

BBOLMC Secretary Newsletter (July 2005)

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Notes on Verification of Fact of Death

A recent case causing difficulty in Oxfordshire prompted me to do some research and liaise with other professional groups

My conclusions are bulleted below:

- Requests (perceived or real) for GP attendance after apparent death is a source of friction between professional groups
- There is no list of professionals who can verify that death has occurred
- Ambulance crews are able to verify death
- GPs have no contractual or legal obligation to verify that death has occurred.
- GPs are responsible for issuing certification of cause of death in defined circumstances (eg seen within last 2 weeks, GP is usual doctor of patient, etc)
- GPs are responsible for the care of patients on their list distressed by bereavement
- To issue a certificate of cause of death, a GP does not have to see the body
- Where ambulance crews are the first professionals to attend an apparent death they often call GPs

- This call is often meant/interpreted as a request for the GP to attend asap
- The purpose of calling the usual GP is to determine whether he/she will be able to issue a certificate or whether the coroner's officer needs to be involved.
- Ambulance crews are able to refer to the coroner's officer and this is achieved via contact with Thames Valley Police
- The coroner's officer may use a police surgeon
- Ambulance crews are able to guide relatives on how to contact an undertaker in situations where GP will issue a certificate and does not feel coroner's officer needs to be involved

5% QOF Checks (Post Payment Verification or PPV)

In conjunction with the TVPCA in Reading (and Aylesbury PCT), I recently selected the following list of practices to undergo the new 5% probity check. The list has already been circulated to practices and PCTs.

5% QOF PPV Visits selected randomly by LMC

PCT	Practice(s) pulled randomly by LMC
Reading	Dr MA Jacobs, 72 London St Dr Narayan, 10 Eldon Rd
Bracknell Forest	Dr M Woods, Balfron Practice
Slough	Dr E Campbell, Langley HC
WAM	Dr A Dalton, Datchet HC
Newbury	Dr L Lowenthal, Downland, Chieveley
Wokingham	Dr M Haslam, Tudor House and Rectory Rd
Chiltern and South Bucks	Dr P Flint, Lindo Close, Chesham
Oxford City	Dr A Chivers, Jericho HC
Cherwell Vale	Dr D Burton, Byfield
North East Oxfordshire	Dr N Bryson, Islip
South West Oxfordshire	Dr O Sharpley, Burford
South East Oxfordshire	Dr T Vernon, Wallingford
Wycombe	Dr Hayter, Marlow
Aylesbury	Dr M Jones, Edlesborough
Milton Keynes	Dr Julian H Bradley, Stony Stratford

The original list circulated by the Secretariat did not contain any practice from MK, Aylesbury or Wycombe because they were slower in identifying their audit provider.

I now know that Milton Keynes and Wycombe also plan to use TVPCA and Aylesbury CEAC

I have had some initial difficulty in restricting the 5% to the nearest whole number (eg 23 practices in a PCT requires 1 audit not 2) and have had to be assertive with PCTs.

The purpose of 5% PPV is to act as a deterrent against fraud. Auditing >5% does not add to the deterrent value but does add to the workload of the extra practices. The Secretariat would not participate in randomisation where a policy of always rounding up was insisted on by a PCT

I have been involved in developing the checklist of how each QOF item will be verified and hope practices will not meet any shocks.
Please let me know of your experiences.

QOF 04/05 and Next Year

- Some PCTs are now planning their QOF visits for 2005/06. As in last year, these should take place between October and February.
Early signs are that the emphasis will be slightly different to year one. I will keep you posted as I receive details.
- There seem to have been few persistent QOF disputes
I have been involved by one PCT in assessing practice arguments where there has been a QOF withholding
Most seem to revolve around the practice not reading the QOF organisational requirements in sufficient detail and missing deadlines for supplying evidence.
The QOF outline in the first Blue book was supplemented in the second.
The combined requirements were included in the SFE (Statement of Financial Entitlements)
This can be downloaded from:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4107508&chk=dc/lzz

My advice for 2005/06 would be to adhere rigidly to the complete wording and start preparing now.

