinations £8000

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| | |
|---|---|
| Reimbursements | £136,775.00 |
| *Premises* | |
| Rent | £50,000.00 |
| Rates and Water | £5000.00 |
| Health centre charges – Cleaning, electricity etc | £5000.00 |
| *Ancillary staff Costs* | |
| Registrar costs | £75000.00 |
| Other | |
| GP appraisals £355x 5 | £1775.00 |
| Other appointments | |
| Occupational health Dr 2 sessions to Mr Soft ice cream manufacturer | £15000.00 |
| Other Income | |
| Insurance examinations HGV, PSV, holiday cancellation forms etc | £45000.00 |
| Research | £4000.00 |

**Expenditure**

| | |
|---|---|
| Practice expenses | £105501.50 |
| Drugs and instruments | £50,000.00 |
| Locum fees | £12,000.00 |
| Hire and service of equipment | |
| NHS Levies<br>This includes LMC and statutory subscriptions | £1381.50 |
| Meeting expenses | £120.00 |
| Subscription books and courses | £22,000.00 |
| Cleaning and laundry | £5,000.00 |
| Employers' superannuation | £15,000.00 |
| Premises expenses | £63,502.00 |
| Rent | £50,000.00 |
| Rates and water | £5,000.00 |
| Heat and Light | £5,000.00 |
| Insurance | £650.00 |
| Maintenance and repairs | £1050.00 |
| Health Centre maintenance | £1000.00 |

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| | |
|---|---|
| Use of furniture | £300.00 |
| Administration charge | £500.00 |
| | |
| Staff Expenses | £380,250.00 |
| | |
| Ancillary staff expenses | £300,000.00 |
| Training expenses | £1,000.00 |
| Recruitment costs | £2,000.00 |
| Staff Welfare | £2,000.00 |
| Travel expenses | £250.00 |
| Registrar | £75,000.00 |
| | |
| Administration expenses | £23,400.00 |
| | |
| Telephone | £6,000.00 |
| Printing and stationary | £3,000.00 |
| Postage | £2,500.00 |
| Accountancy Fees | £7,000.00 |
| Computer costs | now fully reimbursed from PCT |
| Partner expenses and meetings e.g away days | £1,000.00 |
| Sundries cakes biscuits tea coffee etc | £1,000.00 |
| Professional Fees e.g practice solicitors etc | £900.00 |
| Uniforms | £2,000.00 |
| Bank Charges | |
| | |
| Depreciation | |
| Equipment | £750.00 |
| Computer equipment | £800.00 |

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## Partners Current Accounts

| | Dr Brains | Dr Well Organised 50% partner | Dr Politically Astute 50% part time | Dr Caring | Dr Financially astute New partner |
|---|---|---|---|---|---|
| Net Income | £95,313.37 | £47,656.68 | £47,656,68 | £95,313.37 | £95,313.37 |
| Less: Drawings | £48,000 | £24,000 | £24,000 | £48,000 | £48,000 |
| Extra Drawings | £15,000 | £7,500 | £7,500 | £15,000 | £15,000 |
| National Insurance | £104.00 | £52,00 | £52,00 | £104.00 | £104.00 |
| Superannuation | £12,000 | £6,000 | £5,000 | £11,000 | £10,500 |
| Insurance to cover partner illness | £1000 | £500 | £700 | £800 | £500 |
| Balance on account at tax year end<br><br>NB remember you need to save money for your tax bill much of which is at 40% | £19,209.37 | £9,8408.68 | £10,604.68 | £20,409.37 | £20,209.37 |

Some practices bring new partners in on parity others may build up to parity over a defined period usually 3 years. This situation may vary according to market forces.

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# Primary Care Contracts

**Background**

In the past, the majority of GPs have operated to national terms and conditions called the General Medical Services (GMS) contract. This provided little opportunity to influence the range of services available in a local area. During 2002-2003 a new GMS contract was agreed with the BMA. Its implementation began in April 2004.

The new contract is between practices and the PCT and is designed to benefit GPs, primary care professionals and patients. It means that, for the first time, PCTs can consider all local health services in their area, identify shortfalls in services and negotiate with practices to provide any extra services that are needed.

At the same time, the Personal Medical Services (PMS) contract became permanent. This is a locally agreed arrangement between practices and PCTs and was first piloted in 1998.

Also, for the first time, PCTs can now contract with non-NHS bodies such as voluntary or commercial sector providers to supply primary medical services. PCTs are also able to contract with themselves to provide primary medical services e.g. by directly employing GPs or other practice staff to care for patients in their area.

### The New General Medical Services Contracts

From 1st April 2004, new contracts were introduced for local family practices, accompanied by new, extra funding for local health services. The contracts are supposed, over time, to lead to the development of a wider range of quality NHS services closer to where patients live.

The new contracts give doctors greater flexibility over what services they provide and may allow some to be able to reduce their workload and others to take on new services. Practices can also choose to hand over responsibility for out of hours services to their local PCT.

The contracts encourage practices to make more effective use of other health professionals' skills e.g. nurses, pharmacists and therapists. They may be able to carry out some of the tasks previously done by GPs, leaving the doctors to do the jobs only they can do.

Under the contracts, practices must continue to provide essential services which means treating sick and terminally ill patients. However, they can chose to forfeit a portion of their income and opt out of providing some 'additional' services such as child immunisations, maternity and contraceptive services. This would usually only happen though if a practice's workload got bigger than it could cope with. The majority of practices are maintaining or expanding the range of services they provide.

The idea behind the new contracts is that for the first time practices are being rewarded for the quality of care they provide not just for the numbers of patients they treat. Over time this should lead to improved health care.

Under the changes, PCTs enter into direct contracts with all practices in their area. In the past they have been able to enter into direct contracts with GPs under PMS arrangements. However, the majority of GPs have operated to a national GMS contract over which the PCT has previously had no say.

The new contracts are designed to give PCTs a better overview of what services are available locally and help them to plan improvements in both the quality and range of local services.

### Personal Medical Services (PMS)

The PMS contract was first introduced in pilot form in 1998 as a local alternative to the national GMS contract. The key aims of PMS when it was introduced were to provide greater freedom for GPs and other primary care staff to address the needs of local patient populations and address inequalities in health care provision e.g. offering different surgery opening hours, setting up new services for special groups such as minority ethnic communities or training more nurses to safely carry out procedures once only done by the GP.

PMS was also introduced to address recruitment and retention problems in areas where there had traditionally been doctor shortages. It gave GPs the option of being salaried, so they benefited from a steadier, more assured income based on the quality of services they offered to patients.

The pilot stage of PMS ended in March 2004 with PMS becoming a permanent alternative to new GMS. More than 40% of GPs in England now work under PMS contracts.

**PMS is different to the new GMS contract** because it is a truly local arrangement. Under PMS it will be for PCTs to agree local contracts with PMS providers – the GP, a salaried GP, nurses or other primary care professionals. GMS, on the other hand, is a national contract with local flexibilities. Unless the

PCT is the provider then it is up to the Strategic Health Authority (SHA) to agree the contract.

**PMS is different from the old GMS contract** in that payment to practices, GPs and other PMS providers is more closely linked to the quality of the services they offer - not the quantity as was the case under the old national contract.

PMS is designed to improve team working, provide more opportunities for primary care professionals to extend their roles, be less bureaucratic, improve cash flow and reduce time spent chasing claims for fees.

