NORFOLK LOCAL MEDICAL COMMITTEE

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January Flyer

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Principal's Edition

GMS2 - New GP Contract: See attached for latest guidance

HAROLD'S LEGACY

The demise of an infamous mass murderer, who happened to be a GP, coincided with a couple of further changes to the procedures which we have to adopt following the death of a patient. These were introduced in the wake of Dr Shipman's crimes.

1 Reporting a death on practice premises

GPs must report to Eastern Support Services, on the appropriate form, the circumstances around the death of a patient on practice premises. This form is available on the LMC website.

2 Completion of Cremation Forms

Whilst the procedures for completing the Cremation Form Part 2 (Form C) haven't legally changed, practices were sent recent guidance on the expected level of information to be entered on crem forms and, in particular, the Part 2 (Form C).

With respect to questions 5 to 8, we understand that Referees will expect one of these to be in the affirmative, as well as questions 1, 2 & 4. This might entail, for example, a telephone call to a third party which is mentioned in question 11, or the nursing home cited in question 13 of Part 1. The Part 1 GP could help be entering a contact number. To put this in perspective, we have permission to reproduce the following quote from Dr John Grenville, Sec of Derbyshire LMC, who was the GP expert at the Shipman trial and is currently giving evidence to the Shipman Inquiry.

"My view is that every doctor completing a Crem Form (B.C or E) needs to look very carefully at the declaration he/she is signing and needs to be absolutely sure that it can be signed in all good faith. Hopefully, as professional we learn from experience and we should have learned that, very rarely, colleagues lie to us. That being the case, we may well feel the need to seek corroborative evidence before signing Form C. Unfortunately, this isn't new work - it is simply a restatement of what has always been expected of us, I have always worried that the fee for Form C implies something more than a quick look at the name tag on the wrist and writing 'Yes' three times. In practical terms it may be worth negotiating locally between colleagues who are doing Forms B and C a way of ensuring that the doctor signing Form C can have sight of the deceased's records (there is usually space on the form for any other comments). But, of course, records can be falsified. J Grenville"

Remember there is no contractual obligation on GPs to complete Part 2 but we believe the fee remains realistic for the work involved

Training Practices and Patient Notes

We have learned from the GPC that the drive to increase training capacity, and funding allocated to deaneries to facilitate this, means that many deaneries are able to provide support to training practices, or those practices aspiring to become training practices.

Such support can include funding for the summarisation of records or the transfer of summaries from paper to computer. This would have beneficial effects in the context of the new contract.

Training, or potential training, practices might considering clarifying the situation with their own deaneries with a view to applying for such funding where possible and appropriate.

Stupid Requests for Letters etc etc

We know you enjoy hearing about examples we get sent so here is a selection to start off the New Year..........

Disability Rights asked for a letter to say a person was "disabled" and so couldn't travel to the Disability Rights Office!

A kick boxing association wanted a doctor's letter to say a patient with a painful knee had permission to cease - kick boxing!

Norfolk Social Services have asked a GP to complete a nine page form just so the parents can apply for a child restraint for the car.

Social Services have also unilaterally decided that "carers" need their GPs to construct a "carers' register", identify a "carers' lead", set up a "carers' support group, offer "well carers'" clinics, with annual check-ups, and participate in an annual award for the surgery that "best supports carers".

Just think, after April we can invite PCTs to commission Local Enhanced Services for the lot of them!

Cataract - Post Op Access at NNUH

A vigilant GP has managed to encourage the NNUH Ophthalmology Directorate to alter its post-op instructions to cataract patients.
For the first six weeks following discharge, after cataract surgery, patients may access ophthalmology direct without going through their GPs. In-hours they are to contact the NNUH
Day Case Unit and OOH they may 'phone the on-
call SHO directly. If they had their operations

done at Cromer they may be asked to go to eye casualty at the NNUH

Out of Hours – what's happening ?

It's no secret that the preferred provider for a Norfolk-wide out of hours service, East Anglian Ambulance Trust, has yet to submit a price for the service which matches the funding which PCTs say is available. At the moment it certainly doesn't look like an April 1st start for the opt-out. However, there are very sound reasons for practices to send formal written notice of intention to opt-out as soon as they have signed their new contracts during March.

The LMC has written to the Strategic Health Authority asking why there is so little funding, but has yet to receive a reply. Both PCTs and The EAAT are acutely aware of the likely haemorrhage of goodwill from GPs if the opt-out is delayed. Not only will less GPs be prepared to do shifts, but the going rate for doing them will increase. GPs will also be less inclined to be accommodating in the essential vs enhanced services debate. We believe that PCTs should get on with it and bear the financial risk because the funding available is short across the country - not just here in Norfolk - and it is going to be a DoH problem.

