Secretary’s Newsletter January 2005

Contents

(CTRL and Click to hyperlink)

Freedom of Information Act 1
FOI Act: Early Experience 2
PCT Administered Funds 2
MMR LES Variation 2
Access 3
Choose and Book (C&B) 3
Practice Based Commissioning (PBC) 3
GP Letterheads 4
Appraisal 5
Enhanced Services This Year and Next Year 5
Enhanced Services Floor 5
Home visits for people who are tagged 5
CRB Checks 5
LMC Levy 6
LMC Merger 7
AGMs 7
QMAS at end of Year (QOF Prepayment Verification) 7
How do we know what are our Negotiators doing? 8
Computing (Bucks) 8
Revalidation Post-Shipman 8
Bowel Cancer Screening 9
OOH (Bucks) 9
OOH Governance and Complaints (Bucks) 10
OOH changes in Oxon 11
Chiron Flu Debacle 11
QOF Visits 11
Deanery Training Day for those wanting to supervise Registrars OOH 11
Automatic call diversion to OOH Provider 11
Flu vaccines for asthmatics (QOF Exception Report?) 12

Freedom of Information Act

Came fully into force on 1.1.2005.
Under the first part of the Act practices were required to have a “publication scheme” in place by 31.10.2003
Many were helped to do this by practice managers groups and PCTs.
Under the second part of the act practices must make available on public request information that is produced by them

Secretariat has circulated GPC guidance and its own summary
Still some debate about when charging can take place. Secretary trying to clarify.
See www.foi.nhs.uk

FOI Act: Early Experience

All PCTs nationally seem to have been emailed by one man asking:

"I would be very grateful if your PCT would supply me with details of the QOF aspiration points applied for in respect of 2003/4 for each of the GP practices in your PCT area.

Secondly, if you have already determined the actual or indicative number of points to be awarded following your inspection visits, could you please supply those too."

Some resourceful LMC Secretaries have "googled" this man and it may be that he wants this information for own commercial purposes

I was phoned 10.1.2005 by a Berks PCT officer wanting to make LMC aware of this early FOIA request. He feels he cannot refuse. I agree

PCT Administered Funds

The nGMS negotiations and the resultant Statement of Financial Entitlements (SFE) left some areas rather unfinished and unclear
Berkshire PCTs and LMC jointly drafted a PCT Administered Funds policy
This covers

- Seniority payments
- Locum payments for sickness adoption and maternity
- Golden Hellos, GP Retainer, Flexible Career Schemes (FCS)
- Prolonged Study Leave (PSL)

This has been circulated within the Thames Valley and with some necessary local variations seems likely to be widely adopted.
Practices are advised to ask their PCT for their policy document
Without such knowledge GPs may have gaps in their personal/practice absence provision or be over-covered and wasting money
In future handling of Retainer, FCS and PSL may be different. Practices need to know this in order to plan

MMR LES Variation

DOH advises that 2 MMRs should be routine in the UK
Because of the changing vaccination schedule over the last 25y the cohort born between 1980 and 1980 (possibly 1992 as there is some dispute in public health) remains unprotected against mumps. Recent mumps outbreaks amongst students have resulted in DOH advice to initiate a catch up programme. It is unclear whether 1 or 2 vaccines are needed. DOH guidance tends to be purist "give 2 doses to all eligible"
PCTs variably question whether this is good use of their stretched resources.

Some have given target vaccinations to first year students, all students or all within the vulnerable year groups. Some have used their own staff in specially set up clinics whilst others have designed a LES for practices. The GPC view is that they agreed with government that any LES pricing would mirror the flu/pneumococcal NES at £7.28 per vaccination.
The Secretariat has had to point this out to some PCTs who wished to price it differently.

Access

Game playing continues. Possibly with star ratings in mind some PCTs seem obsessed with never dropping below 100%. The result is various LES initiatives to provide overflow arrangements when any practice cannot meet access target on a particular day.
Is this money well spent?
Is it reasonable to deduct money from the practice concerned?
Does the country have enough doctors and nurses to satisfy 48h access and advanced booking for chronic care?
In his annual report Nigel Crisp (CEO NHS) thinks we do!

