Secretary's Newsletter March 2005

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Post Graduate Education Allowance (PGEA) Legal Ruling

- The media have reported widely on the case of Dr Cornel Fleming who won his case against Islington PCT to claim a full year's PGEA following the start of the new contract.
- PCT ordered to pay £2944 plus £519 costs.
- PCT request to appeal was refused.
- The GPC sought legal advice on this matter last year. They were advised that PCT views similar to that taken by Islington PCT were correct. The whole crux of this matter hinges upon whether PGEA was paid in arrears or advance.
- LMC Secretary had also looked at this issue last year and concluded that PGEA payments were paid in advance. GPs started getting PGEA payments at the beginning of the first year of the 1990 contract change
- Undergoing the necessary education in the previous 5y was a requirement to receive quarterly payments in the current Red Book year. When the Red Book ended so did PGEA.
- GPC are currently looking at the details of this particular legal ruling to check whether this is ruling is specific to this particular doctor or is relevant to all GPs

- GPs also need to be aware that, even if there is a “class” effect, it will only apply to GMS GPs
- Once GPC have assessed the implications of the ruling, LMC will inform practices

Premium Rate Numbers Banned

- The Department of Health has announced a ban on the use of higher rate telephone numbers within the NHS
- From April 2005 practices will not be allowed to use premium rate numbers beginning with 087 or 09 for patients contacting practice.
- Practices already using them expected to switch to lo-call numbers beginning with 0845 or 0844.
- Ban thought to affect 290 practices.
- GPC states that it is sympathetic to the view that patients should not be charged over the odds for contacting their family doctor
- They also believe that a relatively small number of GP practices use premium rate numbers and that by introducing these telephone systems, practices and patients will have benefited from improved equipment installed with the aim of ensuring patients were able to get through to the practice quickly, deliver their message or request speedily, and in general spend less time on the telephone than with previous systems.
- GPC adds that some of these GP practices were encouraged to switch to 0870/1 systems by their PCT.
- However, as this announcement has now been made, GPC welcome the Government's intention to fund the cost of the change back to *lo-call rate* systems. GPC believe this should apply to all affected practices, whatever their telephone system supplier.
- The Department of Health has identified the main supplier of the premium rate lines (NEG) and have come to an agreement that they will make funding of around £500 per practice to convert GP surgeries using these lines to 0845 numbers.
- The amendment regulations incorporating the phone lines ban itself (but not the transitional arrangements) into the GMS regulations will be bundled up with the other miscellaneous amendments that are currently being discussed at meetings between GPC and DOH lawyers.

QOF Visits and Confidentiality

- GPC are sorry for the confusion that has been generated by this issue and for the delays in getting substantive advice to practices.
- This is in part due to the complexity of the matters and GPC wish to get clear legal advice
- GPC received their own legal advice which in many areas agreed with that of the DOH. Discussions are ongoing.
- Ian Gatt Q.C. advised the GPC. He did not conclude that explicit consent must be obtained for all disclosures.

- The rule of thumb is that where practices can anonymise records relatively easily, without a huge administrative burden, then they should do so in order to comply with the Act.
- Where it becomes burdensome to a degree where it would be unreasonable as well as time consuming and costly for the practice to anonymise, or the anonymising software is not effective, then the GP can hand over the patient record without having to go through the anonymisation process.
- This falls within a specific exemption in the DPA under provision of healthcare and especially applies where the GP is disclosing to another healthcare professional.
- There are certain factors which the GP must take into account in order to ensure he/she is protected. Firstly, the practice must be able to demonstrate that anonymisation cannot be undertaken with relative ease;
- Also the practice must ensure that there are clear notices/leaflets in the surgery informing patients as to how their records may be disclosed.
- If a GP is aware that a particular person would object, or a record contains third party personal information which has nothing to do with QOF, or certain types of information in a record may in future override the DPA (e.g. gender transfer due to be implemented this year), then the GP must recognise that in these cases consent will be required.
- Under the current Code of Confidentiality section 31 the onus is on the PCT to obtain consent in these cases
- Where this obligation is disputed LMC advice is for practices to produce the Code of Confidentiality and refer the PCT to clause 30(ii) and clause 31 which clearly states that where anonymisation is not possible the PCT obtains consent.
- If PCTs are threatening to withhold payments, GPC would be prepared to support a challenge that this is an illegality and a clear breach of contract.

