WESSEX
Local Medical Committees

Bulletin...

Spring 2006

Editorial - Threats and Opportunities

It is becoming clearer how the Department of Health (DoH) sees general practice developing over the next 2 - 3 years. This needs to be considered against a background of significant financial deficits in PCTs and hospital trusts and a significant increase in funding in general practice over the last two years.

The new GP contract promised an increase in investment from £6.1 billion to £8 billion and this has been exceeded by £1.5 billion. As a result there is no increase in the global sum payment for 2006/7 and it is expected that PMS budgets will be treated the same as GMS. The only new money for 2006/7 will be in the new Directed Enhanced Services (DES); it would appear that general practice is in for a lean time over the next two years.

The Quality and Outcome Framework (QOF) would appear to be a route by which the DoH could improve quality of care in areas where there is sufficient evidence to support it. It will be essential that all additional areas are backed up with funding to enable full implementation.

Over the last few months a number of significant documents have been published which clearly demonstrate the Department of Health's thinking, these include:

- The White Paper - "Our Health, Our Care, Our Say: a New Direction for Community Services"
- Revisions to the GMS Contract, 2006/7, Delivering Investment in General Practice
- Practice Based Commissioning - achieving universal coverage
- Commissioning a Patient Led NHS

So what are the key messages these documents tell us?

The White Paper praised general practice for being efficient and of high quality. The proposals show increased investment in primary care from 27% to 33% and a clear undertaking to ensure higher growth in funding for prevention, primary and community care rather than secondary care. There is a commitment to provide services closer to people's homes. Incentivising practices and rewarding responsive providers are key proposals.

So that's all ok, because all the evidence suggests that we either deliver all the above or could do so with adequate resources BUT the White Paper states that the problems with the existing system of general practice are as follows:

- The practice chooses who it registers, rather than the patient having choice
- Moving between practices is often difficult
- Having "open but full" lists (will no longer be acceptable)
- Closed lists (to be restricted or new providers brought in)
- Practice information is often poor and not easily available
- Patient cannot see a GP easily if they work a long distance from their home
- Commuter population cannot see their GP at a time that is convenient to them

So what are the proposed solutions?

- Make it easier for a patient to register with a practice
- Ban open but full lists
- If practices close their lists, alternative providers will be brought in that will not only look to "fill the gap" but will also compete with local practices for patients and existing work
- Develop walk-in centres in commuter areas
- Reward providers who deliver extended opening
- Require practices to publish significantly more information to patients
- Abolish practices boundaries (but not clear how home visiting will happen in these circumstances)
- More money to follow the patient, currently most practices find significant growth in Patient numbers uneconomical, but more money would change that equation, the issue will be the additional money will come from the practice that is decreasing in size.

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Practice Based Commissioning (PBC) is still failing to make the impact that was intended. The DES for PBC should begin to engage practices in a process designed to demand manage a system that is "over-heating". In addition PCTs need to be imaginative in redesigning pathways of care that will be more cost effective than current ones.

There are two major problems with PBC at present, firstly many PCTs think the DES is the only investment required or can be afforded for PBC. Secondly, with large deficits in several PCTs there seems to be a lack of incentive to fully embrace PBC, as it would appear any savings will not improve patient care, only reduce the deficit.

Commissioning a patient led NHS will result in a significant reconfiguration of PCTs and Strategic Health Authorities in England. The new organisations will be announced in the summer to be in place for October 2006. It will then probably take six months to appoint all senior staff. This could all result in organisations unwilling or unable to make decisions, which would prove to be a disaster for the NHS.

All the above means funding will be tight in general practice for the next 2 - 3 years. There will be many threats but with this will come tremendous opportunities. I am certain the major survivors in the brave new world will be GPs and their practices.

NFW

Transfer of GP Records

The LMC has been receiving reports of practices not printing out the complete patient record for the receiving practice but sending incomplete printouts omitting the attachments or just a disk or CDROM which may only be readable by a practice that has the same clinical system.

All practices using electronic rather than paper records have had to sign up to abiding by the joint BMA/RCGP Good Practice Guidelines for General Practice Electronic Patient Records (latest v 3.1 April 2005). In this, it states that they agree to deliver to the PCT the medical record (for example when a patient leaves the practice) "in a format approved" by the PCT. Previously, PCTs have only accepted a full paper printout of all the information that a practice holds. This necessitates the new practice typing in all the details into their computer system, with the risk of human error, and would require scanning in all letters or images to have the information on their system.