Childcare for GPs and their Staff

The person to contact is Margaret Dewsbury, Childcare Cop-ordinator for Norfolk NHS Trusts, whose role is to try to help health workers access quality childcare. She can be contacted on 01603 622292 or email child.care.info.gov.uk

Managing Short Term Sickness

We continue to receive reports of employers, some of whom really ought to know better, insisting upon their employees obtaining a certificate from day one of their sickness. A recent example is HM Prison Wayland.

The LMC office still has a supply of the very useful leaflet "Managing Short Term Sickness" which is specifically designed for employers and which points out very clearly that "GPs are not obliged to provide their patients with sick certification for illnesses of seven days or less". If you would like more copies contact the office or download it from www.managingabsence.org.uk

NEW CONTRACT – WHAT'S NEW?

No apologies for devoting the rest of this bumper edition to New Contract Issues; by the time this flyer reaches GPs there will be less than 2 months to go - pretty scary! Of the 5 major document releases since Christmas, the most accessible is the DoH Guidance Notes – "Delivering Investment in General Practice". If you just read one document, this is the one. It takes about two evenings to get through but, hey, this our future. This and all the other documents (The Regulations, The Statement of Fees and Entitlements, the actual Contract and the definitive post-April PMS guidance) are available on-line via links on our website. Electronic links were forwarded to your practice manager immediately they were published.

Essential Services - Page 24 of the DoH Guidance gives a useful reminder of the definition of Essential Services; "management" of presentations includes the requirement to "make available such treatment or further investigation as is necessary….". We don't think that this means that GPs should always actually *provide* phlebotomy, for example. 3-yearly checks for under-75's and annual checks for over-75's have found their way into the Regulations as part of the PCTs patient services guarantee despite the efforts of the GPC to have these abolished. The big difference is that practices won't have to offer or invite them. An implication is that say, an over 75 yr old requests a check but is actually physically unable to come to the surgery, the GP - or at least a health care practitioner - may well be obliged to go and visit. However, this would occur extremely rarely and besides the patient would probably need at least a BP recording for the QOF points.

Enhanced Services - The shouting is not over with respect to what constitutes Enhanced Services. The main debate is over the areas of activity done by GPs but which really aren't included in the "core services" funded via the Global Sum. Add-ons, such as National Enhanced Services (NES) will be commissioned by PCTs as they see fit, and we have no direct influence except a) to ensure that NES pricing is adhered to if done within GMS and b) to monitor the PCTs' overall ES expenditure. Para 2.78(v) of "Delivering Investment..." is particularly helpful as it makes it difficult for PCTs to label any old activity previously placed in a Trust thus re-commissioned "outside" the acute sector as an Enhanced Service (ie in order to "bump-up" their apparent ES spend). GPs should realise, however, that apart from four Direct Enhanced Services, a PCT may commission any *new* enhanced service from whoever it chooses and for any price that it negotiates. What's more, any suitable party could provide primary medical services - GPs no longer have the NHS monopoly. This is most likely to occur if a single handed practice winds up; the PCT would want to look at directly-employed alternatives.

Local Enhanced Services - The LMC's paper on what it expects to be commissioned as local enhanced services is still our position and statements from PCTs about how, for example, phlebotomy is a Global Sum essential service should be challenged. We have the informal support of the GPC and unless PCTs commission these non-essential services we recommend that practices serve written notice to PCTs that they will discontinue them. We also firmly believe that the same applies to PMS practices unless a service or activity was specifically commissioned and written into the PMS contract. You should remember that the GMC expects you to give reasonable notice if you intend to change a service. This is presumably to allow the PCT to commission the service from another source. For many practices they will wish to continue these services in return for a realistic reimbursement

Additional Services – accreditation - The lists of GPs approved for antenatal, child health surveillance and minor surgery are to be abolished. Accreditation for these additional services will be based on the practice as a provider, and approval will be a formality. Clinical governance and appraisal will ensure standards are maintained

Flu immunisation DES - We are aware that at least one PCT is considering commissioning flu jabs as a DES from a non-GP provider, inviting that party to undercut the DES price. We think this is illegal as flu jabs are a "current funded contract". The GPC is taking legal advice on this at present.