Lithium Levels and QOF

Worth 5 clinical points
The following changes have now been agreed for 05/06:

- That the therapeutic range for serum lithium levels be changed to 0.4 – 1.0 mmol/l (was 0.6 – 1.0)
- That the upper achievement threshold for this indicator be increased from 70% to 90%
- These changes will be introduced from April 2005
- For 04/05 practices can ask PCT to agree a pre payment alteration to QMAS based on their own audit of lithium patients and therapeutic range achievement

QMAS at end of year

The GPC has issued a Focus on QMAS
This can be found on

http://www.bma.org.uk/ap.nsf/Content/FocusQApayments0205?OpenDocument&Highlight=2,Focus,on,QMAS

Timetable

- 14.2.05. is National Prevalence Day.
  A snapshot of practices disease register sizes on this day will be used to calculate national disease prevalence. Practices' pounds per point will be affected by how their prevalence compares with the national average prevalence for each clinical domain
  (NB: controversial square rooting of prevalence ratio to damp down payment extremes)
- On 14.3.05.practice clinical systems will automatically submit disease register sizes coded at or before 14.2.05.
  Practices can check between 14.2.05 and 14.3.05. that prevalence data has been entered completely and correctly.
- On Saturday 2.4.05 QMAS calculates each practice's final clinical achievement.
  Non-clinical achievement is based on the most recently submitted QMAS data submission by the practice
- On Monday 4.4.05. each practice should examine their final achievement report on QMAS and either submit their Electronic Achievement Declaration or query result with their PCT

LMC Levy Mandate Returns

The current actual and percentage returns by county are:

County	Numbers	Percentage
Berks	90/109	83
Bucks	83/90	92
Oxon	81/86	94

Some practices have consciously refused to pay the voluntary levy only
Others have just not returned the levy despite several letters and phone calls

In reality Secretary cannot easily separate what is paid for out of the statutory and voluntary levy
This is why Bucks and Oxon now have a combined levy and Berks has agreed to follow suit

- The voluntary levy has financed negotiation of nGMS and the obligatory parallel additions to PMS contract sums, QOF and OOH opt out
  It also finances the excellent GPC staff who provide an invaluable problem solving resource for the Secretariat
- The Statutory levy funds a 5 days a week office of 5 people including myself, newsletters, local reference committees, website, telephone and written advice, pastoral care for practices and GPs often with severe

problems, continuous monitoring of PCT activity and action to limit PCT decisions potentially adverse to practices

All practices benefit from local LMC and national GPC activity yet some seem not to want to contribute financially.
They are being subsidised by those that pay yet I do not see non-payers refusing Enhanced Services, negotiating personally with PCTs, turning down QOF money, or continuing their own OOH cover including Saturday morning surgeries

The Secretary has met a small hard core of resistance to the subsidy argument
Discussion will soon take place on how to handle this.
It is not impossible that non payers will be listed in Newsletters and on the website

Locum Reimbursement Frozen

- It has become apparent that the DOH is not intending to increase the level of payments throughout part 4 of the SFE (PCT Administered Funds)
- Seniority Payments and Dispensing Fees are excepted.
- The Department's position is that fees have been uplifted for 2005/06, only where there is a specific, documented undertaking to do so, and believe that in the absence of such a written agreement, they have the discretion not to uplift these allowances.
- GPC strongly contend that the default position is that all payments would be uplifted unless stated otherwise, as had been the case in all previous years, and that the only payment not to be uplifted for 2005-06 was the Global Sum payments
  (as set out in the joint J Chisholm/M Farrar letter of 30 May 2003).
- The Department maintain that, although it is understandable that GPC should think this and that in normal circumstances this would be the case, the new contract is over delivering, and that they are using this loophole to avoid uplifting payments and therefore save money
- In reality, if part 4 fees are not uplifted, this will obviously provide a disincentive for practices to take on sessional doctors.
- The Department has agreed to come back to GPC with some proposals about how to take this issue forward.
- In the meantime GPC will continue to put the pressure on the Department on this issue, warning them that, in the lead up to an election, it will not reflect well on the Government's expressed wish to get more doctors into General Practice.

Enhanced Services (ES) Underspends in 04/05

- GPC have received worrying reports about PCT enhanced services underspends in 2004-05.
- GPC concerned to ensure that this money is not lost to enhanced services and used to pay off deficits elsewhere in PCT's budgets.