The way these problems will be avoided in the future is by the electronic GP2GP transfer of records programme, which is being piloted presently and will be rolled out nationally as the third element of the Connecting for Health workplan. Currently similar systems communicate well i.e. InPS to InPS but there are issues with cross system transfer i.e. iSoft to EMIS and there are particular issues with the recording of allergies. Unfortunately, the Government has made GP2GP the third priority after Choose & Book and EPS (Electronic Prescription service, previously known as ETP, Electronic Transmission of Prescriptions). It is a widely held view that GPs would have signed up in droves to this new electronic world if they had been offered the benefits of the GP2GP system first.

Frustrated by the delay to GP2GP and the time wasted by all the retyping of information, some practices have suggested downloading the patient record onto a CD-ROM, the information on which can be uploaded onto the receiving practice's system, particularly with EMIS. As this has not been, and is never likely to be, agreed by PCTs, because practices using other systems cannot use it, this is a breach of the practice's undertaking and the PCT could insist that the practice return to keeping all records on paper, with all the consequences of "double running" or attempting to prove QOF points on a manual system. Even worse, some practices are, allegedly, sending a subset of patient records on paper or disc and suggesting that the receiving practice should contact them for any further details required. THIS IS QUITE UNACCEPTABLE. This potentially serious medico-legal situation can be defused by advising the LMC which is quite happy to advise the sending practice of their obligations but repeat offenders will need to be reported to their PCTs.

Whilst we are awaiting the benefit of GP2GP, the LMC is investigating an interim solution which ensures all the record is passed on in a way that any computerised receiving practice can access. If the record is written to a CD-ROM, including a simple, clear readme file, using widely accessible file formats (plain text, rft {Rich text Format} or Word doc for the record and TIFF for any scanned images) this should enable the vast majority of practices to find it useful. However, it remains that the PCT would have to approve this and we are still in discussions over it. To prevent practices running into trouble and strengthen our negotiation, it would be helpful if all practices kept to their present agreements and printed out ALL data.

AD

Change of GP/Practice Manager and email addresses

With so many changes happening within the NHS, the LMC strives to ensure that practices are kept fully informed of all information affecting general practice.

The best and responsive way to do this is via email and we have set up an 'all practices' email grouping to do this (over 450 practices). Increasingly however, we are receiving many rejected emails (sometimes as many as 40) which then requires us to ring up each practice confirm correct details. This is very time-consuming and delays getting the information to you.

Can we please ask that you remember to notify the LMC of any changes to your GPs or Practices Managers and their email addresses. We really do wish to keep you well informed in a timely manner.

Our contact details are on the reverse of this Bulletin.

SDW

'Tomorrow's People'

This organisation is an independent, charitable trust that helps those people who are not in employment to get back to work and stay in work. They are not Government linked. They already have advisors working in a number of GP surgeries to offer support to patients at that GP practice and occasionally, to other patients in the surrounding area. Obviously this is not GP work but following the DWP's Green Paper that envisages some patients being supported by occupational health and employment advisers, it may be a useful resource. We are not suggesting that all practices take forward this initiative, however you may find it helpful to know that such a group exists should you get enquiries. Further information can be found at http://www.tomorrows-people.co.uk/

SDW

SICKNESS CERTIFICATION

Please find included in this Bulletin a poster that you may wish to display in your surgery to inform patients of the procedure regarding sickness certification following admission to hospital.

SDW

Same Practice Income - Different Superannuable Profits (and Pension)

No doubt this situation will cause many questions in the future between doctors and their accountants. Under 'old' GMS all, part or none of the various different fees were superannuable. Therefore, in a partnership where all partners were fully and equally sharing the profits, their superannuable income should have been the same. Actually, in most practices certain amounts, like PGEA but especially seniority, were retained personally thus giving unequal superannuable amounts.

Under the new arrangements, even if all income was shared equally it is vanishingly unlikely that the superannuable profits (and so payment of the 6 and 14%) will ever be the same. This is due to the fact that most, if not all, doctors have different expenses to deduct from their gross income and the proportion that is attributable to their NHS and non-NHS will differ again.

