**Introduction**

A vast amount of documentation has arrived following the revisions to the GMS contract so we have endeavoured to circulate those that are of immediate help via email to your practice managers. An updated GMS2 implementation tool is attached as a CD from the West Midlands Regional Local Medical Committee.

Queries received from colleagues are included in the newsletter if felt to be useful for us all.

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**Revisions to the GMS Contract 2006/07**

Revisions to the GMS contract are available on the BMA website at: http://www.bma.org.uk/ap.nsf/Content/revisionnGMSFeb20062 but is easily accessible on the attached CD-Rom.

A guidance note Focus On…Revisions to the GMS Contract at http://www.bma.org.uk/ap.nsf/Content/focusrevgms06?OpenDocument&Highlight=2,focus,on,revisions,to,GMS,contract,2006/07 has also been produced by the GPC to help understand the changes and development that have been made to the Contract.

The LMC will work with PCTs to ensure that Enhanced Service Floors are spent up to the expected levels. We will also discuss the maximum level for maternity reimbursement with PCTs to ensure that their protocols in respect of locum cover payments are updated, and to seek that the maximum level for reimbursement is increased to £1,500 per week.

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**Quality and Outcomes Framework 2006/07**

A full list of all the indicators in the new QoF and the Guidance related to them are also available on the BMA website where there is a "Focus On…The Quality and Outcomes Framework 2006". This has previously been circulated to practice managers together with a useful aid from the West Midlands Regional LMC Secretary, Dr Grant Ingrams.

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**Confidentiality and QoF**

Confidentiality and QoF continues to raise queries so the GPC have produced a definitive view outlined below:

"Wherever practicable, patient data disclosed for purposes other than the patient's care should be anonymised. Anonymised or statistical information is not confidential and may be used with relatively few constraints.

There are circumstances where it will not be practicable for anonymised information to be generated in order to satisfy the purposes of third parties. This may be because there is limited capacity to anonymise information by a contractor, or where the contractor is unable to anonymise data with a reasonable degree of ease - for example because it would involve substantial additional work, or because the purpose to be satisfied requires examination of original records. Where any of these apply, care must be taken to ensure that disclosure of information is lawful.

The circumstances in which the PCT, or persons authorised by the PCT, may need to access and

obtain information that identifies individual patients should be limited. A decision to disclose such information to the PCT will be a matter for the contractor. However, a contractor may risk being in breach of its contract if it refuses to produce information which the PCT reasonably requires and which it has requested in accordance with the relevant requirements of this Code.

The circumstances in which, in the view of the Department, patient identifiable information would generally be reasonably required by the PCT and could lawfully be disclosed by the practice would include where the practice is unable to anonymise data that is needed to support the wider functioning of the NHS, including the management of healthcare services, such as the QoF annual review process. For example, this may be where the practice does not possess an IT system which can ensure complete anonymisation, or where it is not practicable to anonymise paper records - such as where this would require substantial additional work on the part of the practice, or where the practice cannot guarantee to erase all identifying information. The practice should make a judgement in the context of each request for information as to whether or not anonymisation is practicable. Where anonymisation is not practicable, data may be released to the PCT in patient identifiable form.

Where the patient's consent is not sought to identifiable information, the reasons why must be documented and there must be a clear audit trail."

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**Managing Practice Lists**

A joint statement from the GPC and NHS Employers on managing practice lists has been produced. This is designed to encourage practices and PCTs to work together to ensure that patients are clear when and where they can register with their primary medical care provider:

"It is recognised that in certain circumstances there are difficulties in managing practice lists. In an attempt to offer a practical and transparent solution to patients, practices and PCTs the following advice is offered. This advice is provided in the context of promoting constructive working relationships between practices and their PCTs.

In the situation that a practice is unable routinely to accept new patients (beyond immediate family members of existing patients), a discussion between the practice and the PCT should take place to allow the situation to be explored. The PCT is expected to work constructively with the practice to try to jointly achieve resolution. This could take the form of, for example, additional support given by the PCT to the practice. In some situations, practices may wish to use the closed list procedure.

It is recognised that GMS contractors retain their freedom within the contract not to register new patients, provided they have reasonable, non-discriminatory grounds for doing so in each case."