Charging for Services - It looks as if current rules and exceptions will, after all, be preserved. That is, for patients registered with a contractor unit, the contractor may not provide services privately that are available to the patient somewhere on the NHS. There is ambiguity, however, around Paragraph 462.3 of the Draft Contract, which we will pursue. However, there seems to be no bar to providing any service privately to a patient seeking this but not registered with the practice.

Choice of Practitioner - Patients will be entitled to name their preferred practitioner; this would be any practitioner working within the provider unit. In other words, employed GPs who are not partners may well find themselves with a "list" of patients. Practices are required to "endeavour" to meet the wishes of a patient seeking their preferred practitioner, although the 48 hr access requirement will be waived. However, a "preferred" practitioner may direct a patient to a colleague (GP *or otherwise*) if the service required is normally provided by that individual (eg BP checks etc)

Surgery Opening Hours - Whilst core hours are 8-6.30, Monday to Friday, practices may choose their "normal hours", which merely have to be "to the extent necessary to meet reasonable need". Practices which close during core hours (eg lunch time or a half day) merely have to make services available to patients seeking them during these times in a timely manner. Practices must advise PCTs of their proposed normal hours during the pre-contract period of February. We can also confirm that recent rumours in the "comics" about Saturday mornings remaining as "core hours" are absolutely untrue.

Practice Areas and List Closures - Prior to signing New Contracts, practices and PCTs have to agree anew on practice areas. This is the time to review your practice area. Remember you will be obliged to accept patients and TRs from your declared practice area. That does not mean you cannot accept someone from outside the area if you choose. Whilst allocations to closed lists will still be possible, the process will be a much bigger rigmarole for PCTs. The LMC will be involved if and when. For the initial contract we advise all practices to declare their lists "open" so that they are eligible for enhanced services. It would be more difficult for PCTs to withdraw enhanced services should the practice go on to declare their list "closed". Lists can be "full", whilst "open", however, so that patients would need to be allocated.

Removals - A feature of the new contract is that GPs must always give a reason for removing a patient and inform the PCT. There will be two kinds of removal - immediate (for violence) and 8-day notice although you will retain the 30 day responsibility for patients who move out of the area.

Temporary Residents - Practices must be aware of their obligations to see TRs who supply a temporary address within your declared practice area. The Global Sum is based on the previous 5 years' activity. It is important to continue to complete TR forms as these will be counted and will inform

future payments into Global Sums in the years to come.

Improved Access DES - We are certain that previous advice on the DES for improved access (based on a letter from Rob Webster) is incorrect. The DoH Guidance (see Table 14, Contractor entitlements, item 7) clearly shows that all contractors should expect a minimum of £5000 (for an average size practice list of 5891) over the course of 2003/4 for this and, thus, if your previous incentive money for access was less than this amount you should expect a top-up. For next year all contractors will be offered a similar DES which will be £5160 per (average) practice.

2004-5 Quality Information Preparation DES - For both PMS and GMS, the next set of payments due by the end of April 04 may be dependent on the amount of work remaining to be done. So consider spending *only* the amount badged for this work during 2003-4, to ensure a good chance of next year's payments. Remember this payment is a contribution to the costs and even adding both years together there will almost certainly be a shortfall. Obviously this will be less for practices that have invested heavily in previous years, which seems fair.

Health Service Body Status - The LMC does not perceive any advantages to GMS practices in becoming NHS bodies at this stage. Practices may choose to "become" Health Service Bodies and most PMS practices have become NHS bodies already. NHS body status doesn't even offer exclusive "rights" to have disputes resolved by the NHS dispute procedure (as opposed to through the Courts) because Private Law practices may also use the NHS procedures if they want (see DoH guidance Page 147).

Out of Hours Opt–Out - There is an element of contradiction in that whilst practices could cease providing out of hours from April 04 provided there is a PCT alternative, strictly speaking the practice must give formal notice to opt-out, which is additional to the informal communication with PCTs thus far. The trouble is that formal notice cannot be given until the new contract has been signed, and there would then be 3 months' delay. PCTs could even delay things by up to 9 months which means that it is imperative to give formal notice as soon as possible from March (as soon as the contract is signed). Para 2.63(x) of the DoH document provides for earlier dates by agreement but the LMC would not advise practices to count chickens.