If a Dr A and Dr B earn exactly the same from their joint practice say £80K and have exactly the same annual expenses related to medical practice (unlikely I know but follow the logic) and Dr A also earns say £20K on private or non-NHS income, then Dr A will "only" be able to offset 80% of his total expenses against his NHS income, so he will have a higher superannuable income and must pay more contributions. Therefore, to be fair to all partners, the 6% and 14% contributions should be dealt with as a separate drawing for each doctor. If the overall superannuable contributions were deemed an equally shared expense, Dr B has paid some of what should be Dr A's contributions thus subsidising Dr A's pension.

Following all this logic, I think you can see it is most ***unlikely*** for two doctors in the same practice ever to have the same superannuable earnings. However, the doctor with the higher superannuable income is paying for the whole 20% (plus any added years) and gets the individual benefit of the pension gained.

AD

Road Traffic Act Fees – a summary

Victims of road traffic accidents (RTAs) have to pay a flat fee for NHS treatment after an accident. Governments seek to restructure the costs to taxpayers of the NHS but the only area where it has felt able to charge is that of victims of road traffic accidents where that victim has gone on to successfully claim in respect of personal injury.

Historically registered Medical Practitioners have been able to levy a fee for "examination, medical treatment or surgical treatment" if they are the first doctor to see the patient following a road traffic accident (even if the victim is one of their registered NHS patients)

In the Chancellor of the Exchequers Budget announcement of July 1997, he stated that steps would be taken to improve the collection of fees for treatment of road accident victims seen at accident departments or admitted to hospitals where that victim has gone on to successfully claim in respect of personal injury. This was enacted via the Road Traffic (NHS Charges) Act 1999 and the practical effects of this Act were summarised in HSC 1999/007.

The fees payable in law as a simple contract debt are if the first doctor to attend a RTA victim is seen and are as follows:

Outside hospital by a legally registered medical practitioner	**£ 21.80**
Plus 41p per mile (the "158 RTA fee)	
As an outpatient at hospital, a flat rate of:	**£354.00**
As an inpatient at a hospital daily rate of:	**£435.00**

All fees are subject to a £1000 ceiling

These changes have caused confusion within the insurance industry with some firms refusing to recognise valid claims from registered medical practitioners under s.158 Road Traffic Act because the claim does not arise via the DSS Compensation recovery Unit. Their refusal is erroneous as the right to charge under the s158 Road Traffic Act 1988 remains.

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Claiming the fees
Those of you who are BMA members can obtain a standard pro-forma from the regional offices to use when billing the victims. Please remember though that you MUST be the first doctor to attend the victim.

Tell the victim that:

- These services are not part of the NHS
- They are covered by all UK motor insurance policies
- Payment does NOT constitute any admission of guilt
- Payment of such fees per se does not count against `no claims' bonuses
- The driver of the vehicle is responsible for paying the fee, irrespective of who is to blame for the accident
- The fee is set by Parliament
- Failure to pay the fee may result in civil proceedings for recovery of the debt
- They (or the driver) should submit the bill without delay to the insurance company

Remember:

- You DO NOT have to attend the victim at the roadside – you may claim if you are the first doctor to attend the patient
- You can claim, even if the patient is you NHS registered patient
- The details of the driver, vehicle registration number (if this is not known then this can be obtained from the Police under s.156 of the Road Traffic Act 1988)
- You must render the account within 7 days of attendance
- You cannot charge a fee if you are working in and A&E department as an employee

The "158 fee" is unfortunately set by regulation and not indexed by the Doctors' and Dentists' Review Body. For reasons of political expediency, Ministers have been loathe to increase the fee for over 10 years.

SDW

Practice Staff being registered at same practice of employment

It is sensible that staff employed in a general practice should **NOT** be registered as patients of the same practice.

We recognise that this can create problems in some remote rural areas but believe that this advice should be followed in order to prevent conflicts of interest if staff experience health problems.

It would therefore seem sensible to advise you that all new staff should have this included as a condition of employment and if you wish, the letter of appointment can also say that the new employee is expected to re-register before taking up their employment with the practice

SDW

Jury Service

The BMA has issued new guidance regarding potential liability for and exemptions from, jury service as a result of discussions with the Courts Service. This resulted from changes to the law relating to jury service that came into force in 2004.