Practices are reminded of their right to refuse to register new patients and paragraph 17 of part 2 of schedule 6. The practice does not need to make an official declaration of its intention to refuse to register new patients. It must however provide the patient with a written notice of the refusal and the reason for it. The PCT may still assign patients to the contractors list under paragraph 32 of part 2 of schedule 6, as its list is open to assignments within the meaning of the regulations. A contractor should bear in mind that the PCT may ask it to justify the reasonable grounds that it has used to refuse to register a patient.

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**Referral Management Centres**

We have previously discussed the role of local muscoloskeletal services, orthopaedic triage and assessment services. The GPC have produced a guidance available at http://www.bma.org.uk/ap.nsf/Content/refmanfaqsjan06?OpenDocument&Highlight=2,referral,management,centres

On page 2 you will note that GPs do not have any "rights" to have referrals accepted by a particular consultant so the LMC will be raising this with the GPC. The MDU has also produced advice for GPs: -

·Explain to the patient that the referral will be made via the RMC and seek their express consent
·Formulate a plan for how referrals will be made, for example, consider copying the referral letter to the patient and track the referral
·Indicate on the letter the type of specialist required
·Indicate the urgency of the referral
·Make a plan with the patient about what to do if they do not hear from the centre within a certain time. Some practices give patients information sheets.

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**Practice Based Commissioning DES**

GPC guidance has already been circulated to practice managers and is available at http://www.bma.org.uk/ap.nsf/Content/focustpbcdes?OpenDocument&Highlight=2,focus,on,towards,practice,based,commissioning

Key parts of the DES are the initial 95p per patient up front from April 2006 and paid by June 2006, if we agree a plan with the PCT. A template plan has been included within the DES specification and it can be an individual or a joint plan:

1.Practice name and details of clinical lead.
2.Agreed scope of services covered by indicative budget.
3.Method by which quality of the redesigned services will be assured/demonstrated.
4.Agreed baseline of referrals and/or admission by speciality for 2005/06.
5.Agreed threshold for meeting the objectives in this DES plan to trigger the award of the 2nd payment of 95p per patient by end of April 2007 and at latest June 2007.
6.Details of practice clinical engagement, meetings and how the plan links to the PCTs strategic plan and local priorities.

If resources are freed up at the end of the year and exceed the 2nd payment we are entitled to at least 70% for reinvestment in 'services for the benefits of patients'.

It is recommended that practices use the GPC-NHS Employers template plan as found at Appendix A of the DES specification and also refer to the sample plan in the Focus On…Towards Practice Based Commissioning Directed Enhanced Service document. It is not the case that in order to trigger payment of the initial 95p per patient that practices and PCTs must agree a plan based on the Department of Health model/template. The GPC is seeking written clarification about the verbal assurance regarding the entitlement to at least 70% of freed up resources (FUR) when practices do not achieve the objectives of their PBC plan.

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**Focus on... Guidance from GPC**

There are further Guidance notes from the GPC that we recommend your practice manager

downloads.

Focus on… Choice and Booking DES -
http://www.bma.org.uk/ap.nsf/Content/focusCandB?OpenDocument&Highlight=2,focus,on,choice,booking,des

The financial implications of increasing list size -
http://www.bma.org.uk/ap.nsf/Content/increaselistsize?OpenDocument&Highlight=2,financial,implications,increasing,list,size

Partnership Agreements –
http://www.bma.org.uk/ap.nsf/Content/partneragreefeb06?OpenDocument&Highlight=2,partnership,agreements

This is the long awaited guidance and will help you update your Agreement.

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**Providing Travel Health**

"Providing Travel Health in the Primary Care setting including Financial Considerations" is a useful document recommended by the LMC and attached with the newsletter. Please note the comments about item of service payments under the old Red Book which are now included in the Global Sum for GMS practices and within the baseline for PMS practices.

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**Doctors Health**

Over the past few years there has been a rise in the number of sites addressing doctors' health and wellbeing, driven in part by increasing awareness of this issue. One good example of this activity is the recently launched site http://www.support4doctors.org by the Royal Medical Benevolent Fund. It's a comprehensive directory of sources of help and information for doctors, containing the categories of health and wellbeing, work and career, family and home, and money and finance. The site is easy to navigate and each category provides a link to its listed websites.

