

The future of General Practice

There has been much discussion about the future of General Practice over the last 2 – 3 years. Nobody can deny that we are all working in increasingly difficult times, with more and more demands being placed upon a service which seems to lurch from one financial crisis to another. So are we seeing the end of General Practice or are we at a crossroads with challenges and opportunities ahead?

I am an optimist and therefore I think that General Practice has a secure future at the centre of patient care. Does this mean the way ahead is clear and untroubled? Probably not - even optimists would add words of caution.

As I see it there are two possible ways forward:

- The practice as a unit becomes less important – with services being taken away and additional services being given to other providers of General Practice. This will inevitably lead to breaking up of established practices with either the PCTs (or their successor bodies) employing GPs to provide care, or the private providers employing GPs.
- The practice as a unit becomes the centre of all developments in the future. The practice is seen as a focus of strength which can evolve and develop, engaging and addressing many of the issues that face us now.

I am still a practising GP so it should come as no surprise that I think the only way forward for practices and PCTs is model b. So what does this mean for the LMC and practices?

You are all aware of the significant financial problems that PCTs and acute trusts in Wessex are facing at present and we need to ensure that by addressing these issues we are part of the solution and not the problem. We must be fully engaged to prevent even more money going into secondary care, thus decreasing funding for primary care.

LMCs need to resist initiatives that are poorly thought through and create additional work without additional resources, for example the initial presentation of “Choose and Book”. The LMC have indicated a willingness to work with PCTs to make sure the system is better than the one we have now; by doing this, practices will want to use it. This would not be achieved by trying to insist practices use a system which is clearly not “fit for purpose”.

The LMC's role is changing - it has always been good at reacting to problems, it now needs to be equally good at being proactive and taking the agenda to the PCTs. The future agenda is huge and to some extent, daunting; we cannot avoid the issues. We therefore need to tackle the problems head on; a challenge which the LMC embraces willingly and with enthusiasm and with a belief that we can make a significant difference.

Dr Nigel Watson, Chief Executive

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Medical Certificates for non-attendance at court

It is becoming increasingly common for GPs to be asked to provide a medical certificate to permit patients not to attend court; you need to consider this very carefully before agreeing to this request.

The statement below comes from a very senior Judge.

“Defendants who fail to surrender to a court generally impact on the effective administration of Justice, and it is often a medical reason that is given to the Court for the non-attendance when rarely it will state ‘unfit to attend Court’. The Lord Chief Justice, in a Practice Direction to the Courts, reiterates the obligation that is placed on a defendant to ensure they attend Court when

required and if they do not attend, the Court will take appropriate action (which may include issuing an arrest warrant).

As a medical practitioner we are asking for your assistance. If a defendant fails to attend Court due to ill health and in your medical opinion this ill health would prevent them from attending Court, you are asked to clearly state on the medical certificate ‘unfit to attend Court’.”

You could be summoned to court at short notice to defend the certificate that you have issued; this has happened on more than one occasion.

NFW

Practice Based (led) Commissioning (PBC) – Good or Bad?

The LMC believes over the next two years that this will prove to be one of the most important issues for General Practice.

There are potential benefits and significant risks.

Commissioning has not been one of the major successes in the NHS. It is clear that the clinical involvement has been lacking. The consumption of resources is directly related to the actions taken by GPs and hospital doctors, with managers largely powerless to control either body.

Fundholding gave practices a real budget and allowed them to negotiate specific areas of care. PBC will cover a much larger range of services, e.g. unscheduled care.

From 1st April 2005 practices will begin to receive information about their use of resources. This will include outpatients, elective care, unscheduled care and investigations and diagnostics.

From this date practices have the right to be given an indicative budget and can then work with the PCTs to improve the commissioning of care to their patients. Initially budgets will reflect historic spend, but over a three-year period will move to a weighted capitation budget.

What could be the benefits?

Services which are provided are not always efficient or effective. Practices will have the opportunity to address issues that are important to patients in their locality and can choose to work in groups though this cannot be imposed on them. By working collaboratively with other local practices, it may be possible to move services to where they are more appropriate. PCTs and practices will have to first agree on their obligations including compliance with local targets and degree of risk sharing.