The BMA reminds doctors that they have a legal obligation to serve as jurors but that the Employment Relations Act 2004 permits employers to request deferral or excusal if absence should cause `substantial injury to the undertakings of the business'

The new guidance explains a number of matters of details that help identify likely exemption criteria and the processes involved in applying, some of which are very time-specific.

The guidance is available on the BMA/GPC website or advice on specific cases can be obtained from the LMC office.

SDW

OOH Complaints/Comments/Feedback

Can we remind GPs working for local OOH services that all complaints/comments/issues should be communicated (preferably in writing) to the Manager of their OOH service at their earliest opportunity.

SDW

OOH – Clinical Responsibility

In the new OOH services, GPs are only responsible for the clinical decisions that they themselves make. Other professionals, such as Emergency Care Practitioners (ECPs) have their own clinical responsibility and more importantly it is now the service that is responsible for ensuring calls can be handled, triaged and completed to an acceptable standard. GPs working in the service should work at a rate that they feel is safe, referring back to the OOH Hub if they are not able to deal with the work volume. Where there are more immediate urgent visits to be completed than cars available, the Hub can be asked to request an ambulance or paramedic attendance.

SDW

NHS IT that seems to work

There is widespread and justified cynicism about the grand IT plans of the public sector, with the various NHS plans being fine examples. There have also been many preaching about the benefit of IT assistance during consultations but most colleagues turned a deaf ear, due to the speed of their computers, links and the thought of shuffling CD-ROMs.

In the old days, we used to get occasional waiting times printouts from hospitals which had a varying degree of accuracy when received, let alone three months later. However, my practice always kept them as it gave a

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method of reminding one who the consultants were, where they worked and what their sub-specialty was. These printouts stopped a few years ago and one relied on the private hospital booklets to find consultants sub-specialty.

In the middle of 2005, the NHS revamped their Waiting Time website and it is now very good. Through an N3 connection, it is fast enough to give the waiting time for specialties but will also enable you to find who works in each department. Unfortunately, some trusts are trying to steer all referrals away from individual consultants to the team. This is not part of Choose and Book but a public website and I believe it is quick enough through an N3 connection to be truly useful during a consultation.

The link I use is,

www.nhs.uk/england/aboutTheNHS/waitingTimes/Default.cmsx

But to get it into your Favourites list,
Google, select uk button, type nhs and the second hit is www.nhs.uk

Or Yahoo, type nhs and it is the first hit.
In either case type waiting time into the search box in the upper right of the screen, the first hit will be Find Consultant Waiting Times, select that and you can select this page to be added to your favourites by hovering over a blank white section and clicking the right button.

Clicking on Waiting Times Search on the upper right takes you to the types available. Say select Outpatient Appointment which takes you to the speciality box (tip – use a letter U takes you to Urology much quicker than scrolling). I use our practice postcode for speed and then select 10 miles as that covers our main providers. One gets minimum and maximum waits and you can drill down to find the individual specialist.

Alternatively, selecting Waiting Times Consultant Search, type in the surname and select the Trust and speciality, which both will take an initial letter, this displays which sites a specialist works at and sometimes which sub-speciality.

AD

Medico-legal cover for work in community hospitals

Some of the work carried out by general practitioners in community hospitals will be above and beyond the scope of General Medical Services. If this applies to you then it would be advisable to check with your medical defence organisation that any such work is appropriately covered.

AM

Key to Contributors:

AD	Anthony D'Arcy, Medical Director
AM	Andrew Mostyn, Medical Director
CED	Christine Dewbury, Medical Director
NFW	Nigel Watson, Chief Executive
SDW	Sheila Williams, LMC Director

Hepatitis B immunisation fees for occupational health purposes.

The GPC issued revised guidance on Hepatitis B immunisation for employees at risk in November 2005. (for full details please see http://www.lmclive.co.uk/hepbguid1105.pdf)

This includes a change to the previous GPC advice that a practice was not permitted to charge an employer for giving Hepatitis B vaccination to an individual registered patient. The previous advice was that a GP could only charge an employer to immunise a registered patient if the service was offered as part of an occupational health service to any or all of the company's employees.
We originally advised that it was permissible to charge the employer for immunisation of an individual registered patient, but changed that advice to mirror the previous GPC legal guidance, much to the consternation of many of our practices.

