

## Secretary's Briefing Paper 28.10.04

### **Violent Patients**

All 14 Thames Valley PCTs are currently meeting to harmonise their procedures and paperwork for patients thought to be too violent to obtain primary medical services in the normal way. The LMC is actively involved. My view is that patient misbehaviour can be graded from the extremes of being rude to GBH/murder. Graded responses are therefore needed both by Practices and PCTs. Any system needs to balance professional safety and human rights. Official responses by organisations to a patient incident need to be proportionate to patient misbehaviour. Getting all the facts and sensibly assessing both risk and intervention are vital, but are sometimes done inadequately. All PCTs seem to be in agreement with this view. As an interim measure, patients removed immediately from Practices list (GMS Regulations paragraph 21, schedule 6, part 2) will be placed temporarily on the register. Whether this should be made more permanent will be decided later by either PCT, Thames Valley or County groups still to be constructed.

Further meetings are planned in the next few weeks. I will send further details as they emerge.

### **Premises Finance**

In its September 2004 GP Bulletin the DOH announced an extra £108m for GP Premises. LMC has had difficulty finding out how this money will be used locally. At a recent meeting of Thames Valley Primary Care Leads, which LMC regularly attends, it became apparent that about 6 weeks ago all the 14 TV Chief Executives agreed to defer a decision on using this money for approximately 2 months. I gather the deferment was suggested by senior TVHA officers because of a TV wide deficit. LMC was meant to have been informed but wasn't for reasons that are still unclear. I made my unhappiness about this situation known, but have still not had any formal communication. I plan to make my feelings known to all CEs and the TV Chief Executive.

### **OOH Opt Out**

Berkshire Opted Out on 1.10.04 and Bucks on 1.11.04. I have not had reports of major problems over the past month.

Following several calls from practices over preparation difficulties, I have recently made efforts to increase the LMC profile within the Harmoni organisation. My initial approaches seem to have been well received and I am optimistic that the identified issues can be resolved. These include payment of 14% superannuation, non-agreed additions to the workload of GP they employ, and handover both at 8am and 6:30pm

### **Berkshire Sessional GPs (formerly the Berkshire Non Principal Group)**

The group is now 5 years old and are celebrating with a name change. Like the umbrella organisation, the National Association of Sessional GPs (formerly NANP), it has been decided that the term "Non Principal" is a negative term with little meaning

to many people. The local organisation will now be known as Berkshire Sessional GPs (BSGP).

The group welcomes any GP who is working as a locum, freelance, assistant, retainer, returner, flexible career scheme or salaried GP and who lives or works within Berkshire. They have an educational programme of monthly evening meetings. Future meeting topics include: Appraisal/PDPs, Adult and Paediatric CPR, Aggression & Conflict Management, Palliative Care and Journal Clubs.

To find out more, please contact Dr Susannah Denny at [sjd.enigmamm@ntlworld.com](mailto:sjd.enigmamm@ntlworld.com) or on 0118 9796876

Unfortunately no equivalent group exists in Buckinghamshire. Any enthusiast willing to start one?

### **Practice Based Commissioning**

Within the last month the DOH has issued a discussion document.

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4090357&chk=p7UCbg](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4090357&chk=p7UCbg)

Representatives from all 14 Thames Valley PCTs met in Oxford on 13.10.04. From 1.4.05 all practices will be eligible but not compelled to take a role in commissioning. Unlike fundholding the administration and budget will stay at PCT level. Practices (or groups of them) will be able to influence commissioning policies and money flows and be able to retain 50% of savings made for reinvestment in patient care. Legitimate practice administrative costs would be paid for out of the 50% savings retained by the PCT.

PCTs are keen to make this work, as a means of engaging primary care, diversifying referral patterns and putting a brake on referral flows into expensive secondary care. As always early GP adopters are likely to benefit most, but the workload and responsibility involved are currently vague. I will keep you posted.

### **Data Protection Act and Duty of Care to Doctors**

As part of LMC helping to fine tune the handling of patients behaving badly in primary care, it has become apparent that some officers of PCTs and Agencies unreasonably deny GPs information vital to making the work environment safe. Practices with important information on violent patients no longer on their lists may want to speak to the patient's new GP and alert them to previous difficulties. In these circumstances it is my view that a public interest defence and duty of care to practitioners would justify overriding any obligation under the Data Protection Act.

The local organizations I have spoken with agree, but recognise that some of their more junior employees sometime play safe and refuse information. If you meet these circumstances please ask to speak to someone more senior.

### **No Pay: No Work**

The issue of PCTs not commissioning particular enhanced services in primary care (eg alcohol misuse or minor injury) and then not commissioning elsewhere has cropped up in several Reference Committees. Other non-GP clinicians often assume that practices will play a bigger clinical role than has been purchased with subsequent practice resentment.

I am clear that these issues should be raised with both PCT and LMC whenever they occur. If they cant be resolved then I would have no hesitation in supporting a policy of “no pay means no work.”

### **QOF Visits**

Many have now taken place, with mostly good feedback. Light touch seems more common than heavy handed bureaucracy, but there have nevertheless examples of the latter. Please continue to give LMC feedback of both good and bad practice form the GP perspective

### **PMS Contract Deadline**

Each PCT seems to have acted independently in deciding how it responded to the obligation to bring pilot PMS agreements into line with the PMS Regulations 2004. Most PCTs seem to have taken the opportunity to do more than ensure conformity and have attempted to develop one agreement for all their various PMS waves, sometimes with fairly significant changes. I know of only one practice likely to reject this approach.

Few locally have used the Lockharts model, but some practices have still taken Lockharts advice on PCT developed agreements. It should be obvious that major contractual changes should not be rushed and practices should be completely happy before signing. LMC is happy to help in interpreting wording that might be disadvantageous to practices and to help with PCT negotiations but it remains a fact of life that a personally negotiated PMS contract places greater obligations on the signatory to research and understand the implications of any documents they wish to sign.