Over the last twenty years all GPs have complained about work being moved from Secondary Care to Primary Care without any additional resources. PBC will allow appropriate work being referred to a primary care "provider" and in

addition take work out of Secondary Care with resources to be invested in Primary Care.

With Enhanced Services as a model – PBC would allow a practice to become a provider of care and be funded for doing so. The potential here is endless.

What could be the danger?

An indicative budget is one thing, but if practices become responsible for a "real budget" then they may become responsible for significant deficits which currently lie with most PCTs.

Much emphasis is placed on savings; in Wessex with large deficits in Hampshire, Isle of Wight and Wiltshire it is hard to see how savings will be made. It is therefore important to ensure all practices are rewarded for additional work and are incentivised to engage with PCTs regarding PBC.

Once practices receive regular updates relating to expenditure for in-patients, out-patients, unscheduled care, x-rays and laboratory tests, the PCTs will be tempted to apply pressure to decrease demand on Secondary Care whether this is appropriate or not.

The Technical Guidance

Some 'highlights' from the guidance:

- the intention to use Choose and Book has been made a condition of taking on PBC
- PCTs will create a contingency fund by the top slicing of budgets
- budgets will be available to other groups of clinicians eg nurses and community matrons
- initial budgets will be based on hospital data on referrals and diagnoses

The LMC will be working hard to ensure practices have a significant influence in PBC and to minimise the risks associated with it.

NFW

Enhanced Services

Underspends for 2004/2005

Due to some PCTs underspending to their allocated Enhanced Services floors for 2004/2005, the GPC and DoH have agreed that for this year only, PCTs may vire any unspent funding for 2004/2005 into 2005/2006.

The money vired MUST be added to the 2005/2006 notified allocation and used for services that meet Enhanced Services Criteria. It MUST NOT be used to pay off deficits elsewhere in PCT budgets.

We are working with PCTs in both monitoring Enhanced Service spend and development and the GPC Primary Care Development Sub-Committee continues to answer queries nationally on all issues relating to Enhanced Services. This Sub-Committee has now published an authoritative list of Enhanced Services which identifies services that can and cannot be funded from the Enhanced Services Floor. This will be expanded over time.

You can access this list on: <http://www.bma.org.uk> SDW

Vaccinations and Immunisation

Since the introduction of the new contract we have received an increasing number of queries relating to vaccinations and immunisations, particularly with regard to travel and payments.

We will shortly be issuing up to date advice which will be circulated to all practices. SDW

Have you got your licence yet?

Did you know all NHS staff (including GP staff) are entitled to free IT training leading to the European Computer Driving Licence (ECDL)?

For more information, go to the ECDL website where you can find details of how to contact your nearest centre.

www.ecdl.nhs.uk

JS

QOF VISITS – WHAT HAS BEEN LEARNT?

The round of visits has been and gone, just in time for the arrival of formal advice on how to handle the issues surrounding confidentiality. The general consensus appears to be that the visits were less disruptive than had been expected and that in some cases they were even helpful. For many the hard work required beforehand was a useful exercise that identified gaps and areas of work still to be done.

The approach from the PCTs has largely been one of facilitation and of working together but there was always going to be an element of data verification and ensuring probity. Specifically, your visitors will have been looking for:

- very high or low prevalence rates when compared to PCT or national averages;
- very high or low levels of exception reporting or exception reporting that does not comply with any of the stated criteria;
- very high or low levels of achievement compared to the stated aspiration, or PCT or national averages;
- sudden large changes in the figures or, perhaps, disproportionate amounts of data entry at certain times of the year.

All of the above are areas that might lead to further enquiry. This will not be a problem where there is a suitable audit trail or a rational explanation.