Our new advice reflects the recent GPC change of opinion.

It is now permissible to charge the employer to immunise an individual registered patient who is judged to be at risk of contracting Hepatitis B in the course of their employment.

CED

GPs, sick notes and Incapacity Benefits

There has been some recent discussion about the role of GPs in issuing sick certificates and making decisions on Incapacity Benefits. It is apparent that there is some confusion at the DoH about the GP role in this area and not inconceivable that some of this confusion might also exist at the ground level. This is a helpful summary of what is and what is not expected of GPs (adapted from a GPC briefing):

GPs do not make decisions on Incapacity Benefits (IBs).

Statutory sickness benefit is payable from day three of an illness and is available for 26 weeks. From day three to day seven of an illness the patient should fill in a self certification form (SC1) provided by the employer. On day seven the GP or the doctor looking after the patient becomes responsible for certification of the illness in relation to sickness benefit.

GPs are responsible for issuing sickness certificates from day seven of a patient's illness to the end of week 26. A specific time must be stated (i.e. the certificate cannot say "until further notice"). After week 26, patients move to the Incapacity Benefit system if they qualify. Unlike the sick note scheme which states you are not well enough to do your own job, the IB scheme talks about whether the patient is capable of doing ANY job.

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If a patient is still off sick after about week 20 the patient is told by the Department of Work and Pensions (DWP) to get a "Med 4". They go back to the GP for this form which gives fuller details of the patient's condition than the original Med 3. Based on the information in Med 4, the DWP may be able to decide that a patient is incapable of work and would qualify for Incapacity Benefit.

If further details of the illness are required by the DWP, the patient is contacted requesting completion of a form IB113. If an IB113 is required, the DWP writes to the GP and the NHS GP has to complete a form IB113 (contractual obligation). On the basis of IB113 information, the DWP decides if the patient gets called up for a Personal Capacity Assessment (the All work Test). This assessment is not done by the patient's GP.

If a Personal Capacity Assessment is required it will be conducted by an examining medical practitioner who will be employed by Atos Origin - the company holding the DWP contract for this work. The examining doctor does not decide if the patient gets the Incapacity Benefit. That decision is made by a lay adjudication officer. When the Personal Capacity Assessment has been done and a decision made by the lay adjudicator a letter will go to the patient's GP to say whether the patient has been accepted for Incapacity Benefit or not. If the decision is that the patient is capable of work (ie any work) the GP must not issue any more sick notes unless the patient's condition changes. If the patient gets the IB they do not go back to the GP for any more sick notes.

NB The Disability Living Allowance is another quite separate benefit but again the patient's GP does not make the decision as to who gets it, and neither does the doctor employed by Atos Origin who carries out the medical examination of the patient. The decisions are made by lay adjudicators.

In short GPs are required to provide facts (not opinions) and do not take decisions on who gets benefits.

AM

GP LOCUM INSURANCE COVER

We cannot emphasise strongly enough the need for all GP practices to check that they have planned for such situations as long-term sickness, hold insurance policies AND that these provide adequate cover.

In view of PCT financial positions and the Statement of Financial Entitlement which states that PCTs will reimburse practices up to maximum of £948.38 per week subject to the PCTs budgetary position, we believe that practices should be checking and reviewing the amount of policy cover they have now.

PS – PMS doctors. This is the nGMS situation, what does your contract say?

SDW/AD

GMC GP REGISTER

On 31st March the GMS introduced a register of doctors who are eligible to work in NHS practices and from that date all doctors working in general practice, other than GP Registrars, will be required to be on the GP register.

The register will be populated by drawing data from the Medical Performers List held by PCTs.

By mid February 2006, all GPs will receive a letter explaining the new system and asking for confirmation of accuracy of data held. If you wish your name to be included on the register, you do not have to do anything (unless the data held is inaccurate).

If you do not wish your name to be included on the register (and this will mean that you will be unable to practice as a GP in the NHS after 31/03.06), you will need to inform the GMS and relevant PCT.