November PCAS return form contained a new question asking practices how far in advance patients are able to book an appointment with a GP
GPC was not consulted on this
Goes beyond specification of the Access DES
GPC advice to practices is to answer question but make it clear that this will not affect their achievement of Access DES target or payment

Choose and Book (C&B)

Government wishes to offer more choice to patients and implement electronic booking.
Some PCTs have opted to be early adopters of this government initiative.
Patients must be offered a choice of 5 providers, one of which must be a private provider.
Most GPs feel government has underestimated what C&B might add to the length of a consultation.
Most see referral hubs as the best vehicle for offering patient choice
There is currently no compulsion for GPs to use C&B
GPC is seeking adequate resourcing and sensible systems that do not convert GPs into “medical travel agents”

Practice Based Commissioning (PBC)

From 1.4.2005 PCTs must offer practices indicative commissioning budgets
The GPC has given the initiative a cautious welcome. I agree.

The second DOH guidance increased to 100% the maximum percentage of savings that PCTs could allow practices to spend on patient services.
It also seems to have abolished any concept of a minimum %

Progress across Thames Valley PCTs (and nationally) seems slow.
PCTs have been consulting GPs via practice visits, protected study sessions and GP forums.
Secretariat has seen no detailed plans from PCTs despite enquiries.
Some PCTs are now talking of a "shadow" year to collect data.

PBC is **not** fundholding mark 2
Practices or localities (?30K) can reconfigure patient pathways, moving activity away from hospitals but the administration, contracting and IT will sit within PCTs.

Second non-technical guidance seems to preclude practices from spending savings on buildings. Not very helpful in my view.

PBC is seen as a counter balance to "Payment by Results" which also begins on 1.4.2005
Hospitals will then be paid according to an NHS tariff price for each unit of activity
PCTs will then not be protected by block or cost and volume contracts for services
The role of practices as gate keepers to hospital services likely to be even more valued

Referral hubs will allow PCTs to document referral flows better and identify where development of alternative provision might be appropriate.
Some GPs fear they might also offer PCTs too much control over where a GP refers a patient
Enhanced Services are a mechanism for practices to become alternative providers.
PBC could offer practices the chance to influence the shape of purchasing and ensure practices are positioned to take on new provider opportunities eg wider range of GPwSI.
Potential conflicts of interest for GPs may become important.

GP Letterheads

Issue recently figured prominently on LMC Secretaries' Listserver
Is it appropriate and legal to show the names of GPs who are not partners? (Locums, retainers, salaried doctors, Flexible Career Scheme doctors)
Might it mislead public about who the real partners are?
Potential to breach the Business Names Act
Practices are advised to ensure that their letterhead makes clear the legal status of all doctors

Appraisal

Some PCTs are getting worried by the numbers of GPs who have still not been appraised in 2004/05
They fear a last minute rush which will test their appraiser capacity.
Should this result in appraisal being delayed into next year the legal position is a little unclear.

Enhanced Services This Year and Next Year

Secretariat is pushing all PCTs to look at additional plans for commissioning in primary care in 2005/06.
Enhanced Services Floors are now available for each Thames Valley PCT. Up usually by about 11-12%
Several PCTs are reporting that practices are not submitting their activity for these services. This will have an impact on practice income so please double check.
There is less flexibility for late payment with nGMS compared to old GMS.

Enhanced Services Floor

GPC view is that:

1. The floor has been guaranteed to GPs through the Gross Investment Guarantee (GIG) and forms part of the GP pay rise for 2004/05
2. If PCTs fail to spend to the floor in 2004/05 then the unspent money will be clawed back and distributed to GPs in a different format
3. There will be no possibility of PCTs carrying the sum forward to next year or viring it into other overspent budgets

Home visits for people who are tagged

Scenario: Patient physically able to attend surgery but unwilling to do so for fear of breaking conditions of curfew.
Covered by section 12(1) of the Criminal Justice Act 1991
Patient is allowed to attend as part of the "short absences" flexibilities covering and irregular and unexpected medical appointment.
Appointment card from practice deemed sufficient evidence.

CRB Checks

By 1.2.2005 all GPs must have submitted a request form for an Enhanced Criminal Record Disclosure (ECRD) to their Agency
This exercise follows government legislation and is not a PCT whim!
Failure to comply will prevent a GP from practising
Various original documents must have been seen by senior agency staff
Some have held special clinics in each PCT area.

In Bucks 112 GP forms are still outstanding despite 2 reminder letters from Primary Care Support Services

LMC Levy

Practices from all 3 counties have now been sent (in staggered fashion) a new levy mandate to consider and hopefully sign.
The secretariat process involves 2 letters, then phone call then visit if necessary

Before signing several practices have got back to us with queries.