New Waste Management Obligations

GPC has issued guidance which the Secretariat has sent to all practices and PCTs

New regulations come into effect on 16.7.05.

The full *List of Wastes Regulations (England) 2004* can be found at:

<http://www.defra.gov.uk/corporate/consult/wastereg-haz/annexb.pdf>

After 16.07.05 it will be illegal to dispose of hazardous waste without a license if GP surgeries produce >200kg/year.

GPC expects most practices to exceed this
The definition of waste is quite wide and includes clinical waste, PCs and fluorescent tubes but not POM medicines.

The TVPCA has now block registered all practices in Oxfordshire and Berkshire Bucks PCTs and Primary Care Support Services have also confirmed their intention to reimburse practice registration costs, although they expect practices to perform the task of registration themselves

- The cheapest way to register is online and costs £18.
This can be done by accessing the following link:
<http://www.environment-agency.gov.uk/subjects/waste/1019330/1029396/>
- Registering by telephone costs £23 per premises and can be done by ringing 08708 502858 and asking to make a Hazardous Waste registration. Applications by phone can be made between 0900 and 1700 hours Monday to Friday.
The registration number is provided instantly when you pay by credit/debit card only.
- Registering in writing can be done by obtaining a registration form by ringing 08708 502858 or from downloading the form from accessing the link below and sending it to the Environment Agency, PO Box 544, Rotherham S60 1BY. The charge for this is £28 per premises.
http://www.environment-agency.gov.uk/commondata/acrobat/paper_app_1030944.pdf

MMR Vaccine Shortage

- The DOH has responded to an MMR vaccine shortage by arranging for non-UK licensed vaccines to be imported from the USA and Germany
The manufacturers are apparently the same as before but the labelling is different hence the non license!!
- Dorian Kennedy (DOH Immunisation Policy Manager) has written to practices (13.5.05 and 26.5.05)
Unlicensed products cannot be given using a Patient Group Direction.
Patient Specific Prescription is needed eg a list of eligible patients signed by a doctor
- Despite DOH reassurance practices are nervous about using these products
- The GPC is trying to get the DOH to indemnify all GPs who use this vaccine or take responsibility for rapid licensing of the substitute vaccines

Enhanced Services spend against floor 2004/05

Obtaining final end of year figures has been a slow process but PCTs are now identifying whether they have under-spent or not.

PCO	ES Floor 2004/05 (£K)	Actual Spend (£K)	Spend Disputed	Variance (£K)
Milton Keynes	2268	2397		+129
Aylesbury	2095			-66
Wycombe	1543	1527		-16
C&SBucks	1731			-139
Cherwell Vale	1422	Not Available		
NE Oxon	824	Not Available		
Oxford City	1955	1957	Y	+2
S Oxon	2989	2907		-82
Newbury	937	Not Available		minus
Reading	2223	2274		+51
Wokingham	1307	1065		-241
Bracknell Forest	976	1012		+36
WAM	1579	1685		+106
Slough	1355	Not Available		

I am encouraging PCTs to present a formal spreadsheet with row items that can be assessed against the criteria in the Xmas 2003 Implementation Guidance. Once the size of any under-spend is known then DOH instructions require PCTs to seek a letter of grant from LMC to roll under-spends into 2005/06

Many LRCs feel some 2004/05 ES were under-priced as part of first year inexperience and the desire to maintain goodwill. They are seeking some form of end of year recognition of this rather than roll over which is perceived as GPs having to earn the money twice. Some discussions between LRCs and PCTs have ended in impasse. Compromise solutions are now emerging which involve under-spend roll over into non recurrent ESs with low workload and high reward. The alternative is for either party to refer the dispute to the National Implementation Co-ordination Group via the SHA. I would welcome views from practices and representatives on this issue.