If you have not received a letter by the end of February 2006, please contact the GMS by email on: gpregister@gms-uk.org

New GPs can apply for inclusion on the GMS register, free of charge, by accessing an application form and fact sheet from www.gmc-uk.org

GP registrars are required to be on the GMS register following completion of their training and hold a CCT.

SDW

QoF Sign-Off - Reminder

Please remember that the practice QoF Lead needs to sign-off the practice's final QoF certificate to ensure completion of the process and to receive payments. Some clinical systems show a screen which provides the total point achievement for the practice and therefore some practices are omitting to proceed to the final stage - sign off. Please check that your practice QoF Lead signs off otherwise this will delay payments.

SDW

Forthcoming LMC Events

Date	Function	Timings	Venue
16th May	LMC Spring Conference	Day £75 pp	Botley Park Hotel
23rd May	Hampshire Practice Based* Commissioning Workshop	*Half day PM £20pp	Botley Park Hotel
12th July	Workshop on LIFT	Half day PM	Botley Park Hotel
27th Sep	Workshop on Finance	Half day PM	St Mary's Stadium, Soton
29th Nov	LMC Autumn Conference	Day	St Mary's Stadium, Soton

** Anyone outside Hampshire wishing to attend will be welcome, please contact Sue Parsons (sue.parsons@wessexlmcs.org.uk) for further information

Briefing note on Allergies for GP IT Systems

Arguably, one of the most important aspects of patient records that should be accessible to all that provide care is their known allergies and sensitivities. For historic reasons, the different GP clinical systems handle the recording of allergies in several different ways. Some have specific parts of the patient record database designed solely for that purpose. This presents problems when electronically transferring GP records. System "A" may hold the knowledge of an allergy to penicillin in a form that cannot be recognised by system "B" and vice versa. These differences can only be overcome by the application of complex translation tables and mapping rules, these are potentially unsafe.

All GP systems have the full range of Read Codes available to them and the Read Code system has a wide range of specific codes that deal with allergies. Any Read Coded data will be transferred with 100% accuracy between GP systems using the GP2GP transfer process.

We would therefore recommend to all GPs and surgeries that they begin recording allergies and sensitivities as Read Coded entries. Known and confirmed allergies are relatively rare and the numbers of patients involved are likely to be small. Some practices might consider doing searches of their existing records and adding Read Coded entries to supplement any system specific entries that may exist.

Dr Paul Cundy, Chairman of the GPC IT Committee has written GPC guidance:-

- GPs should continue in all cases to use their system-specific mechanism for recording allergies. It is essential that allergy information is properly recorded on your own system to ensure it can be recognised and dealt with during GP2GP transfer.
- Receiving systems will have any incoming allergy information that has been entered using the sending system's specific mechanism presented to them as part of a receipt workflow (for detailed advice see references below). This workflow should facilitate appropriate translation into the receiving system's allergy alerting mechanism.
- For systems that use Read code(s) as part of their system specific process no additional entries are required for drug related allergies. The Read code(s) will be unequivocally recognizable by the receiving system although some system specific qualifiers may not be.
  However if your clinical system's allergy recording mechanism does not use Read Codes to record allergies, then you should in addition double enter all allergies as Read coded data, as well as via any system specific mechanism.
- This will have the effect of providing a backup to any system specific entries, adding another level of patient safety and mitigating any possible liability in respect of the clinician. We hope that most GPs will see this as a worth while duplication to enhance patient safety.
- All of the double entered read codes will be reliably transferred between systems via GP2GP and it will be possible to search for any such codes in the receiving system. Care will have to be taken in interpreting the context around these codes such as certainty and severity.
- Please check with your supplier or your users group for precise advice as to how this applies to the system you use. They will know whether your current system's allergy recording uses Read codes.
- The Read codes available are not exhaustive and may need expanding but where they exist they should be used. They do change from time to time and GPs should keep themselves up to date.
- GP2GP import mechanisms will evolve over time and GPs should keep themselves up to date.
- All GPs are reminded of the Good Practice Guidelines for GP electronic patient records http://www.dh.gov.uk/assetRoot/04/11/67/07/04116707.pdf which contain detailed guidance on the use of electronic records in General Practice. Chapter 5 and appendix 2 deal with G2GP record transfer. Updates to this guidance will be prepared and published by the GP2GP team as further supplements available from the GP2GP website http://www.connectingforhealth.nhs.uk/delivery/programmes/gp2gp .