- **It is very clear to me that LMC must advertise what practices get for their money**
  Put simply the LMC exists to make GPs lives easier, maximise earning potential and help those in trouble
  We articulate strongly the GP view with NHS opinion formers and decision makers.
  We represent GPs, liaise with national representative bodies, support practices and provide digestible information for busy doctors and their staff.
  LMC must offer a valued service at a price GPs can afford. We must not be seen as a profligate organisation.

Other queries have been about

- **The likely actual drawdown per patient (35p is max)**
  We anticipate 25-30p this coming year
- **What happens if not all in practice are happy**
  Secretary to meet/discuss with those who are unhappy. Seek decision based on majority voting. Secretary could improvise a solution.
- **Dissatisfaction with GPC and reluctance to contribute that component**
  The Secretariat could not function half as well without input from the GPC
  They did negotiate QOF, OOH opt-out, pension growth and portfolio careers
  Would non payers be happy being subsidised for these benefits?
- **Agency mechanism for telling practices when sums are removed at source**
  The mechanism for levy collection is:
  Provided a signed mandate exists each payment agency holds back an amount from each practice's quarterly payments. This is passed to county LMC treasurer
  Transaction is documented on a separate line in each practice's financial statement
  It should be submitted to practice accountants as a tax deductible expense.

- **Why merger has not produced a levy reduction**
  It may well in time but now is not the moment to do so.
  We hope for significant economies of scale quite quickly.

LMC Merger

The Secretariat took over responsibility for Oxfordshire on 1.1.2005
The need for all 3 counties to retain a separate identity is supported by all.
New work involves servicing 3 Local Reference Committees and a county LMC all at approximately 2 monthly intervals, together with 87 practices and 395 principals.
Workload and staffing levels will be assessed over the next few months

AGMs

Both Berkshire and Buckinghamshire AGMs were held before Christmas
They are important meetings that provide a mechanism for agreeing accounts and next year's budget/levy
However attendance has never been good.
Many are worried about the embarrassment of inviting a national figure as guest speaker for a tiny audience, and whether current attendance really fulfils accountability and probity functions
Suggestions for the future include

- holding the AGM as part of the last pre Christmas county LMC meeting
- Having a combined 3 county AGM at central or rotating Thames Valley venue

The Secretariat Board feels that each county should agree its own solution.

QMAS at end of Year (QOF Prepayment Verification)

(Quality Management and Analysis System)
QMAS calculates points, pounds, prevalence and weighted list size in accordance with the SFE
National Prevalence Day is on 14.2.2005
End of year details are now emerging
Nationally 20% of practices are reported as still not having filled in the non clinical yes/no sections. This is worrying.
Soon after 1.5.2005 practices will expect to receive achievement payments for QOF 2004/05.
The Secretary understands that each practice will nominate someone to sign their end of year QMAS figures as being a correct claim. They will be provided with a special password. A similar procedure will occur at each PCT.
Where neither practice nor PCT have any queries/objections then an authorisation for payment will then go to the relevant payment agency

If either party feels unable to agree the figures then they should attempt local resolution.
If this is unsuccessful then the issue will go to a SHA based disputes procedure.
The precise timescale for payment post 1.5.05 is unclear.
The Secretary intends to seek clarification asap.

How do we know what are our Negotiators doing?

All LMC Secretaries receive a weekly bulletin from Hamish Meldrum (GPC Chair) describing all discussions with DOH and other relevant organisations.
I am not allowed just to email it on but I use extracts for my emails and newsletters to practices.
As an example the topics covered in the latest are listed below

- **Dispensing Doctors Association and GPC**
  met last week and discussed the new Pharmacy Contract and Dispensing superannuation issues
- **Allocation Formula (Carr-Hill) Review Group**
  now functioning. Eric Rose (Bucks) involved
- **QOF and confidentiality**
  Final legal opinions to be discussed with DOH 13.1.04.
- **New SFE in draft form for 2005/06**
- **Enhanced Services Underspends**
- **QOF review Group**

Computing (Bucks)

Secretary sent Bucks PCTs (all 4) Collaborative Tender Document for the supply of a managed service for support and maintenance of practice IT hardware and networks
Produced by Kevin Garthwaite Head of Health Informatics VoA PCT (22.12.2004.)
20 pages long.
Difficult to see disadvantages for practices but would like others to read it and comment
Successful organisation would be first point of contact for practices with computing problem.
Would manage everything except server support
Within 5y envisages suppliers (EMIS, Torex, IPS) having centralised data centres which practices access via NHS net (N3)