There are a number of lessons that have emerged:

- use QMAS! Discrepancies between QMAS and e.g. population manager, should disappear by year end but might not and it is the QMAS data on which payments will be based.
- be aware of your prevalence figures. If practice prevalence is above or below local averages then you need to understand why and whether it is a factor that can be legitimately adjusted.
- there are exceptions to prove the rule but it works well where there is a single clinician to oversee the whole process. Splitting responsibility for chronic disease registers amongst partners works for some but in many cases has led to differing levels of input and slippage.
- everyone involved with clinical data needs to understand the clinical system and they need to use it. There are lots of examples coming out of the visits of work having been done but the data not being entered e.g. the details of diabetic checks or medication reviews.
- manage your exception reporting with regular reviews to ensure that no rogue exceptions are creeping in through misinterpretation or a lack of understanding. Use exception reporting legitimately and tactically.

Following the QOF payment PCTs will be required to carry out a random counter fraud check on 5% of their contractors. The selection of this 5% should be truly random and being selected does not imply any suspicion. The counter fraud check may look in more detail at the areas listed above.

NATIONAL LEVY

There are still a few practices in the Wessex area who have not returned their National Levy authority. We will be writing soon to remind you but it may be worth reminding all what you get for this money.

Whilst the Statutory Levy provides you with LMC representation and advice, the National Levy ensures your interests and any problems will receive GPC advice, expertise and possibly representation and negotiation at national level. Those practices who choose not to have this available will inevitably limit the amount of help we can mobilise for you. AD

The visit process has been a lot of work for both practices and for PCTs. It is difficult to see the process being repeated later this year without change. To date there is no guidance on what changes there might be but watch this space. AM

QOF Payments

Your PCT will get your QOF outcome figures at the beginning of April. They will check these against their expectations gained from their QOF visits. If these seem reasonable to them they will have to ask the practice to agree and sign its agreement and return this to the payment authority within 2 weeks.

Some paying authorities aim to pay QOF money at the end of April so make sure you have a good idea of your achievement and you will be ready to agree the figures and return them promptly. NFW

QOF (Quality & Outcome Framework) Money

Don't order the Bentley yet!

At the end of April 2005, we are all looking forward to our "brownie points" money, at a minimum, those that are agreed by the PCT. Remember that you will have to pay superannuation at 20% as well as tax on this. If you have not raised your regular superannuation deductions through this year then you might be in for a delayed shock.

You have already had 30% payment of aspiration points level through the year, so you will get 70% of the achievement level paid (assuming your aspiration was a good guess). However, you will have to pay 20% of the gross amount as superannuation (6% employee contribution and the 14% employer's contribution), which leaves you £50 out of each £100 achievement. Then you will have to pay tax on the £94, say at 40%, equals £37.60, which actually leaves you £12.40 of the £100 total to pocket (or order the Bentley).

Obviously, those doctors who have increased their regular superannuation contributions and/or put aside increased reserves for tax will not get such a shock next year when their increased tax bill in January 2006 is followed in (probably) February by a demand for the 20% superannuation contributions. The others might want to keep the Escort limping along.

The good news is that we can expect to get 60% of our Achievement Points as advance payments through next year. This is good for cashflow but, of course, means there will be less "headroom" for paying tax and superannuation if you do not increase your put-aside.

The new increased complications in superannuation, which apply to all the income you have earned since 1/4/04, reinforces the long-standing LMC advice that it is much better to use a specialist medical accountant rather than a generalist accountant who may not understand all the nuances of the changes to the old NHS scheme, let alone the implications of the proposed changes to the scheme in the future. AD

Destruction of Controlled Drugs

There are very clear regulations on obtaining, storing, recording and disposing of controlled drugs. Post Shipman we are well advised to be aware of these regulations and to comply with them and this article concentrates on the safe disposal of controlled drugs. In this respect there is a distinction between 'date expired stock' and 'patient returned stock'.

DESTRUCTION OF 'DATE EXPIRED STOCK' CONTROLLED DRUGS (CDs)

Healthcare professionals are required by law to maintain a CD register and are not allowed to destroy expired Schedule 1 and 2 CDs from their stock without the destruction being witnessed by an authorised person.