In addition, PMS providers will benefit from many of the same provisions offered under the new GMS contract, for instance: the ability to opt out of providing out of hours services, the same pension rights and access to financial rewards for quality through local versions of the GMS incentives system – QOF.

**Specialist PMS.**

This is a new model within PMS where the provider is not expected to deliver the totality of essential medical care services. Specialist PMS providers may register patients, but they would be expected to have in place a sub-contractual arrangement with another GP practice to deliver essential primary medical care services to those patients.

### Alternative Provider Medical Services (APMS)

APMS is one of the four contracting routes now available to enable PCTs to commission or provide primary medical services within their area to the extent that they consider it necessary to meet all reasonable requirements. The other routes are GMS, PMS and Primary Care Trust Led Medical Services (PCTMS). These four contracting routes are designed to provide a strategic framework to enable PCTs to plan, commission and develop high quality primary medical services.

In common with GMS, PMS and PCTMS, APMS can be used to provide:

- essential services
- additional services where GMS/PMS practices opt-out
- enhances services
- out of hours services
- a combination of any of the above

Under APMS, PCTs are able to contract for primary medical services with:

- commercial providers
- voluntary sector providers
- mutual sector providers

- public service bodies
- GMS/PMS practices, through a separate APMS contract
- NHS Trusts and NHS Foundation Trusts (also eligible for PMS)

It is for PCTs to decide how to use the contracting routes. It is envisaged that APMS could be used to:

- improve capacity
- ease workload on overburdened practices
- address need in areas of historic under-provision
- re-provide services where practices opt-out
- improve access
- provide services for a specific population
- develop innovative approaches to service delivery

APMS gives PCTs considerable discretion to shape locally appropriate services responsive to the needs of the community. In negotiating APMS contracts, PCTs are advised to consider additional issues e.g. price of contract, quality standards? including links to QOF, performance monitoring and reporting arrangements and list arrangements.

**PMS vs GMS a personal view from James Lavin GP in Malvern**

**Old GMS**

Capitation fees
N
(contraception claims, minor surgery claims, etc.)

**PMS**

Standard capitation fees agreed based on list size (reviewed quarterly)

No further claims to make as payment for minor surgery, contraception, etc. made on a basis of historical claims. Practice submits a business plan with its PMS allocation stating its case and explaining what special features of the practice) eg lots of asylum seekers, lots of elderly) mean that extra GROWTH MONEY is justified. Detailed plans of what the growth money will be spent on (eg annual nursing home reviews) had to be submitted.

Practices received up to £100k per annum **recurring pm** growth money to pay for Drs or nurses to carry out the extra work.

Lots of claim forms and returns to be submitted.

**Old GMS**

Capitation fees

Item of service fees (contraception claims, minor surgery claims, etc.)

Lots of claim forms and returns to be submitted.

**PMS**

Standard capitation fees agreed based on list size (reviewed quarterly)

No further claims to make as payment for minor surgery, contraception, etc. made on a basis of historical claims. Practice submits a business plan with its PMS allocation stating its case and explaining what special features of the practice) eg lots of asylum seekers, lots of elderly) mean that extra GROWTH MONEY is justified. Detailed plans of what the growth money will be spent on (eg annual nursing home reviews) had to be submitted.

Practices received up to £100k per annum **recurring pm** growth money to pay for Drs or nurses to carry out the extra work.

## 2004 – The New GP Contract

Both GMA and PMS doctors allowed to opt out of on call at a cost of £6000 pa per principal.

Some GMS practices were going to lose out financially under the new contract, so the MPIG (Minimal Practice Income Guarantee was agreed between the GPC and the Government. This made sure that practices were not worse off, but it is possible that the MPIG may disappear in the future.

QOF points available to GMS and PMS practices.

2004

Superannuation (employer's) contribution increased substantially – GMS practices get this reimbursed, but PMS practices do not (legal action going on).

2005

Government realised that what many PMS practices had received growth money for was now being covered by QOF – in effect PMS practices were being paid twice for the same work. Government encouraged PCTs to review PMS contracts to make sure it was getting value for money, but nothing has happened locally (or nationally, I think) due to the national reorganisation of strategic Health Authorities and PCTs, which occurs later in 2006.

2007

? If the growth money is stopped and PMS practices have to continue paying a Employers' Superannuation Contributions, there may well be a trend of PMS practices changing back to GMS

(Advances PMS (APMS) is a specialised set up where practices receive a budget with which they employ D/Ns HVs etc. – this is relatively uncommon)

# Quality and Outcomes Framework (QOF)

The new contractual arrangements introduce a new funding formula, which marks a radical change to the way practices are paid. It rewards them for improvements to the quality and range of services they provide rather than just for the number of patients on the books. Practices are paid an amount calculated according to the needs of their patients and their practice workload. They are guaranteed at least as much as they got under they old funding formula (the red book). On top of this, practices can earn extra money through service improvements or by extending the range of services they provide.

The contract includes a system called the Quality and Outcomes Framework (QOF) which awards 'quality points' for improved or extra services and for ensuring patients get to see a GP or other health care professional within national waiting times standards. Practices get additional money for every point they earn. The core philosophy of the new system is that the best way of driving up standards is by recognising achievements.

Under the new quality framework, practices get extra money for:

- delivering high-quality treatment and prevention of chronic conditions including CHD, diabetes and cancer
- providing additional services such as cervical screening, child health, maternity and contraceptive services
- providing more time for consultations
- ensuring their patients get fast access to a doctor or other primary care professional
- organising effectively their backroom systems such as patient records
- ensuring that patients get a high quality overall service

Patients will see little immediate change. Over time, however, there should be a gradual development of more high quality services closer to where they live. Patients suffering from a range of long-term conditions should see improvements to the treatment of their condition as practices are rewarded for following best practice in the treatment and prevention of:

- Secondary Prevention in Coronary Heart Disease
- Heart Failure
- Stroke or transient ischaemic attacks
- Hypertension
- Diabetes
- COPD
- Epilepsy
- Hypothyroidism
- Mental health
- Asthma

The QOF indicators are renegotiated year on year and in addition to the above, the following have been added for 2006 /7:

Atrial Fibrillation
Chronic Kidney Disease
Obesity
Cancer
Palliative Care
Smoking Indicators
Dementia
Depression
Learning Disabilities

Over time, this is designed to reduce the number of people who die prematurely and improve the quality of life enjoyed by many chronically ill patients.
In addition to good clinical care, the QOF indicators were also designed to encourage practices to develop a well structured and better standardised care.
The 4 Domains covered by the quality and outcome framework are:

- Clinical
- Organisational
  - *Records and Information about Patients*
  - *Patient Communication*
  - *Education and training*
  - *Practice Management*
  - *Medicines Management*
  - *Patient Experience*
- Patient experience
- Additional services
  - *Cervical Screening*
  - *Child Health Surveillance*
  - *Maternity*
  - *Contraceptive services*

**Secondary Prevention in Coronary Heart Disease**
As an example of a QOF

CHD 1.
The practice can produce a register of patients with coronary heart disease
CHD 2.
The percentage of patients with newly diagnosed angina who are referred for exercise testing and/or specialist assessment
CHD 3.
The percentage of patients with coronary heart disease, whose notes record smoking status in the past 15 months, except those who

have never smoked where smoking status need be recorded only once
CHD 4.
The percentage of patients with coronary heart disease who smoke, whose notes contain a record that smoking cessation advice has been offered within the last 15 months
CHD 5.
The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months
CHD 6.
The percentage of patients with coronary heart disease, in whom the last blood pressure reading (measured in the last 15 months) is 150/90 or less
CHD 7.
The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months
CHD 8.
The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the last 15 months) is 5 mmol/l or less
CHD 9.
The percentage of patients with coronary heart disease with a record in the last 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side effects are recorded)
CHD 10.
The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)
CHD 11.
The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor
CHD 12.
The percentage of patients with coronary heart disease who have a record of influenza vaccination in the preceding 1 September to 31 March