PCT Reconfiguration

The predicted post election push to merge PCTs seems to be a reality especially in Oxon.

Amidst rumour and official denials, there seems to be some acceptance that Oxon might become 1 PCT, Berks 2 and Bucks 1 or 2.

Many voice concerns about losing the local responsiveness of current PCT configurations, whilst recognising that larger units could commission better and lessen wasteful duplication on many levels.

The timescale seems uncertain with both April 2006 and 2007 being mentioned. The final decision lies with PCT boards that will likely be subject to conflicting external pressures

Practices and LMC need to involve themselves in planning system change. There is already dialogue between PEC Chairs, PCT CEOs, SHA and LMC.

Police asking Patients to see GP after Assault

Many GPs have been frustrated by increasing numbers of patients consulting apparently on the advice of police officers, solely to document the consequences of assault however trivial and unimportant clinically

I have therefore asked the Thames Valley Police for their policy and this is documented below

The important bit is at the end

“However, you are correct in stating that we should not be routinely asking patients to see their GP, simply to have injuries documented.

Payments (for GP statements) are arranged through our File Quality Managers and officers should assist in this area.”

Email to Secretariat (30.6.05)

(Jane Meadows, Policy and Procedures Inspector, Thames Valley Police, Tel: 01865 856381)

I have been asked to contact you in relation to your recent complaints regarding the increasing number of requests for Doctor's statements GPs have been receiving.

I hope that I have rectified the situation by putting out the attached message to our entire workforce.

Medical Evidence

The force is receiving a growing number of complaints from GPs where officers are incorrectly advising victims of assault to attend their GP in order for their injuries to be documented.

Medical evidence from a doctor should only be required in the more serious cases, usually ABH and above where the injury will usually require A&E treatment. For common assaults and the majority of ABHs photographic evidence, descriptive evidence from a police officer and details from the aggrieved will suffice. CPS Lawyers should not be insisting on medical evidence and any unnecessary requests should be challenged through your File Quality Manager (FQM). Unfortunately there are no hard and fast rules for when an ABH will require medical evidence, but the best guidance is that it will be required when the injury is not obvious externally (e.g. broken bone in the hand). If you are uncertain, check with your FQM before instructing a victim to see their own doctor.

There is a protocol in place with all A&E Departments which is agreed at ACPO and British Medical Association level. This protocol allows for the payment of medical statements and systems are in place with your local FQM to obtain such statements. The full protocol is available on the Criminal Justice Website at (A-Z site Protocol for the provision of Witness Statements from Hospital Accident and Emergency Staff).

I believe that some of the confusion may have arisen as we have moved to a Prosecution Team approach with Crown Prosecution Service in the past year. There have been many requests from the CPS to obtain medical evidence that perhaps should not have been made. I have also discussed these issues with colleagues in the CPS before putting this advice out. There may still be a few cases where the individual has seen their own G.P. rather than an A&E doctor and we would request a statement. However, you are correct in stating that we should not be routinely asking patients to see their G.P. simply to have injuries documented. Payments are arranged through our File Quality Managers (see listing below) and officers should assist in this area.

I hope this is sufficient to sort this situation out, but accept that messages do take time to get through to 4,500 staff.

Second Email about FQM

FQM stands for File Quality Manager. When an officer submits case papers to support a court case they are quality assured by these individuals before going off to the Crown Prosecution Service.