Authorised persons cannot delegate the task of witnessing the destruction of CDs and persons currently authorised include:

- Police officers and Home Office inspectors
- Chief Executives of NHS trusts or senior officers in an NHS trust who report directly to the trust chief executive and who have responsibility for health and safety, security or risk management matters in the trust
- PCT chief pharmacist/prescribing adviser who reports directly to the Chief Executive or to a Director of the PCT
- A registered medical practitioner who has been appointed to the PCT Professional Executive Committee or the PCT board with responsibility for clinical governance or risk management or Medical Director of a PCT
- An authorised person cannot witness the destruction of CDs that have been supplied to them or by them – there must be an appropriate separation of roles and responsibilities

When date expired stock is being destroyed, the following must be entered into the CD register:

- Drug name, form, strength and quantity
- Date of destruction
- Signature of the authorised person present

PATIENT RETURNED CONTROLLED DRUGS

Doctors and other authorised practitioners must not re-use CDs that have been returned to their premises by/from patients, their relatives or carers.

Patient returned CDs must be destroyed. The LMC advises practitioners, where possible, to avoid being involved in this destruction.

Currently the destruction of this group of CDs does not have

to be carried out in the presence of an authorised witness or to be recorded.

Patient returned CDs must not be entered into the CD register. It is good practice to record all such returns in a separate book designed specifically for that purpose. **AM**

Choose and Book

The GPC has received reports that some PCTs are trying to enforce Choose & Book protocols without negotiation, objective study or appropriate funding.

PCTs are under pressure to move from the present system of referral and booking management to the "Choose and Book" electronic system. There has been considerable negative publicity about the concept and implications for consultation times.

The "Choose" part would involve a discussion of where the patient wishes to go, as all GPs do now. The GP authorises a referral, some relevant information will be available to assist on, or behind, the displayed screens. The end point for the GP and practice can just be a print-out of the 5 providers. This is given to the patient who can then phone the "Booking Service" or go online and finish the actual choice and make the booking, perhaps after discussion with family, carers or transport. Of course, the GP can do all these parts if they wish or see a need to do so. The main concerns for GPs are the time taken in the "Book" element and the lack of obvious benefits for practices to do the whole "Choose and Book". The original proposals have already been modified to address some concerns raised by GPs. This process has not finished and work is going on nationally to improve the system to ensure it meets GPs requirements and not just the DoH's.

To speed implementation, new incentive funding was recently announced for PCTs which is attached to meeting certain roll-out targets. It equates to approximately £6000 per average size practice. At the moment, we do not know how PCTs are going to apportion this funding. The LMC view is that practices should not take on any additional work that they are not contracted to do, and for which they do not feel they are adequately resourced.

There is nothing in the GMS contract or most PMS contracts to say that practices have to do this. If it is better than the present system for patients, GPs and practices, then we are sure all will want to use it. However, we believe practices should engage with PCTs at this stage to discuss options around the 'roll-out' of this DoH 'PCT-must-do' initiative. But we reiterate that practices should not accept additional work without reward and there is no compulsion to do it.

The Strategic Health Authority's (StHA) "Choose & Book" teams have arranged local events across the area for attendance by GPs and PMs to provide further information on how Choose and Book will work. If you wish to attend, please contact your Choose & Book Lead at your StHA. You can also access the 'dummy software' via their web-site but you need to register, again via the Choose & Book Lead at the StHA.

The LMC is continuing to work with the national and local "Choose and Book" teams to maximise the benefits and reduce the problems already highlighted. **SDW/AD**

Contacting us

We have recently introduced a general email address for those who want to contact the office and require a prompt response. This address is accessed daily and any messages are re-directed to the person who is appropriate and available to answer. Hopefully this will ensure queries receive immediate attention.

office@wessexlmcs.org.uk

Have we missed something?