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Practices will receive income based on fulfilling clearly specified targets laid out in the QOF document. Each item has so many points attached to it making certain areas more attractive to target than others e.g. CVS disease has many more points than hypothyroidism
Payment is made in two stages to help the cash flow of the practice. Aspiration payments made at the beginning of the year – based on what the practice thinks it can achieve
Achievement payments based on what the practice actually achieves achieve. Aspiration payments are paid monthly, thus generating income to service staff and equipment needed to provide the services.
For 2006- 2007 the practice will receive the following income from QOF.
Number of points x £124.60 x contractor practice population
Below find a table indicating the clinical area and the likely amount an average practice would generate if they were to hit the maximum QOF Points

| Clincal Area | Number of Points | Income for an average list size Practice with normal prevalence of the disease |
|---|---|---|
| Asthma | 45 | £5,607 |
| Atrial Fibrillation | 40 | £4,984 |
| Cancer | 11 | £1,370 |
| COPD | 33 | £3,738 |
| CHD secondary prevention | 82 | £10,217 |
| Dementia | 20 | £2,492 |
| Depression | 33 | £4,111 |
| Diabetes | 93 | £11,587 |
| Epilepsy | 15 | £1,869 |
| Heart Failure | 20 | £2,492 |
| Hypertension | 83 | £10,341 |
| Hypothyroidism | 7 | £872 |
| Chronic Kidney Disease | 27 | £3,364 |
| Learning Disabilities | 4 | £498 |
| Mental Health | 39 | £4,589 |
| Obesity | 8 | £996 |
| Palliative Care | 6 | £747 |
| Smoking | 68 | £8,472 |
| Stroke and TIA | 24 | £2,990 |

A similar process is undertaken for the other domains. In addition to these areas there are also payments for Direct enhanced services – DES .An example of this is Access.

Access

In 2006-7 the improved access scheme is a direct enhanced service which attracts payments based on the practice

1. Producing a plan to improve access
2. Performing a survey of patient satisfaction of the service. The % satisfaction rate determining the rate of payment e.g. if only 50% patients satisfied the practice will only be paid 50% of the maximum possible

Improved access = £2663.70 x practice contractor population 2005-6

Immunisations

Immunisations generate income in the following way. The % of immunised two year olds and the %immunised five year olds are assessed in the practice. It is assumed that in the average practice their would be 56 two year olds and 60 five year olds.

If at the end of the quarter the practice has achieved a 70% target immunisation rate for all the prescribed schedule the payment would be

No of two year olds in the practice x £707.35
56

If at the end of the quarter the practice has achieved a 90% target immunisation rate for all the prescribed schedule the payment would be

No of two year olds in the practice x £2,122.50
56

A similar formula is used for 5 year olds

If at the end of the quarter the practice has achieved a 70% target immunisation rate for all the prescribed schedule the payment would be

No of five year olds in the practice x £219.0
60

If at the end of the quarter the practice has achieved a 90% target immunisation rate for all the prescribed schedule the payment would be

No of two year olds in the practice x £657.30

56

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## Practice Based Commissioning (PBC)- A Simple Guide

By the Secretariat of Wessex LMCs

*Introduction*

PBC is a concept that has been around for nearly 2 years and yet when the LMC talks to various groups of GPs, Practice Managers and PCT staff, there seems to be much confusion about various aspects of this initiative. I thought it helpful to de-mystify and clarify the main issues that seem to be causing confusion, including providing a summary of the background leading to the introduction of PBC, the terminology used and the practicalities of engaging and implementing PBC schemes – thus "A Simple Guide to PBC" follows.

*Background*

When Labour were elected into Government in 1997, they identified early in the parliamentary cycle that the NHS had suffered years of underinvestment. The Government committed itself to 'increase spending year on year', but did not commit itself to any specific figures. In 2000, the Prime Minister announced that by 2008 the investment in the NHS, in terms of Gross Domestic Product[2] (GDP), would be 9.4% and exceeds the European average of 9%.

**UK Spend on the NHS**

| % of GDP | Actual investment | | Investment per person |
|---|---|---|---|
| 1997 | 5.7% | £46 billion | £783 |
| 2006 | 8.4% | £94 billion | £1700 |
| 2008 | | 9.4% | |

The Prime Minister stated that over a 10 year period annual growth in NHS spending would be 7 – 9%. Most other Government Departments would have to settle, during the same period, for 3 – 4% growth. The Prime Minister also confirmed that from 2008 onwards NHS growth would return to 3 – 4 % growth per year.

The Government agreed to this unprecedented investment with the intention of improving the quality of the health service, decreasing waiting times and generally introducing a programme of "modernisation".

The question that has since been asked by many is why, with this increased investment, was the NHS deficit over £400m in 2004/5 and nearly £800m in 2006/7?

The media have been quick to blame the deficit on increases in pay for Consultants and GPs; the truth is far more complex.

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The NHS employs over 1,000,000 people and therefore any pay settlement will have a significant impact on finances. In 2000 the Government introduced the NHS Plan, a 10 year blue-print of major reform for the NHS. Reform is not cost neutral. In addition to a small rise in the number of GPs, there has been a significant rise in other sectors such as Nurses, Consultants and Managers.

***So what are the causes of the increased costs?***

- Service improvement
    - *Reduced waiting times*
        - *Out patient appointments reduced from 26 to 13 weeks*
        - *Elective operations reduced from 18 to 6 months*
    - *New technologies (e.g. Down's screening)*
    - *Advances in drug treatments e.g. Statins for CHD,*
    - *Increased numbers of Consultants, Nurses & GPs*
- Increasing elderly population
- Cost of new drugs (and NICE[3] Guidelines)
- Technology costs
    - *IM&T – a 10 year programme of development in both primary and secondary care*
    - *Diagnostic equipment, such as CT and MRI scanners*
- Increased investment in staff
    - *Consultants contract*
    - *GP Contract*
    - *Agenda for change*
- Competition and capacity
    - *Independent Sector Treatment Centres[4] (ISTCs)*
- Reorganisations
    - *The NHS has had a significant number of reorganisations in the last 20 years. The rationale is to provide more efficient structures and often to reduce cost. The reorganisations have rarely saved any money and any efficiencies that have been gained are negated by the stagnation that occurs during the process.*

In essence the problem is that, despite significant increases in funding, the NHS budget is insufficient to meet new demands placed upon it. The challenge that the NHS faces now is to try to achieve financial balance before the annual growth in funding is reduced to 3 – 4%. This could be achieved by a number of different routes, for example:

- Reduce demand
- Reduce the number of people working in NHS
- Reduce work done by hospitals that can be done at a lower cost in the community
- Provide services in a different way (e.g. move work from in-patient to day-case)

The Government decided that it would tackle these problems through a number of routes, hence the heralding of PBC

***1. Commissioning***

Despite PCTs' best efforts, the commissioning of patient care services has not been seen to be a great success. This is for many reasons but one important factor identified is the lack of clinical accountability. Commissioners have largely failed to engage in a meaningful dialogue with GPs and Consultants to make the most effective use of resources in designing appropriate patient care pathways.
To enable commissioning to be more effective the NHS must allow managers to manage.
Currently the managers have only been allowed to administer the PCT's contract rather than truly commission patient services.
Clinicians need to engage with other clinicians but will only effect change if there is true leadership and working in partnership with senior managers.