<u>We have been asked which codes GPs might use. The following are examples from the 5 byte Read Codes;</u>

Chapter title	Read codes beginning with
Drug – Adverse reaction – AR	TJ…
H/O Drug allergy	14L..
H/O Non drug allergy	14M..
Allergy unspecified	SN53.
Anaphylactic shock	SN50.
Food allergy	SN58.
Personal history of drug allergy	ZV14.

Equivalents exist in the Clinical Terms Version 3 and SNOMED code sets.

AD

Dispensing Doctors and VAT

A decision imposed by the DoH & Welsh Assembly and effective from 1st April 2006, requires that dispensing doctors who wish to recover VAT incurred on the drugs they dispense will need to register for VAT.

Information on how to register for VAT is now available on the Revenue and Customs (HMRC) website: http://tinyurl.com/8yvhe

The website contains information on:
- How doctors can register for VAT
- VAT treatment of the goods and services they provide
- How much VAT can be recovered on purchases.

We would encourage all dispensing practices to visit the HMRC website as soon as possible and follow the advice to register for VAT.

The information applies only to dispensing GPs operating under GMS or PMS contractual arrangements. Please note the BMA does not provide specialist advice on VAT and practices should therefore seek the advice of their accountants.

SDW

Contract Review Guidance

Hopefully most practices will have now received their two printed copies of the contract review guidance. We have been asked by the GPC to remind practices that only two hard copies will be received per practice and that no further copies are available. If practices want further copies you will need to print these from the website. Further information is available at:
http://www.bma.org.uk/ap.nsf/Content/gmsguid0406

SDW

Collaborative Arrangements 2006/2007

As you may have read, the DDRB have not set collaborative arrangement fees for 2006/2007 and seem unlikely to do so in future, but have advised doctors to set their own fees for work done under the collaborative arrangements (the main items are below).
Competition legislation and the Office of Fair Trading prohibit the LMC, or the BMA, from advising on fees and it is also illegal for individual doctors or staff to discuss their fees outside their practice. The penalties for breaching this law are severe and can be up to 10% of practice turnover (not profit).

The LMC advises practices that they should establish their fees for this work, however we do advise a degree of caution on both contractual and ethical grounds.
The BMA obtained a legal opinion last year which advised that a three month notice period should be given when withdrawing from collaborative arrangements. The DDRB's recommendation may have changed that but, as I have been unable to obtain detailed advice over the last few days, felt that practices should be in a position to make an early decision about their fee structure.
Practices wishing to set their own fees should, and notify their PCT that as there is no DDRB recommended fee any request for collaborative work received after a set date, (at present three months hence, but the practice should reserve the right to reduce this after legal or DH advice) will constitute a contract between the practice and the PCT and the practices fee schedule will apply.
Practices may not be aware that they may operate The Late Payment of Commercial Debts (Interest) Act 1998 and apply interest at no more than Base Rate +8%. (see http://www.payontime.co.uk/downloads/commercialdebts.pdf) and that debts are recoverable through the Small Claims Court. If practices intend to operate this scheme they should also include this information in their letter to the PCT.

Collaborative arrangements include:
- Notification of infectious disease
- Reports for Social Services, including Child Protection
- Attendance at Child Protection of other Case Conferences
- Housing reports requested by local authorities
- Mental Health Act work (including a request for an opinion where no `section' is completed)
- Requests by other local authority departments for medical reports
- Requests for Blue Badge reports

NB ***Certificates in connection with brain injury and council tax must be provided without charge***.

Notwithstanding the above, caution should be exercised, prior to turning down collaborative arrangement work, since there may be ethical considerations as well as the need to maintain the doctor-patient relationship. Where a child is at risk, for example, the LMC would always strongly advise doctors to continue to fulfil their obligation to the child and that any fee is considered secondary. The decision to carry out work should, therefore, be made on a case-by-case basis.

SDW

Wessex LMCs
59 Tower Street
Winchester
Hants
SO23 8TA

office@wessexlmcs.org.uk
www.lmclive.co.uk