There contact details are as follows:

Aylesbury	Keith Jackman	01296 396054
Milton Keynes	Audrey O'Connor	01908 686139
Reading & Wokingham	DS Sue Upton	0118953 6340
North Oxfordshire	Charmain Hills	01295 754615
Slough	Maggie Goodwin	01753 506175
Southern Oxfordshire	David Parry	01235 556835
Oxford City	Karin Williams	01865 266326
High Wycombe	Rashmi Sharma	01494 686179
West Berkshire	Martin Robinson	01635 264673
Maidenhead	DS Bob Harvey	01628 645691

Annual Contract Review (nGMS and PMS)

The GMS and PMS Regulations that came into force on 1.4.04 include the following requirements

- That each contractor submits to their PCT an annual return relating to their contract

- That the PCT, following receipt of the return, arrange with the contractor an annual review of the contractor's performance against the contract
- That the PCT produce a final written record of the review, sending a copy to the contractor

The TV SHA has developed a model pro-forma for PCTs and practices to use from April 2006 and if possible before then (ie the current year)

The aim is to get as much information already held by PCT or Agency added to the pro-forma prior to sending it to practices.

Review visits are not compulsory, but if they occur could take place at the same time as the QOF visit

New GMC 'GP Listing'

GMC has asked all PCTs for help in compiling (by 30.9.05.) a national register of doctors eligible to work in general practice

From this date doctors not on the new register will be unable to work as GPs (GP Registrars excepted)

The TVPCA as agent of all Berks and Oxon PCTs is planning to comply and will pass all Performers List details to GMC

The alternative for PCTs unable to assist in this way is that GPs will need to apply individually to the GMC for inclusion in the register.

The current TVPCA plan seems preferable

Agencies will distribute a letter from the GMC to all Medical Performers asking them to let the GMC know if they do not wish their name to be included on the register

(ie opt-out rather than opt-in)

Overseas Visitors

The GPC has recently issued new guidance to take account of altered EU rights wef 1.7.2004

This has been circulated to practices in all 3 Thames Valley counties.

Some key points are

- GPs must provide immediately necessary treatment (INT) to any patient within their practice area regardless of whether or not that patient is otherwise entitled to NHS care
Unfortunately what qualifies as INT is open to interpretation.

- Visitors from EU Countries are entitled to the same services as any UK resident irrespective of their length of stay

- Bilateral Healthcare agreements still get mentioned but in reality are meaningless.

Patients can be legally offered NHS or private treatment with the obvious possibility of inconsistency between practices.

- Eligibility for NHS registration relates to being “Ordinarily Resident” which again is not well defined
The guidance suggests that intension to be in the UK for 6 months or more for a settled purpose should be the threshold for NHS acceptance

Many have compared this guidance with what is issued by the TVPCA or Bucks Agency and found inconsistencies.

I intend to get rid of these through joint working between LMC and agencies.

Normalisation

Errors in the Exeter software for calculating Global Sums have led to some practices being either over or underpaid in 2004/05

GPC has now agreed with the DOH how PCT recoveries or extra practice payments will be made

There are more practices in the latter category and these are mostly in areas with population growth.

Recoveries of <£2000 will be made in August but for >£2000 the repayments will be staggered equally over 6 months

Payments (of whatever size) to practices will all be in August.

Practice Based Commissioning (PBC)

Each of the 13 PCTs I relate to appears to be handling PBC differently. Most are now showing practices their likely budget.

Some are more advanced with detailed plans for savings and administrative costs.

Plans for the latter have sometimes been contentious when the payments act as a disincentive or the proposal is to include this cost in the enhanced service floor.

The GPC is strongly against such inclusion because payment is not for direct patient care and because the national PBC guidance states that PBC administration costs should be a PCT overhead recouped at year end from savings

I would be more inclined to take a pragmatic line in keeping with my last newsletter

(“Support inclusion if income goes to GPs or takes work away from consultation”)

I would welcome GP feedback on this

What do others feel?

Registrar Training OOH

In many areas this appears to be a real problem with little progress towards a solution. Government, Deanery and PCTs all claim the funding lies with someone else.

Are current registrars losing out?

The Deanery opinion seems to be that Trainers and OOH organisations have improvised this year.

There are, however, real fears that unless something more formal is developed goodwill will be less evident next year.

Feedback from those involved would be useful.