***2. Clinical accountability***

Clinicians are largely responsible for the consumption of NHS resources. Clinicians prescribe, refer, investigate and admit patients to hospital. GPs will argue that we are the patient's advocate and therefore should not be placed in the position of deciding between treating a patient or not, on the grounds of cost. Fund holding placed a similar challenge to GPs and, by becoming knowledgeable in understanding the true cost of many investigations and procedures carried out; they changed clinical behaviour in ways which were not detrimental to patient care.
Clinicians should understand the costs incurred on behalf of their patient populations and be able to justify this if challenged. Clinical accountability must not be a "witch-hunt" with which to blame clinicians for differing practise, based solely on account of activity and cost.

***3. White Paper: "Our Care, Our Health, Our Say" –*** *A New Direction for Community Services*

This clearly looks to increase investment in Primary, Community and Preventative Care and to decrease the percentage of the total NHS budget spent in Secondary Care. The current spend in primary care is 27% of the total NHS budget and by 2011 it is expected to rise to 33% (which is the current OECD[5] average).
The White Paper states that care should be provided as close to a patient's home as possible and identifies at least six clinical areas that could be moved from hospitals into the community.
As with most things it is much easier to talk about how you would do something rather than find practical solutions and make them work. The "only game in town" with which to shift the balance of power and influence to GPs, to regain financial balance, achieve more clinical accountability and redesign services, is Practice Based Commissioning.

**Practice Based Commissioning**

The concept of PBC was initially introduced in 1990 when there was a split between the purchaser (Health Authorities) and the providers (Hospitals). Practices were allocated a budget to commission care from alternative providers and looked to make best use of the funds by a system of "demand management" and skill-mix.

Fund holding certainly changed the way services were provided and also made hospitals more responsive to the demands of Fund holding Practices. Inevitably this led to what has been
commonly referred to as the `post-code lottery'. A big problem was that savings were out-stripped by the costs. This was largely due to the 'high transactional costs' incurred. [King's Fund analysis]

***How should PBC work?***

To make PBC work all GPs in the practice have to work together and be prepared to work differently. Practices need to work within a well defined locality to ensure they are addressing patient population needs. Localities need to be actively engaged with the Commissioners of Patient Care within the PCT.

- ***Demand Management***

The first stage of PBC is demand management. It has been identified that in many areas the number of GP referrals has not increased over the last couple of years but the number of emergency admissions has increased significantly, as have Consultant to Consultant referrals.

- ***Payment by Results***

PBC is the counter-balance to Payment by Results (PbR). PbR is a national tariff used by all Hospital Trusts (and Foundation Trusts) as a method by which each area of activity, whether a first Consultant out-patient attendance or follow up, elective procedure (day case or in-patient), attendance at A&E, or emergency admission has a specific price. The only slight variation is an adjustment for the cost of staff (more expensive in London than Scotland).

PbR should mean that a patient who requires treatment can choose the hospital they want to go to with the cost to the PCT (or, under PBC, to the practice) being the same. This assumes that the procedure is "coded" the same in each hospital. Sadly, early evidence shows this not to be the case due to the different employment of coding staff in hospitals and therefore, as with Fund holding, verification of high cost procedures and significant anomalies in billed activity is essential. Unfortunately this verification largely has to be clinical and performed by the person who knows the patient history best - i.e. the GP.

The NHS budget for 2005/6 was approximately £84 billion, and the deficit at the end of the year will be between £809 million and £1 billion; this is approximately 1% of the total budget. The deficit appears greater in some parts of the NHS because of the uneven distribution of financial problems (called 'lumpy' distribution).

**Ask yourselves the following questions:**

***Are there referrals we currently make, that on reflection are unnecessary?***

Practices have found it useful to collect all referrals made to an agreed specialty over a period of a month and then discuss them in a constructive and supportive environment. Practices have reported that this has identified variations which are significant and can be addressed simply and in a non threatening manner. For example, a part-time partner had effectively become de-skilled in a particular area of medicine and referred patients to hospital rather than discussed alternative routes of treatment within the practice (this is not a dig at part-timers - I am a part-time GP and recognise these issues personally).

There are also issues in training practices where they have GPs Registrars and referral rates to hospitals often increase.
It is far better to discuss these issues internally and to support each other, rather than a PCT publishing lists of high referrers and taking inappropriate action.

***Are there referrals we make that could be managed in a different way?***
Referral to a consultant used to account for 90% of all referrals. Can these be managed in a more appropriate and cost effective way? Many PCTs are working with practices to introduce alternative pathways via other practitioners, GPs with a Special Interest (GPSI) or Community-Based Consultants.

***What is happening regarding Consultant to Consultant referrals?***
Many areas nationally have identified little in the way of increase in GP referrals to Consultants, but have noticed a significant increase in Consultant to Consultant referrals (in some cases up to 600%). Appropriate inter-Consultant referrals should be allowed without referral back to originating GPs, but a significant number are being referred from Consultant to Consultant when the problem could be managed better in General Practice. This is one of the inevitable consequences of increasing specialisation of secondary care clinicians.

***Are you aware of the cost of referrals?***
Did you know that some Foundation Trusts are charging for each piece of telephone advice or advisory letter that does not result in an out-patient appointment? Or that a five minute appointment with an SHO in surgery can cost £150 (see Annex 1). This knowledge can have two consequences:

- Does the person need to be seen? If not - a saving of £150.
- Can the work be done outside a hospital at a cheaper rate? If so, how much can be saved?

***Are you aware of the number of acute admissions of patients registered at your practice?***
The most significant rise in costs has been that associated with unscheduled care (emergency admissions). The majority of the increase recorded has either been via A&E or during the Out of Hours (OoHs) period.
Control of who needs to be admitted to hospital is a key issue that requires addressing. Practices can start by looking at their own admissions but can also work in localities and with the PCT to reduce OOHs admissions and those via A&E.

***Are you aware of the cost of an emergency admission under PbR? (See Annex 1 for further information)***
Community Matrons[6] (CM's) are supposed to be in post shortly and they will be tasked with carrying a caseload of approximately 50 patients who have the most serious long term conditions and are therefore the patients who are most frequently admitted to hospital. Pilot studies have shown that when CM's work closely with practices, acute admissions in this group are reduced and quality of life is improved for the patient. It would be best to ensure that Community Matrons are part of the Practice Nursing Team and not a group who work independently of GPs and practices.
So we have identified all the above, discussed it within the practice and pulled the information together within the locality - what next?

The PCT are required to allocate indicative budgets to practices and also provide monthly data to include acute admissions, A&E attendances, elective admissions (day case and in-patient)
and out patient referrals from 1st April 2006. This will be benchmarked against your locality, PCT data and against national statistics.
Focused discussion, using this information, and work carried out within the practice will hopefully not only be useful but potentially will also identify improved ways of managing certain patients.
These six questions are really the core of ***demand management.*** Improved management of patients resulting in a reduction in costs can be achieved without compromising patient care.