- GPC and DOH have agreed that for one year only PCTs can roll over into 05/06 any unspent ES funding for 04/05
- Funds available for 05/06 ES spend will then total 05/06 ES Floor allocation plus the 04/05 underspend
- Enhanced services subgroup of the Primary Care Development Subcommittee is continuing to answer queries from LMCs and advise on all issues relating to enhanced services
- The group has now published definitive lists of enhanced services that can and cannot be funded from the floor.
  See
  http://www.bma.org.uk/ap.nsf/Content/ESfloors0205?OpenDocument&Highlight=2,enhanced,services,guidance

GPC Election for Oxon and Northants

- Nominations are now being sought for the election of the regional GPC representative for the combined constituency of Northamptonshire and Oxon
- Current representative is Rick Godlee (Wantage) who is not seeking re-election
- LMCs asked to encourage any interested members to stand.
- The deadline for nominations is Friday 1st April at 5pm.

The 2005 election pack and nomination form are available to download from the website at: http://www.bma.org.uk/ap.nsf/Content/GPCelection2005

Choose and Book

- GPC have received reports that certain PCTs that are trying to enforce Choose & Book protocols on practices without negotiation, objective study or appropriate payment.
- LMCs are reminded that there is no contractual requirement for GMS practices to participate in Choose & Book
- This also applies to most PMS practices, although it may be worth checking local PMS contracts in case there are any relevant clauses about participating in new initiatives or the equivalent.
- We advise that practices should not take on any work that they are not contracted to do, are not happy to do or for which they do not feel they are being properly resourced.
- The GPC will support any practices that refuse to participate in this initiative where these conditions are not met.
- The main concerns for GPs are the lack of clear information on the programme, the implications for workload, and concerns about patient confidentiality, together with a belief that the government's version of Choose and Book is not the best way to offer our patients appropriate choices about their treatment.

- In an attempt to address some of these concerns, new 'incentivisation' money was announced by John Reid last month, but with no clear indication as to exactly how this money will be used.
- LMC will continue to monitor developments and keep GPs informed.

QOF review group

- QOF review sub-group is to appoint an independent QOF expert review panel
- Fully independent panel of experts with the relevant knowledge and expertise in developing quality indicators and assessing and researching evidence.
- Each short-listed party will be asked to give a presentation to the QOF review sub-group next week.

Doctor and Dentists Review Body Report

- The 2005 report of the DDRB was released on 22.2.05.
- GP Trainers awarded 3.225% rise plus £750 annual continuing professional development grant
- Trainer resignation talked about
- 3.225% increase also for salaried GPs, doctors in training, and GPs working in community hospitals
- Registrars supplement kept at 65% (hospital equivalent is 70%)
- GPC disappointed and believe it will fail to encourage GPs to continue with essential work as GP trainers and in community hospitals.

A summary of the main points that affect GPs can be found on the BMA website:
http://www.bma.org.uk/ap.nsf/content/ddrb2005GP

Practice Based Commissioning (PBC)

- The long-awaited technical guidance on PBC was eventually published on 23.2.05.
- Can be accessed from the Department of Health website: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4104152&chk=/K4etf
- Described by a disappointed Hamish Meldrum as "neither technical nor guidance"
- Although some information on setting default budgets is given, a lot of decision making on financial allocations will be at local level.
- GP practices interested in taking on PBC will need to know how these local budgetary decisions will be made, how to work out "reasonable" management costs and how to be sure that data for monitoring practice based commissioning will be accurate.
- The technical guidance also explicitly links Choose and Book with PBC.

- GPC stresses that linking PBC with the largely untried and untested Choose and Book proposals will act as a deterrent for practices to take on PBC.
- In the meantime, practices are reminded that there is no contractual requirement for GMS practices to participate in Choose & Book, and that this usually also applies for PMS practices.

Relevant points extracted

- Practices may choose to work in groups but this cannot be imposed on them
- Other clinicians can hold a budget, particularly community matrons managing chronic care.
- PCT and practice to agree obligations, including details on national and local targets such as NSFs and access, and PCTs right to intervene and risk-sharing
- Practices must consider PCT's existing agreements with foundation trusts and private providers, and patients must get a choice of providers.
- PCTs and practices to use 2003/04 hospital activity and referral data to set budgets. Hospital statistics can be requested at pbc@dh.gsi.gov.uk These figure can be uplifted to 05/06 levels by using SHA local delivery plans
- Guidance contains calculations for list-based adjustments
- PCT to top slice budgets to create a contingency fund
- Management costs should include clinical time needed. PCT to provide initial costs and recoup them later
- Practices must use profits and savings for patient care, but this can include capital developments. Practices to agree with PCT how to use such money.