Quality Points - The LMC still cannot find any good reason for practices not to aspire to high levels of achievement, and the perception of "realistic" and "reasonable" seems somewhat intangible. The SFE is quite clear about the non-discretionary nature of the funding for both aspiration and achievement. If practices "over-achieve" with respect to their aspirations, this would indeed be a financial risk for PCTs, but the money is guaranteed. Real time feedback for practices about how they are doing will become available from August with the QMAS system (it should work automatically with any RFA99 system). Prevalence factors won't apply until achievement payments are made in April 05 and will be based on the returns from National Prevalence Day (14/2/05). However, the Guidance does give some rough ideas of what average prevalences are thought to be - just for an idea of how your practice compares. Most importantly, however, GPs are advised not to take drawings from practice income which makes assumptions about achievement income. It would be sensible to keep the monthly aspiration payments in the practice account until the achievement balance has been determined in March 05. That holiday in Bermuda may have to wait a while.

READ Codes - The useful FAQ sheet about the READ codes issued by the GPC in January (circulated to PMs and on our website) and the Guidance are complementary. Taken together, there is advice on retrospective alterations of READ codes, contemporaneous revision of codes and where wilful omission of READ codes could constitute fraud. One of the questions that concerned us was where secondary care investigations (ECHOs, CT scans and exercise ECGs) influenced achievement. If the service is not available, this would be grounds for exception reporting; thus *referral* for that investigation would "count".

Computer Upgrades - Paragraphs 4.31 and 4.32 of the Guidance iterate the definition of "minor upgrades" to GP systems which qualify for full reimbursement - it includes examples such as memory and hard disk upgrades, broken or defective printers, screens and back-up devices. The PCT cannot claim lack of funding as an excuse not to respond promptly to such requests; it *must* fund the claims and manage the financial risk.

Staff Pension Contributions - Employers' contributions rise from 7% to 14% in April. We understand that this increment will be included in whatever *actual* Global Sum is calculated for each practice.

Locum Payments - A number of provisions, subject to a weekly maximum, apply to PCT-funded locum payments for absence of performers (ie not just contractor-providers). Maternity, paternity and suspension are non-discretionary, but sickness and prolonged study leave are discretionary, dependant on the amount of funding the PCT has available - so we know what that will mean. The LMC needs to be consulted on these arrangements.

Signing The Contract - Practices should be given sight of their *provisional* contract by the end of February. This will specify which Additional and Enhanced Services the practice is to provide, the normal hours of opening and the identity of those practitioners who are to be co-providers. It will not be possible for one partner to decline to sign unless s/he is prepared to act as an employee of the practice in future. Any "right" to a list of patients will cease - the only option for a GP to provide primary medical services is as part of a new GMS provider unit, or as a PMS provide /performer. Signing the contract **does not** commit the practice to accepting the provisional Global Sum/MPIG, for which there are separate avenues for discord.

PMS - PMS practices will automatically enjoy many of the new benefits under GMS - the LMC has published these already. The 196 point handicap from the Quality Points will not be applied until April 05, otherwise the same rules apply. In future, PCTs may alter the local PMS QOF scheme, but we don't think this will happen next year. The out of hours opt-out is priced in proportion to the practice list size and £6000 per GP (as opposed to a fraction of their GSE or PMS baseline) and will be payable in stalled deductions rather than all at once. Seniority rules are slightly different in that the practice can elect to have the payments as a simple uplift of their baseline. This may be an advantage to practices with a significant number of younger or salaried GPs. PMS practices considering moving to GMS may apply at will to their PCT and the transfer arrangements would include a MPIG which the PCT would be able to calculate. Para 3.10 of the SFE only applies to new practices. PMS to GMS movers will be entitled to an MPIG up until end-March 06.

Practice Jobs List

February – as soon as possible
- Make final decisions on Additional Services
- Set up disease registers in the Quality clinical domains
- Start recording as many READ codes as possible; smoking status, blood pressures etc
- Get your staff up to speed about the new contract
- Respond to PCT enquiries about future workforce and recruitment intentions

Second half of February
- Write to the PCT about FIVE things –

1. whether you want to be conferred Health Service Body status
2. that all the potential provider/performers satisfy the Conditions (ie GPs need to be on a Medical List)

3. what the practice's normal hours are to be
4. what the practice area will be and
5. whether the List is to be open or closed.

By the end of February

- Should have received a copy of the provisional contract, including the indicative budget and what Enhanced Services are to be provided
- Should have agreed with the PCT what the aspiration points score is.

From the beginning, and by the end, of March

- New contract signed. All partners (at least) must sign.

From April –or as soon as possible if before

- Write formally to PCT giving notice of request to opt-out of out of hours.
- Revise practice leaflets, set up mechanisms for patients to nominate their "preferred practitioner"
- If participating – design and submit a plan for Improved Access DES.

P Harvey, 28 January 2004