***Commissioning***

The first stage of PBC is for the practice and locality to work with PCT Commissioners to determine how the issues raised above can be addressed. This will almost certainly mean that patient care pathways will be different and, as a result, contracts for activity purchased from hospitals will be different in the future.
Remember that the PCT does the contract negotiating and can take advice from the practice but they are ultimately the responsible Authority.
As a result of discussions, it may be identified that work currently carried out in hospital can be provided more effectively in General Practice (see Annex 2 for examples). Alternatively there may be work that could be moved from hospitals into the community, although not all practices would wish to provide this. In these cases, a new service could be commissioned from an alternative provider (again, see Annex 2 for examples).
Some practices are assuming that because they come up with an idea and persuade the PCT that the new service could be provided by the locality, this can occur without challenge. This may not be the case. Remember - PBC is about commissioning the services that are required and where the need is evidence-based.
The **provider** needs to be considered separately. For some contracts, the PCT will offer the new service specification for competitive tender and ask for business cases to be submitted. The PCT will then have to award the contract to the provider who meets the defined criteria in a process that must be robust and transparent. The locality, if it has set up a Provider organisation, may be in a strong position to tender for and win the contract, but it is not something that is an automatic right.
The latest guidance marks a significant shift in emphasis for PBC and it is now clear that PCTs will remain accountable for their allocation of resources and their statutory functions and will retain responsibility for contracting and ensuring quality compliance.

**So, what are the roles within PBC?**

**General Practice or groups of practices forming localities** – Practices/Locality Groups have the right to undertake the planning and prioritisation of services required and also to procure the purchase and provision of these services. PBC is the aligning of practices' clinical and financial responsibilities, whilst delivering innovation, choice and contestability to primary care.
**The Contractor –** The PCT will be the contractor. They will place contracts with providers on behalf of the practices/localities who are assessed as being the most appropriate in terms of meeting the requirements of the service to be delivered. The PCT will also monitor and manage the contracts.

**Commissioner –** The PCT will commission services required on behalf of the Practice/Locality Groups. They will also performance manage these services

**Provider –** Those who provide the services. This can be GMS, PMS, PMS+, APMS, SPMS and external private companies

**What does it all mean?**

***General medical services[7] (GMS)***

GPs under contract with the PCT, through either nGMS, PMS or APMS Contracts, provide what used to be called "core services" - now called "essential services".

***Defining health care according to population needs***

This task, under PBC, should be undertaken by the practice and the locality, with involvement of the PCT. PCTs will then use this information as the basis to form their priorities for the forthcoming year. This and national priorities will establish the general strategic plans and, more specifically, the PCTs' Local Delivery Plans (LDPs[8]).

***Demand management***

As described earlier.

***Commissioning***

This is the work involved in incorporating the practice and locality identified needs of the population into the strategic priorities that are set both locally and nationally and then transformed into a contract.

In reality the national priorities are so demanding that the 'headroom' for 'local' initiatives is very limited.

Although the PCT will be the Commissioners, practices and localities will play an important role but are not the commissioners in the true sense. Some practices and localities believe, mistakenly, that when they receive a devolved indicative budget they will commission services on behalf of their patients. It is important to remember that the budget is an indicative budget only and the purpose of this is to enable accountability without proceeding to the old Fund holding position of real budgets with full purchasing powers.

**PBC Directed Enhanced Service[9] (DES)**

This DES was introduced in April 2006 and is initially for one year only. It has caused more debate and confusion than any other Enhanced Service.

The DES for PBC has to be offered by the PCT to all practices between 01/04/06 – 31/03/07. It is up to each practice to decide whether it wishes to engage or not – either as an individual practice or within a locality.

Demand management and redesign of patient care pathways are core factors of the DES and aimed at engaging all clinicians. The principle is that to change clinical behaviour clinical engagement is essential.

Some PCTs seem to think that by getting practices involved, they can become less involved than before; nothing could be further from the truth. PCTs **MUST** work closely with practices and localities to enable real change.

Practices are therefore required to name a PBC Lead within the practice, and produce a Practice Plan that sets "reasonable and achievable targets". The Practice Plan must then be agreed with the PCT and can be individual to each practice or produced as a locality plan.

The Practice Plan is expected to focus on three aspects of healthcare:

1. Demand management

2. Redesign of patient pathways
3. Verification of invoices

(A flow diagram is included in Annex 3 to show how the Practice Plan fits and links into the bigger picture in terms of service planning and commissioning.)
As hospitals will be paid by the activity they claim to have performed, verification of invoices by the practice will be essential. Fund holding showed that by looking at high cost invoices, costs could often be reduced simply by correcting the incorrect hospital clinical coding. The NHS budget for the year 2005/6 was approx. £800m (or 1%) in deficit and First Wave Foundation Trusts were found to have errors in clinical coding of approx. 30%, with most being in their favour.
Practices will be funded at 95p per patient to carry out the work agreed above. Some practices have already contacted the LMC complaining that the expectation of PCTs, both in terms of what is achievable and the work involved, are out of balance with the funding available.
Firstly the practice or locality need to look at the funding available, work out how much manager or doctor time this will equate to and then agree with the PCT what can be done for this funding.
If the practice or locality achieves the targets set in the plan, or show significant movement towards the target, then a further payment of 95p per patient is available at the end of the year. This 95p per patient is expected to fund continuation of the on-going work involved in PBC and is not "profit" for practices.
There has been much discussion about what happens to any savings or freed-up resources that are made, especially when a PCT is in deficit.
A PCT can only allocate an indicative budget based on the resources it has available. This will be after a sum is top-sliced to fund those elements of commissioning not covered under PBC and also a contingency fund or "risk pool". If a PCT has a budget of £100m but is £5m in deficit, it can only allocate £95m and therefore you are starting out with a budget that has been set to take account of the deficit. The budget it devolves will be insufficient to purchase care for patients if the pathways of care and clinical behaviour remain as they are at present.

**Savings**[10]
Savings can be made either by:

1. providing the service in the same way but at a lower price; or

2. By changing clinical behaviour and care pathways to provide the service differently and at a lower price.

It has been agreed nationally that any savings made will be divided between the PCT (30%) and the practice or locality (70%). Remember that savings can only be used on projects agreed with the PCT and in areas identified in the PCT's LDP.
Whichever way savings are made, it is unlikely that there will be savings on total indicative budgets within the first one or two years because, as discussed above, budgets during this period will reflect existing deficits.
Because of this, some PCTs are objecting to the 30/70 split, saying that all savings must be retained by the PCT while there is a deficit. The LMC view is that PCTs who take this

view are wrong and short-sighted as, in the absence of realistic incentives practices and localities will not produce any savings for them at all. The Department of Health has also confirmed that PCTs cannot do this.

All savings, whether or not they are against the total indicative budget, should be reinvested in further improvements in patient care.

**Conclusion**

The NHS is in financial crisis and times are likely to get worse before they get better. Working as a GP in the current financial environment presents a number of challenges and threats to professional independence.

An added frustration currently is the reconfiguration of PCTs, which may prevent or slow down reform. The Strategic Health Authorities say that this will not be allowed to happen. The only problem is that they are being reduced in number from 27 to 10!

There are two clear options ahead for all GPs:

***Option 1-*** "Not our fault Gov!" – Practices could inform patients that the financial crisis is not of their making and refuse to engage in reform. The result would be political spin (as we are already seeing) with the Government blaming the crisis on pay rises for GPs and Consultants, without acknowledging all the other important factors. Pay would be squeezed and working environments challenging.

***Option 2-*** We can drive some of the reform and ensure that it does not damage patient care, or our working environment. We may need to work in a different way - but let us influence and define this, rather than have it imposed by others who have little idea of general practice.