If you have an issue which you feel we should mention, or have any comments about The Bulletin, please let us know by contacting us at office@wessexlmcs.org.uk

Criminal Record Bureau (CRB) Checks HSC2002/008

The following clarification has been issued by the Department of Health:

Practice Staff are not subject to the directions set out in HSC2002/008. This means that there is no formal obligation to check employees' criminal records or undertake the other checks set out in the circular. This, however, does not mean that they cannot be checked at all. Many employees will fall within the definition set out in the Rehabilitation of Offenders Act 1974 Exceptions Order 1975: **Any employment or other work which is concerned with the provision of health services and which is of such a kind as to enable the holder of that employment or the person engaged in that work to have access to persons in receipt of such services in the course of his normal duties.**

This definition means that relevant staff employed by a GP can be checked by the CRB at least at the standard level. The decision to check will lie with the GP, where he is the employer.

The criterion for an enhanced level check comes from the Police Act Section 115: **Any position whose normal duties include caring for training or being in sole charge of children or vulnerable adults.**

To be checked against the Proceeds of Crime Act (PoCA) list, an individual needs to be employed, therefore GP's who are self employed are exempted. However GP practice staff who work in a regulated position as defined by the Criminal Justice and Court Services Act: **A position whose normal duties include caring for, training, supervising, or being in sole charge of children will be eligible for a PoCA check on a voluntary basis.** NFW

Changes in practice circumstances and contact details

The Services Agencies in our three areas often struggle to maintain up-to-date records, now that there is no requirement to inform them of changes to doctors' status or time commitment. Please do notify them and please copy us in, particularly with changes in e-mail addresses, in order that we too can keep an accurate database.

Your help with this would be much appreciated.

STOP PRESS!!!!!!

Dates for your Diary...

Thursday 19th May, Holiday Inn, Eastleigh,
19:00hrs – **Practice Based Commissioning and
Choose and Book Roadshow**

Thursday 29th June, Tidworth Conference Centre,
Tidworth, Wilts – **Practice Managers Day
Conference**

Details to be sent to practices soon

New Organisational Structures within the LMC

In addition to Dr Nigel Watson (Chief Executive) and Mrs Sheila Williams (Director of Liaison and Development) we now have three Medical Directors, Drs Anthony D'Arcy, Christine Dewbury and Andrew Mostyn.

In order to improve our level of service in each area, Chief Executive, Mrs Williams and a designated Medical Director will work with the Chair and Vice-Chair of each LMC as a team. These are:

Dorset

Chairman	Dr Peter Blick
Vice Chairman	Dr Craig Wakeham
Chief Executive	Dr Nigel Watson
Medical Director	Dr Anthony D'Arcy
Director	Mrs Sheila Williams

Isle of Wight, Portsmouth & South-East Hants

Chairman	Dr Steve McKenning
Vice Chairman	Dr Jim Warner
Chief Executive	Dr Nigel Watson
Medical Director	Dr Anthony D'Arcy
Director	Mrs Sheila Williams

North-East Hants

Chairman	Dr Stephen Linton
Vice Chairman	Vacancy
Chief Executive	Dr Nigel Watson
Medical Director	Dr Andrew Mostyn
Director	Mrs Sheila Williams

West Hants

Chairman	Dr John Dracass
Vice Chairman	Dr Barry Trewinnard
Chief Executive	Dr Nigel Watson
Medical Director	Dr Christine Dewbury
Director	Mrs Sheila Williams

Wiltshire

Chairman	Dr Gareth Bryant
Vice Chairman	Dr Anne Lashford
Chief Executive	Dr Nigel Watson
Medical Director	Dr Andrew Mostyn
Director	Mrs Sheila Williams

PGEA payments

Many GPs have consulted us about the possibility of claiming backdated PGEA payments after a London GP won a test case against his PCT for failing to award PGEA payments for 2003-4 after the new GMS contract was introduced. The PCT argued that the money for 2003-4 had already been paid and that from April 1st 2004 the money had been included in the global sum.

The GPC is seeking legal advice as to whether this has established a legal precedent that would apply to other GPs or whether the London decision was based upon a unique set of circumstances. We would advise GPs to await the final decision of the GPC as any subsequent legal action would probably be best taken at a national level. The GPC's current advice is that only those who can provide evidence that they had been paid in arrears might have a case.

CED

Message from Bob Button...

Dear Colleagues,

I am overwhelmed by the incredible generosity of the cheque that was presented to me on 27 January.