Revalidation Post-Shipman

In the fifth Shipman Enquiry Report Dame Janet Smith expressed her view current revalidation plans are not fit for purpose
Government had been rather quiet in responding until first week in January
Pulse magazine (8.1.2005) now reports:

Government have apparently scrapped April start date for Revalidation
Liam Donaldson to lead a 6 month root and branch review
May lead to the end of the presumption that GPs are fit to practice unless proved otherwise
GPC want government not to base revalidation on assumption that most GPs under perform. Have also criticised Dame Janet for having a jaundiced view of GPs and letting her previous medical litigation work influence her unfair recommendations

Appraisal and revalidation could separate with former becoming a tougher pass/fail
Possible knowledge tests, consultation video, clinical governance data and patient survey needed in Folder. RCGP could take a lead in developing this.

Bowel Cancer Screening

DOH has announced £37.5m over 2 years to finance new NHS national bowel cancer screening programme
Will be phased in from 2006 for men and women in their sixties

OOH (Bucks)

November Bucks LMC asked me to enquire why Harmoni was awarded the Mid and South Bucks OOH contract ahead of AYDOC/WYDOC at a price rumoured to be £1m more expensive.

- **One PCT responded to the LMC Minutes**
  Their view is copied below

The service contract with Harmoni has been agreed at all the PECs and Boards in the early autumn and was signed for the 1 Nov.

Apparently LMC asked why AYDDOC/WYDDOC had not got the contract.
They did not put in an application.
AYDDOC informed us early Dec 2003 that they would be folding.
This was a surprise to us as there had been no discussion with us.
A co-op extra-ordinary meeting was held in Dec 2003 and Tim Jones (who was working on this at the time) asked if he could attend to explain why they should bid for the new service. He was not allowed to attend. Dr Alan Watt, the chair would be able to give you more details about why they decided to fold AYDDOC.

We put the service out to tender and decided VoA PCT would put in an application on behalf of all 3 PCTs.This application was drawn up in close consultation with AYDDOC/WYDDOC co-op mgt teams. There were 3 applications and a detailed selection process.

There was a commissioning framework, selection process, and scoring system. All were agreed and approved by PECs and Board.
(All supplied to LMC)

I have tried to explain the process but I handed over responsibility for OOH to our commissioning team in the summer. We commissioned this service in collaboration with the 2 PCTs in the south. Sharon Kearns is the lead director (Wycombe PCT). I am sure she would be happy to fill you in on the current contract.

It would be helpful to get the facts acknowledged.

- **One LMC member has seen and responded to this. See below**

What is written is largely true though the reason why AYDDOC folded is not quite correct.
It was simply because the 3 PCTs concerned would not guarantee
to underwrite the co-op costs until opt out. I think one of the south of counties PCTs baulked. This left the co-op directors significantly financially exposed if funds weren't available and the decision to close was, in my view sensible and sound.

We know that the PCT bid on our behalf - AYDDOC couldn't by then as it wasn't going to exist. I guess the thrust of our argument is that the bidding process wasn't transparent at the time and now with hindsight the choice doesn't seem brilliant. Having said that, I suspect the old directors of AYDDOC are breathing a mighty sigh of relief that it's not
their problem to sort out the current mess.

I'm not sure there is any mileage in pursuing this further - what's done is done and better to divert our energies in what we can do to improve it.

OOH Governance and Complaints (Bucks)

Wycombe LRC have asked to see Harmoni policies
PCT asked for them on 26.11.04 and reminder sent on 7.1.05 after LMC prompt
Harmoni asked why GPs needed these
LMC responded:
When GPs had 24h responsibility all complaints came through them.
GPs would now like to know:

- how to guide patients with OOH issues
- what standards and criteria the OOH provider is working to

Harmoni have only just recruited a complaints officer for West Herts and Bucks
They promise to send all practices and LMC a leaflet and complaints procedure on 10.1.2005

Carson Standards from November 2002 now succeeded by National Quality Requirements (1.1.2005)
For Mid and South Bucks PCTs, LMC now has:
    Service Specification for OOH
    Selecting an OOH provider protocol
    Framework for Commissioning OOH

VoA has written to practices asking them to refer “issues and complaints relating to OOH direct to Harmoni with copy to PCT contract lead”
No named person within Harmoni or contacts details were supplied!
Is this PCT approach too hands off?