Wessex LMC would endorse Option 2 and encourage GPs to become engaged. To do nothing is not an option if we wish to maintain and sustain the cornerstone of healthcare – general practice

The private sector is being dangled as a potential challenge to traditional general practice. We should take this threat seriously because it is a reality and not just a concept. The recent White Paper ("Our Care, Our Health, Our Say") which focused on care outside hospital is explicit that the Government wants 10 – 15% of general practice to be in the hands of the private sector within the next ten years. An additional challenge to general practice is that, if we are not responsive to the agenda set by the Department of Health, further competition will be introduced.

Practice Based Commissioning **can** deliver the Government's agenda of making the most effective use of limited resources in the NHS **but** only if delivered by independent small units working together with like-minded colleagues who have patients' best interests at heart. This is clearly traditional general practice. PBC may be a way of defending our practices from the private sector and other competition.

*[This document is best considered in conjunction with the GPC's document "Practice Based Commissioning: Consortium Working, April 2006"]*

# Worcester VTS Residential

## - Annex

-

| PbR Tariff price | | |
|---|---|---|
| **IN PATIENT** | | |
| **Medical** | | |
| Chest pain | £1,000 | |
| Management of skin ulcer | £3,800 | |
| **Surgical** | | |
| Inguinal hernia repair | £1,200 | |
| Appendicectomy | £2,500 | |
| Cholecystectomy | £2,000 | |
| Knee replacement | £5,500 | |
| Hip replacement | £5,000 | |
| Repair to fracture neck of femur | £5,000 | |
| Mastectomy | £2,500 | |
| TURP | £1,800 | |
| **OUT PATIENT** | | |
| **Consultations** | **New** | **Follow up** |
| General surgery | £150 | £75 |
| Trauma and orthopaedics | £144 | £71 |
| Diabetic medicine | £240 | £88 |
| Rheumatology | £219 | £97 |
| Cardiology | £151 | £80 |
| General medicine | £215 | £92 |
| **Procedures** | | |
| Flexible sigmoidoscopy | £297 | |
| Subcutaneous injection/injection into skin | £176 | |
| **A & E ATTENDANCES** | | |
| Minor injury | £54 | |
| Simple A&E | £71 | |
| Complex A&E | £99 | |

**Annex 2**

**Example of work that might be transferred from hospitals into the community**

**Minor Injuries**

Each minor injury attendance at A/E costs between £51 and £75. It is clearly better value for money to look after these patients in general practice where appropriate. In addition, it may reduce unnecessary admissions which are even more expensive.

**Echocardiograms**

In some parts of Wessex the waiting times for echocardiograms is in excess of 12 months. Patients are being referred to Cardiologists to get around the wait. With the new

heart failure requirements of the 2006 Quality and Outcome Framework (QOF), GPs require open access to echocardiograms.

**Rectal bleeding**

Patients with rectal bleeding are, in many areas, referred to surgical outpatients and the cost of being reviewed and having a flexible sigmoidoscopy is in excess of £500 per patient. A community-based service, offering direct access flexible sigmoidoscopy, may not only free up access in surgical outpatients but it would also save money.

**Dermatology outpatients**

Many GP referrals to Dermatology OPD are for the purpose of establishing a diagnosis and providing treatment recommendations. Community-based services can be re-configured to make better use of secondary care resources and provide a service which is more cost effective in the community.

**Minor surgery**

Various minor procedures in General Surgery, Orthopaedics, Urology and Gynaecology could be commissioned as community-based services.

**Acute admissions**

A child admitted with a pyrexia, who is given simple treatment to reduce their temperature and discharged 6 hours later, can cost in excess of £1,500. Only clinically necessary admissions should end up in hospital. There needs to be greater investment in alternatives to prevent these admissions.

OOHs and inexperienced doctors in A/E are also identified as key areas that can increase unnecessary admissions.

**Annex 3**

- **PCT Strategic Service Development Plan (SSDP)**

**PCT Local Development Plan (LDP) The Commissioning Plan**

An annual plan which will contain a collection of priority Business Cases developed by each PBC Locality

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**The Business Plan**

Formal Plan produced by Practices/Localities for each service and will contain:

- Information on the service to be (re-) provided
- Evidenced information /qualifications required
- Measurable outcomes and standards (national)
- Agreed targets and minimum data sets
- How improvements will be achieved
- An initial service specification (see below)
- Costs of old and new service
- Planned activity
- If approved, this will be used in procuring the service

**The Service Specification**

Produced by Practices/Localities for each service and will contain:

- Details of service including equipment, facilities, personnel and management requirements
- Details of how the service will be provided
- Cost and planned activity levels of the new service
- Costs of the old service and activity
- Outline of all benefits of the new service

**The Practice Plan**

Practices set reasonable and achievable targets to work towards in the following areas:

- Demand management
- Redesign of patient pathways
- Verification of invoices

**Glossary of Terms**

[1] PBC Practice Based Commissioning

[2] GDP The Gross Domestic Product - defined as the market value of all final goods and services produced within a country in a given period of time.
*GDP = consumption + investment + government spending + (exports − imports)*

[3] NICE National Institute of Clinical Health and Excellence

[4] ISTCs Independent Sector Treatment Centres, these were set up to provide elective, uncomplicated surgical work. The ISTCs were given a guaranteed 5 year contract, being funded an estimated 20% above NHS costs, in an attempt to drive up quality and productivity in NHS hospitals who were considered monopoly providers.

[5] OECD Organisation for Economic Co-operation and Development

[6] CM Community Matrons, announced in 2004/5 but as yet few in place in Wessex. They are supposed to carry a case load of about 50 patients. These will be the most vulnerable patients (approx 25 per average practice). The CM's intervention is expected to decrease the number of acute hospital admissions in these patients.

[7] GMS General Medical Services – this is core (essential services) provided within general practice

[8] LDP Local Delivery Plan – an annual plan produced by all PCTs.
This plan is agreed with the Strategic Health Authority and details the PCTs budget and how it will be used during the financial year.

[9] DES Directed Enhanced Service – an enhanced service as defined in the 2004 nGMS Contract. Specification is defined and costed nationally.

[10] Savings Funding achieved by re-providing a service in a different way

[11] PbR Payment by Results (Secondary Care national tariffs)

[12] QoF Quality and Outcomes Framework

# Worcester VTS Residential

# Practice Based Commissioning in Worcestershire

**Draft**

## 1 Introduction

1.1 The national policy drive is for all practices to be participating in PBC by December 2006. PBC remains optional for practices and therefore to achieve universal coverage PBC must be:

- Easy to engage with
- Demonstrably fair
- Adequately funded
- Above all, beneficial to patients.

1.2 The driving force for all practices looking to engage in practice based commissioning must be to improve the services that are available for the diagnosis and treatment of their patients. Practice based commissioning provides the freedom to make changes to the care pathways of patients. It should not be all about saving money, but the implementation of PBC must look to minimise the potential financial risks to what is already a financially challenged health economy.

## 2 Budget Setting

2.1 The budget is about the health care that is commissioned and provided on behalf of the practice's patients. The budget is not related to the PMS/GMS income that is available to practices. The term 'indicative budget' is used in the guidance although this terminology is not specifically defined. The budget is real in the sense that practices are expected to live within the budget limit, but it is indicative in the sense that practices do not have complete freedom in how it is used and significant changes will need to be agreed with the PCT.

2.2 The budget setting process has been set out in some detail in 'Practice Based Commissioning: achieving universal coverage' and in the accompanying technical guidance. Budgets will be set on historic activity where this is possible. The guidance suggests using the data available for 2005/06.