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**Letters for Housing**

A query has been raised about medical advice to Housing Authorities and discussed on the LMCs secretaries list server. Previously medical reports were provided under collaborative arrangements with the public health doctors but PCTs no longer see this as their responsibility. It is quite clear that the provision of these letters is not a contracted primary medical service. Therefore it is the advice of this LMC that letters for Housing Authorities and Borough Councils are a private matter and therefore should attract a charge. In many cases the councils will refuse to pay so it is the responsibility of the patient to meet the charge.

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**Declaration of Sound Mind for a Will**

It is the practice amongst some solicitors to check that there client is of sound mind and able to make a new will when of advancing years. The LMC has discussed this and feels it is a private matter which should be charged. Colleagues are reminded that they should put themselves in a position to have carried out an appropriate examination when declaring that their patient is of sound mind.

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**Medical Records**

Another query has been raised about what constitutes part of the medical record with respect to case conference reports, solicitors letters and insurance reports.

The BMA advice is that doctors must keep "clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed". Case conferences would be deemed by most doctors to contain relevant clinical information about their patients and families and therefore include them in the medical record. Although they can be very long reports it is possible to scan the information into the electronic records.

The insurance report is commissioned by the insurance company and is generally an extract of data from the medical record. It has to be kept for six months but can be stored separately from the medical record and can be destroyed after 6 months, unlike the medical record. It therefore does not constitute part of the medical record. In a similar way solicitors' reports are usually an extract of data from the medical record and can be kept separate from the record either in paper or electronic form. However most GPs with electronic records will retain the solicitor's letter as an attachment for ease of reference and if patients have queries.

The Department of Health has, through The Royal College of GPs Health Informatics Standing Group and representatives of the GPC, produced "Good Practice Guidelines for General Practice – Electronic Patient Records". On pages 48 – 51 it talks about summarising, shredding and attachments to the electronic patient record. It is interesting to note the legal status that any attachment to an electronic clinical record should be regarded as having equal medicolegal weight as notes made within the system and should be accorded the same stringencies around audit trail and backup. When a query was made about the ownership of the medical records it was stated that the Minister of Health owns the actual paper the record is written on but the content of the record belongs to the patient.

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**Next LMC Meetings**

Main LMC Committee Meeting – 27th April 2006, Cannock Chase PCT.

South East GP Sub Committee – 15th May 2006, East Staffordshire PCT.

South West GP Sub Committee – 18th May 2006, Cannock Chase PCT.

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**Dr V Spleen**

Dear Reader

If it wasn't for patients I just might be able to get my work done, and just how much easier it is to finish a surgery on time if no-one is ill.

Meetings, meetings and yet more meetings. I seem to spend more and more time at more and more bizarre types of meetings. The most bizarre one recently was to discuss our practice patient satisfaction survey with an "educated patient" sent to us by our PCT. It turns out that our patients want to see their doctors when they want, be that morning, afternoon, evening, night or weekends. It's hard to explain that I'm far to busy at meetings to actually see patients.

Another day, another meeting this time to celebrate Practice Based Commissioning or should it be PCT commissioning, as they seem to be increasingly taking over the process. Am I really bothered? To be honest the whole subject bores me. I did not become a doctor to ration health care and take the blame for the shortcomings of the NHS. That was yesterday, today I learn that I will get 97p per patient for taking part and that changes everything I'm now "on the bus". Lets employ lots of non-vocationally trained doctors, who will work for less, to do whatever bits of our job they can do as long as its not core GMS. Just like our esteemed ambulance trust have done with Out of Hours, I think they call them immediate care practitioners. Bring on the smear and sexual health practitioner as I think they will be cheaper than a practice nurse. At least it all will free up more time for me to attend meetings.

I'm glad to hear that some PMS doctors in East Staffordshire may finally be getting a new contract, well done PCT, only 3 years late.

Where did the phrase Quality Adjusted Life Years come from? Is it ethical? It appears that the cheapest operation is one that is never done and the most cost effective patient is a dead one – roll on commissioning.

Any way I've got to go to a critical incident meeting, but as I've been too busy at meetings to actually do any critical work I've not got any incidents to report.

Yours sincerely

Venture