PCT Contact leads are:

- Philip Clarke (AoV) 01296 318657
- Tom Wilson (CSB) 01494 606606
  (From 18.4.05: Caroline Langley)
- Sharon Kearns (WYC) 01494 552200

OOH changes in Oxon

From 13.4.2005 call handling for all Oxon GP OOH services will be performed by Oxfordshire Ambulance Service (OAS)
PCTs will no longer use Border Medical
IT being attended to

Chiron Flu Debacle

The Secretariat is still pursuing the issue of reimbursement for expenses incurred by the practices affected.
We have kept the debate going in the medical press and national newspapers.
So far we have had no direct response from the company except for a rep asking if they could bid for the coming year!

QOF Visits

The Secretariat have attended QOF visits in all Berks and Bucks PCT areas.
The overall impression has been of light touch and support from PCTs.
Practices seem to vary enormously in the amount of work undertaken.
Congratulations to all who are set to achieve or even surpass their aspiration.
If however you feel you are struggling then please let the Secretariat know and we will be happy to assist.

Deanery Training Day for those wanting to supervise Registrars OOH

3rd February 2005
9:30 – 4:30pm
Magdalen Centre, Oxford Science Park

Email: ehowdill@oxford-pgmde.co.uk
Tel: 01865 740642

Automatic call diversion to OOH Provider

Re QOF Indicator Information 8
Extract from CSB PCT Bulletin number 50

There has been some discussion about this indicator at Strategic Health Authority level. The following is an extract from an email received from John Derry, TVHA Primary Care Medical Adviser

The QOF indicator is in the Organisational Domain, section B, patient communication, Information 8, which states:
"*The practice has a system to allow patients to contact the out-of-hours service by making no more than one telephone call*"

This is worth one QOF point, which equates to £77.50 this year for an average size practice, and £120 next year.
Note that Information 1 is the same except that two calls are allowed, and is worth half a point.

The only way that a practice can fulfil Information 8 is by automatically diverting calls to the practice number out-of-hours to the OOH provider call-handling service (i.e. the OOH communications hub). However, experience from sites where this is done shows that a large number of calls to a practice, especially just before 8.00am and just after 6.30pm, are not from people seeking OOH primary medical services. For example, people want to know "if the surgery is open", "can they make an appointment to see the doctor/nurse", "can they have a test result", etc. These calls, if diverted direct to the OOH call handlers, result in excessive and inappropriate demand for OOH call handling. The QOF requirement is based on the original Carson model for integrated OOH services (2000), in which it was envisaged that modern telephony systems would be in use so that only callers who thought they needed to access GP services OOH would be transferred directly to the comms hub - callers who did not need to access OOH services would not be transferred because they could hang up when they realised that normal daytime services were not available. For example, they might be informed by a message that their call is being transferred to the OOH service, and that normal practice services would be available from 08.00-6.30pm, Mon-Fri.

PCTs cannot alter the interpretation of QOF indicator Information 8, and a single telephone call is just that - having to dial another number is not an option, for whatever reason.

Flu vaccines for asthmatics (QOF Exception Report?)

(Newbury PCT quoting John Derry advice)
The QOF indicator Asthma 7 looks at the percentage of patients with asthma aged 16 and over who have had influenza immunisation in the preceding 1st September to 31st March.
PCT was asked if the would be prepared to consider allowing those asthmatics with minimal symptoms (e.g. those with less than 5 inhalers a year) to be coded as Flu Jab not indicated?

Advice was sought from John Derry Independent medical advisor at TVSHA his response is as follows

Firstly, the CMO's letter about the flu immunisation programme this year included the following subset of all those with asthma as an "at risk" group which should receive flu immunisation - "asthma requiring continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission". This is the best representation of current official NHS policy on flu immunisation.

The DES Directions 2004 use a broader definition of the at risk group: "suffering from chronic respiratory disease (including asthma)".

The DH general line on PCT interpretation of QOF indicator reporting appears to be that the PCT must clear any re-interpretation of QOF indicators with the PCT's auditors, but also that contractors can legitimately use exception reporting - "practices should either follow the requirements of the QOF in full or opt out of any indicators they believe are in the best interests of their patients".

John Derry's view is that both PCTs and contractor practices could legitimately argue that they should adhere to the CMO's recommendations in regard to flu imms for asthma patients, and so it would be valid for practices to exempt asthma patients not meeting the CMO's categories of "at risk" from this QOF indicator (asthma 7) - i.e. except from this QOF indicator those patients with asthma that do not require continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. To include asthma patients not at risk (according to the CMO's guidance) could be argued to be not in the best interests of those patients at high risk, especially in the context of limited availability of flu vaccines.

If you have any comments or queries about the topics addressed please send them to paul.roblin@bblmc.co.uk of phone 01628 475727