2.3 Practice based budgets will also be calculated on a purely fair shares basis in line with national guidance for comparative purposes. This strongly suggests using the appropriate national formula for different elements of the budgets. The DOH has calculated appropriate practice based deprivation and other scores to facilitate this.

2.4 The PCT(s) will need to develop a policy on movement towards fair shares budgets.

2.5 The guidance states that as a minimum, practice budgets will include:

- All services covered by the national tariff under PbR in 2006/07
- Prescribing

2.6 The first of these includes out patients, defined out patient procedures, elective day cases and elective in patients, non-elective in patients (emergency admissions), and A&E attenders. Budgets will be adequate to cover the historical activity for the bullets points above.

2.7 The guidance states that it should also be possible for practices to include the budget for community services e.g. district nursing , health visitors physios etc, mental health services and budgets that are pooled. The guidance is clear that it is for practices, rather than the PCT, to decide what elements of budgets to hold. In practical terms data are not currently available to allocate these budgets to practices in a meaningful fashion. However it is hoped that practices will be interested in looking at the way these sort of services are provided and the PCT(s) will work with them to deliver change where possible. The only specified exclusions to a practice budget are:

- Core GMS/PMS services
- Services commissioned at regional or national level because of their specialist nature.

2.8 There is a wide range of PMS/GMS funding per head of population across the practices within the county. It is likely that those practices with higher GMS/PMS funding per head will be in a better position to provide more services within the practice and therefore reduce their secondary care spend. Whilst budgets are set on historic activity this may not be crucial as their secondary care budgets may be lower as a result of more in-house services. However, as budgets move towards equity, maintaining inequity in GMS/PMS funding will penalise some practices and reward others. Whilst it is not appropriate to include GMS/PMS in PBC budgets, the county will need to consider this issue as PBC moves forward.

2.9 The guidance is not specific about the inclusion of enhanced services in the practice based budget. At this stage it is thought to be appropriate not to include them in the budget.

## 3 Risk

3.1 All else being equal, and if practices took no positive action with regard to managing their budgets, it is likely that at the year end some

practices will be in deficit against their budget and some will be in surplus. There are two broad reasons why a practice may be in deficit. Firstly, they may by chance have more patients who are sick with relatively common and relatively cheap conditions than in the year on which the budgets were set. Secondly, they may experience a few very expensive episodes of care that did not occur in the baseline year. Clearly, other practices may under-spend for similar but inverse reasons.

3.2 Whilst the consequences of these two scenarios is the same, the means of managing the risk may need to be different. The principle of managing the risk of high cost patients is relatively straightforward. It is possible to set a financial limit, either per treatment episode or per patient per year (or some combination of the two). Practices would pay into a contingency fund at the beginning of the year and this would be used to fund the expensive episodes/patients.

3.3 In practice, initial analysis of the data would suggest that the major component of this element of risk is the additional bed days. Each illness episode has a national price (tariff) attached to it with a maximum length of stay. Any bed days beyond this limit are charged for separately. So a patient with a long length of stay can be very expensive. Other very expensive treatments such as renal dialysis, transplants etc will continue to commissioned at a sub-regional or regional level and will not be included in practice budgets.

3.4 The proposal would be to add up the cost of all of the excess bed days in the 12 months of historical data and to hold either the whole or a part of this value in a reserve to fund all or some of the excess bed days. A judgement needs to be made whether risk managing all of the excess bed days removes any incentive for practices to create innovative schemes within their budget to reduce these excess bed days. e.g practices may set up intermediate care facilities to facilitate early discharge

3.5 The management of the in year variation of low cost high volume episodes is potentially more problematic. An initial analysis of the data suggests that year to year variation at practice level where surpluses are retained by the practice but deficits are the responsibility of the PCT could cause a problem in the order of £2-3 million for the PCT each year.

3.6 One approach is again to top slice all practices to provide a fund to help out those practices who are over committed in year. However, this has the inevitable consequence that every practice is given a budget that is less than their historic spend which is not attractive to practices and is arguably against the guidance.

3.7 An alternative approach is to agree that practices are not able to utilise the benefit of fortuitous savings but are only able to vire resources as part of their agreed PBC plan (see below). Fortuitous savings could then be used by the PCT to offset unfortuitous deficits. This may be difficult to police as it is likely that a practice that knows it is heading for fortuitous savings will be able to increase activity in other areas without needing to formally vire money or amend contracts.

3.8 A strategy that would reduce these risks would be for practices to group together in localities to increase the size of the population and thus reduce the potential financial volatility. The guidance does not allow the PCT to insist on this but practices may see this as a good option.

*3.9* ***Recommendation***

*The issue of in year variability and how it is dealt with is likely to represent the biggest financial risk to the PCT(s) within PBC. It is very unlikely that the PCT will be able to afford to set aside a separate contingency fund with resources outside of those committed to PBC. It is essential that practices and the PCT find a solution to minimise the risks for all parties.*

3.10 It is proposed that the PCT(s) continues with a scheme to manage high cost drugs in line with previous experience.

# 4 Practice Commissioning Plans

4.1 As part of the engagement in Practice Based Commissioning and in order to qualify for the Directed Enhanced Service (DES) of 95p per patient, practices need to produce commissioning plans that need to be approved by the PCT(s).

4.2 Practice plans need to comply with the PCT(s)'s strategic commissioning plans as defined in the Local Delivery Plan, including joint commissioning strategies agreed with Social Care. The practice plan should consider areas in which the practice wishes to change patient pathways in order to deliver better patient care and/or to provide care in a more cost effective manner. The plan will need to set out the following as a minimum. A template for submitting practice commissioning plans is being developed nationally.

- Care pathway to be changed and justifications for change.
- Changes required by practice
- Changes required by others
- Expected benefits to patient care
- Expected costs and savings associated with change including costs and savings required by other organisations including the PCT.

- Involvement of patients/carers in the planning process.

4.3 All practice plans will propose changes to at least one care pathway. Practices may group together to work collectively on a single care pathway.

4.4 The guidance states that plans will need to be approved by the Board. In practice the Board will need to be advised by an appropriately constituted group. This may be the PEC but GPs will often have vested interests in PBC plans. The key issues that the Board will need to be advised about are:

- Clinical appropriateness of proposed change
- Suitability of any alternative provider
- Likelihood of any proposed savings being realised and the timescale in which these may be delivered.

4.6 Practices are encouraged to consider care pathways in the following areas:

- Care pathways involving better management of patients with chronic disease, that is closer to home
- Changes that will reduce the number of emergency admissions to hospital
- Changes that will reduce out patient referrals to hospital
- Changes that will reduce the number of out patients follow up attendances
- Changes that lead to a better use of diagnostic procedures without the need for an outpatient attendance
- Developing the role of community hospitals and other community services.

4.9 The PCT(s) will look to manage the recovery of any necessary pump priming resources over a maximum of two years. Any such proposal will need to be clearly identified in the business case.

4.10 The PCT will need to develop tight criteria to assure itself that proposed savings will be forthcoming. There will also need to be a strict regime of performance management of the business cases to ensure that the proposed changes to care pathways have occurred and that proposed savings are accruing as a result.

4.12 The PCT(s) will need to devise a process for the approval of alternative providers of service, particularly where these are not existing NHS providers. This would apply to situations where a practice was looking to provide an additional service as well as to private and independent providers. The process would need to include such thinks as clinical liability, clinical governance structures and processes, information

recording and governance, complaints processes, incident reporting and infection control where relevant.