Your kindness has been much appreciated by both Rosemary and myself and we are very, very grateful.

I have already bought myself a new bike to try to regain some fitness (and save a little petrol money) and have plans for some new woodworking equipment.

Every time I spend some of it, though, I will remember with great affection the generous people who contributed.

I have also received many letters and cards saying very kind things that I have found both embarrassing and humbling.

We all like to feel we have done a good job and your appreciation of what I was able to do for Wessex LMCs during my tenure has made it even more worthwhile.

I know that the future, under Jim Warner as Chairman, and Nigel Watson and his team in Winchester, will take Wessex LMCs to new heights.

I thank you all again for your generosity to me, and hope that your professional lives will leave you as fulfilled when you retire as mine has left me.

My sincere thanks to you all,
Bob

Freedom of Information Act

Access: All GPs have been designated as public bodies for the purposes of the Freedom of Information Act. The general access provisions of the Act came into force on January 1st and are fully retrospective. Access requests must be in writing (including e-mails) and may apply to all recorded information including;

- paper files
- computer files
- internal e-mails
- audio & video recordings,
- brochures & photographs

Disclosures are protected by the exemptions in the Act as well as the Data Protection Act, the Human Rights Act and the common law on confidentiality.

Within 20 days the applicant has the right:

- to be told whether the information is held by the public authority
- to receive the information as a copy or summary, or by inspecting a record

If a delay is required to obtain a legal opinion or to consider the public interest, the applicant must be informed within 20 days of the reason and probable length of delay.

Access to some or all information may be delayed up to 3 months until the estimated & permitted fee is paid or the request lapses.

The Information Commissioner is responsible for enforcing implementation of the Data Protection and the Freedom of Information Acts.

Further details on the Freedom of Information Act, including the permitted fees, may be found on our website.

www.lmclive.co.uk

CED

Wessex LMC's Tsunami Appeal

The office launched an appeal in aid of the victims of the Tsunami and have raised the grand total of £4,402.37.

Many thanks to all who have contributed to this worthy cause; all donations have been forwarded to Merlin, which exists to provide an immediate and effective response to medical emergencies throughout the world. Their work is based upon the humanitarian principle that all people, regardless of race, religion or political affiliation, are entitled to lifesaving care and medical assistance

ID

Wessex GP Education Trust – looking for New Committee Members

Wessex GP Education Trust (WGPET) was formed in 1990 and has some 1400 GP members, based mainly in the Wessex region. It was formed by the then Regional Adviser to facilitate the funding of GPs' continuing medical education under the new GP Contract and over the intervening years has remained true to that objective. The next members' year will commence on 1st April 2005 and indicators suggest WGPET will continue to attract the majority of local GPs as members.

Policy and general management of the Trust are directed by Trustees who form an Executive Committee that meets three times a year. At present there are nine committee members with nominations submitted annually in line with the Trust Constitution document.

In order for the Trust to continue to look to the future and enlist committee members with diverse experience and providing a balance, Dr. Andrew Paterson has asked for our help in identifying potential candidates. If anyone is interested, could they either contact Andrew (01329 664231) or Ron Travis, the Trust Administrator (01962 870638)

NFW

GP-to-GP

Although there are trials of GP-to-GP electronic transfer of records underway, currently practices must print out ALL of their computer records and pass these on with the Lloyd George envelope when a patient leaves.

Some practices are trying to be helpful to others by also enclosing a diskette or CD of the patient details in case the recipient practice can use this and save typing. Of course when a patient leaves, one does not know the clinical computer system of their next practice and the receiving practice must satisfy itself on the data integrity.

However, it is NOT acceptable to send a diskette or CD without printout and enclosing a note saying the recipient practice can contact for a printed version. This does not comply with the agreed Good Practice Guidelines for GP Electronic Records.

It would be polite to point this out to any practice that sends notes without a printout and refer them to us at the office in case they have any doubts about it. Hopefully some of this will not be necessary when electronic transfer is approved, as it is also envisaged that the few cases of non-computerised practices will have the printout done by the PCT.

AD

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