GP Registrars Handbook

- This specimen handbook has been produced to assist both trainers and GP registrars.
- Handbook should be issued with the model contract of employment.
- Each practice and GP registrar will need to tailor their contract of employment to suit individual circumstances. These must be assessed carefully before finalising the Handbook, taking particular account of any cross-referencing between the Handbook and the relevant contract.
- The handbook and model contract are both available to BMA members on the website at: http://www.bma.org.uk/ap.nsf/Content/handbookforregistrars0105

Assessment of GP Earnings for Superannuation payments

- The BMA, the Department of Health, the NHS Pensions Agency and their accountancy advisers have been working for some time to develop a procedure for the assessment of GP pension contributions following the introduction of the new contract.

- GPC have now seen (and are happy with) the final version of the guidance setting out the procedure, based on the practice Certificate of NHS Profits,
- The requirement to assess GP pension contributions from net NHS profits has been highly complex, and it is important that GPs, and their accountants, familiarise themselves with the procedures before the end of this financial year.
- Details will be posted on the NHS Pensions Agency shortly – LMC will let practices know as soon as these are available.

GPs and Bureaucracy

Cabinet Office wants GPs to report "bureaucratic burdens" via an online questionnaire.
www.cabinetoffice.gov.uk/regulation/pst/projects/mad/data.asp

PCT Allocations

On 9.2.05., the Department of Health released Primary Care Trust (England) Recurrent Revenue Allocations 2006-07 & 2007-08. These are available on the Department's website at the following location:

http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/HealthServiceCircularsArticle/fs/en?CONTENT_ID=4102980&chk=ncBm6F

Out of Hours (Oxfordshire)

- County OOH Group has announced that from 13.4.05 all call handling for Oxfordshire PCTs will be transferred to the Oxfordshire Ambulance Trust (OAS)
- Group was apparently unaware that for periods within core hours (8am – 6:30pm) some practices used Border Medical to call handle for their duty doctor.
- OAS apparently cannot take on this role
- Practices are now faced with a difficult choice between
  - Asking their staff to work earlier and/or later
  - Using a complicated answer machine message, possibly confusing to patients
  - Hoping their phone system can cope with 3 call divert numbers programmed in sequence
- LMC has not been able to get PCTs to change this decision because they say they are required to use national software without the necessary flexibility
- Unclear why Oxfordshire has changed earlier than other areas
- Many aggrieved at short notice period
  Negotiation of new staff hours takes time especially if disputed.

The NHS in Oxfordshire

Secretary has emailed LMC members and PCTs with the following:

I am writing this in the hope of stimulating discussion
Seven weeks ago I took back Oxfordshire for LMC purposes having moved to Bucks and Berks last July
I have been surprised to find Oxfordshire more fragmented than before I left.
Basically PCTs seem not to be liaising with each other effectively.

Several issues illustrate this

- The NOC/Oxford City PCT letter on Hip and Knee Referrals
  Lead commissioning can only work if the lead commissioner takes account of variations in local PCT provision before it changes systems. For this to happen it has to properly understand the situation of other PCTs and liaise effectively. This is difficult and is the reason why I feel that if inter PCT dialogue cannot be improved each PCT should consider commissioning separately.
- OOH Lead Commissioning by SO Oxon PCT
  OAS will apparently take over call handling for all Oxon PCTs from 13.4.05.
  Yet OAS will not call handle for practices after 8am or before 6:30. The current specification negotiated by PCTs for many practices includes call handling between 8-8:30 and 6-6:30. Any change from this creates major problems for practices using call divert. It effectively means they will have to employ staff themselves from 8am and until 6:30
  This issue seems to have been recognised late. It could have been averted if the right people were talking to each other.
- Late notification of Cataract Choice Implementation
- Rejection of Back Triage referrals by the NOC without considering variations in local community provision.
- Late development of policies for PCT Administered Funds and Locum Appraisal
- Poor Contract Documentation of Enhanced Services particularly LES

Before I left, LMC officers and senior representatives met regularly with all the Oxfordshire PCTs together.
The group had its difficulties but I am sure much of the list above could have been avoided if it had not been disbanded.

Berkshire PCTs meet regularly with LMC and TVPCA and I am convinced the whole system benefits. Can we work together to deal with these issues?