## *5 Savings and Deficits*

5.1 The guidance proposes that for 2006/07 practices are eligible to retain 70% of freed up resources with 30% being retained by the PCT to meet wider need across the whole PCT area.

5.2 If at the year end the PCT(s) has uncommitted resources from its retained 30% of savings, this resource may be used the following year as a source of pump priming money for practices.

5.3 As described above, the management of unintentional or unplanned savings and deficits is a significant risk to the health economy. If a practice delivers on its plan it is entitled either to a further DES payment of 95p per registered patient, or to retain a suggested 70% of the resulting surplus. The DES will be calculated on the practice population as at 1st April each year. If a plan releases savings where 70% of the saving is worth more than the 95p per patient DES payment, practices will be able to choose to retain the savings and forego the DES payment. If the savings are less, then the practice can elect to receive the DES payment and forego the savings. The DES payment and the savings must both be spent on patient care or other practice activity which supports the continued delivery of the objectives.

5.4 The first call on any savings will be to ensure financial balance within the practice, or group of practices if this was agreed in the plan.

5.5 Net savings that have accrued to practices at the year end will be available to practices to invest in services for the benefit of patients. This includes spend on equipment, training, clinical and non-clinical staff, and with specific Board approval on premises development. Resources will be able to be carried forward into the following financial year.

5.6 The guidance states that as a last resort in terms of maintaining financial balance the PCT may use practice savings to cover PCT overspends. If practices deliver on their plans they will be able to retain, as a minimum, a second 95p per head of practice population for reinvestment in patient care or other practice activity that continues to deliver the agreed objectives.

## *6 The Directed Enhanced Service*

6.1 Details of this will be made available soon on the network website. Prior to this becoming available there seem to be 3 core elements that would be required of practices:

- Development of a PBC plan and business case(s) where necessary
- Commitment and involvement in an on-going programme of data validation.
- Commitment to a level of clinical and managerial involvement in the process including attendance at regular PBC commissioning group meetings as established by the PCT.

6.2 Commissioning plans are dealt with above.

6.3 Practices may be asked to validate a range of data including that relating to:

- inpatients
- outpatients
- direct access services
- community based services
- mental health services

Practices would be asked to validate elements of this data for two separate months in a 12 month period.

6.4 The PCT is required to provide practices with the following information:

- Elective activity – inpatient and day case
- Non-elective admissions, including information on length of stay
- First outpatient appointments, and follow up appointments
- Use of diagnostic tests and procedures
- Consultant to consultant referrals
- Prescribing
- Community and mental health services
- Primary care including essential and enhanced PMS and GMS services
- Accident and Emergency

6.5 It is likely that a county-wide practice based commissioning forum will be established. This could be open to all practices to attend or could function on a locality representative basis. In addition, it is likely that practices in natural localities will choose to meet together to develop local services. These meetings will be supported by the PCT as far as possible.

# Worcester VTS Residential

## VTS Programme for Autumn 2006

| Date | | Session | | | Subject |
|---|---|---|---|---|---|
| September 2006 | | | | | |
| 06 + 07 | | 1+2+3+4 | | Away days | Residential at Dumbleton Hall, near Evesham |
| 14 | | 5 | | | Mother and Baby<br>Ruth White, MHU |
| 21 | | 6 | | | ENT |
| 28 | | 7 | | | Critical Reading |
| October | | | | | |
| 05 | | 8 | | | Practice Visits (PMCE Meeting) |
| 12 | | 9 | | | Child Health Surveillance ($^1$/2 day) |
| 19 | | | | | Educational Dialogues |
| 26 | | 10 | | | Child Protection ($^1$/2 day) |
| November | | | | | |
| 02 | | | | | Educational Dialogues |
| 09 | | 11 | | | |
| 16 | | | | | Educational Dialogues |
| 23 | | 12 | | | |
| 30 | | 13 | | | |
| December | | | | | |
| 07 | | 14 +15 | All day | Away day | Medicine and the Humanities<br>Holland House, Cropthorne |

# Worcester VTS Residential

## ***Ideas for The Term***

Primary Care /Business Management
**Practice Management and business side of general practice**
**Finance Management**
**QOF**
**PBC**
**PCT**
Occupational Health
**PMS**
**GMS**
DVLA and fitness to drive

Communication Skills

**Dysfunctional consultations**
Approaching Consultants for advice

Self Awareness

**Stress Management**

Models of change and change management
Could use Electronic Prescriptions as example and think how we might implement this change

Clinical

**CKD**
Ophthalmology
**Men's Health**
**Prostate**
**Urology**
Dermatology
Elderly Care
Access to local services
**Mental Health issues**

Professional Values – Ethics, Medico-legal issues

# Aims of Balint group

1. Allow us to handle difficult patients more easily
2. Develop a variety of styles with the patient rather than maintaining same style
3. Step back from consultation and analyse meaning behind their requests
4. Critically analyses the process of the consultation with emphasis on the Dr's own response to the patients' behaviour.
5. Exhibit non-judgemental response to the patients behaviour

Helpful questions to ask are: -

What was the patient's **actual** reason for coming that day?
How did you feel when you saw patients name on your list?
What kind of thoughts and feelings did you have during the consultation?
Are there any other patients, who make you feel this way?
Focus on the doctor patient relationship and not the medical management

N.B.
The aim is to look at the Dr – patient relationship. One should try and analyse what feelings are generated in members of the group, as this may represent what the patient feels. The presenter often takes on the role of the patient and the group that of the Dr. The aim is not to make a diagnosis.

**Characteristics of effective Balint group leadership**

The leaders will:

- Try to keep the discussion centred on the doctor patient relationship
- Discourage too much interrogation of the presenting doctor.
- Encourage people to express their own thoughts and feelings about what they have heard.
- Protect group members from unwelcome intrusions on their privacy or criticism which is hurtful without being helpful.
- Represent the patient if he/she is in danger of being ignored.

## Worcester VTS Residential

# Dysfunctional Consultations

## Some causes of dysfunction

- Mismatch between patients expectation and Doctors e.g. patient wants to be referred to specialist Dr wants to make a diagnosis
- Failing to pick up cues
- Failing to find out the real reason for the patients attendance
- Interruptions to the consultation
- The computer
- Lack of trust of the doctor due to past experiences

### Solutions

- Recognise the problem early and take control, whilst it takes two to tango the doctor is often the more powerful person in the consultation
- Pause and take time out to step back and analyse what is going on in the interaction
- How do you feel about the situation? Angry, sad,
- Look at the patients non verbal cues and see if you can identify how they are feeling, angry, sad, fearful, lost, scared,?
- Consider acknowledging the patients affect
- If you don't understand what is going on and cannot identify their affect then may be just try saying so
- Don't blame the patient for the problem
- Find out and respect the patient's perspective on their illness whether you agree with it or not. Ask what lead the patient to think what he /she thinks
- If a patient appears not to trust your opinion or diagnosis, try to find out what lies behind that distrust. Don't take it personally or become defensive but try to get to know the person as an individual and what makes them tick.

## Anger

- Anger especially aimed at you is an attack and you will feel it as such.
- Empathy is the most effective response to a patient's anger. Try to understand the patient perspective. Empathy is not the same as agreeing with the patient, it is expressing an understanding of how the patients feeling by exploring the patients world.
- Recognise the anger
- Stop and step back to reflect on what is happening
- Acknowledge the anger