



# NEW CONTRACT NEWS UPDATE

# QOF VISITS AND PATIENT CONFIDENTIALITY

**TOP SECRET**

**NORTH AND SOUTH  
ESSEX LMCS**

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Interim Guidance on QOF Visits and Patient Confidentiality is available on the LMC Website [www.essexlmc.org.uk](http://www.essexlmc.org.uk). The Guidance updates the statements published by the GPC on 1st and 19th October.

The following points are particularly important for practices:-

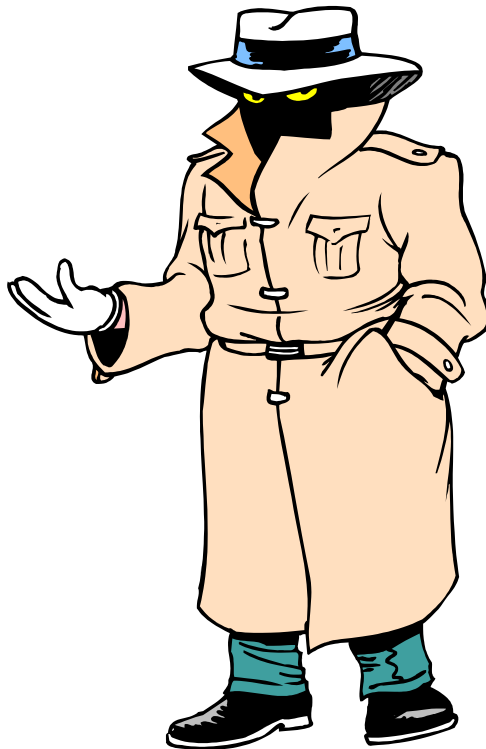
To avoid any possible breach of the Data Protection Act, the GPC believes that practices should not:

- allow QOF assessors access to incompletely anonymised patient records, if informed patient consent has not been obtained
- attempt the 'low-tech' manual methods of anonymisation e.g. photocopying and Tipp-Ex etc., as this involves a risk that patients' records will not be completely anonymised, if the

anonymisation is not carried out properly.

Practices should:

- co-operate with QOF assessors as fully as reasonably possible at the QOF visit



- discuss with their PCO a process for obtaining patient express and informed consent prior to the visit. LMCs may

well wish to carry out these discussions on behalf of their local practices. The GPC believes that the most practical approach is for PCOs to obtain consent.

This approach would also ensure the integrity of the audits, as practices would not have prior information about which records will be accessed. Many PCOs are already taking a sensible approach either by obtaining patient consent prior to the visits, allowing postponements or taking a very 'light-touch' approach in order to allow this round of visits to go ahead as planned.

- discuss any planned course of action with the PCO before making any final decisions. Obtaining consent may mean deferring this part of the QOF visit until

### Special points of interest:

- © Funding Arrangements - Appraisal
- © Information Management & Technology
- © PMS
- © Quality—Access & PCAS questionnaire
- © BMA/ACAS Seminar - 'Employment Law in General Practice'

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**IMPORTANT - PLEASE CIRCULATE TO ALL DRs IN THE PRACTICE**

## Quality—QOF Visits and Patient Confidentiality Cont'd...

consent is obtained. Other aspects of the visit can go ahead, or it may be more sensible to defer the whole visit until consent has been obtained

- refer their PCO to the Strategic Health Authority, if agreement about an approach cannot be reached with the PCO. SHAs have been informed by the Department

of Health that PCOs should take a pragmatic approach to the QOF visits, allowing delays to the visits or at least that part of the visit that requires access to patient-identifiable data until the legal position has been satisfactorily clarified. SHAs are, in turn, passing this message to PCOs

- seek advice from their Local

Medical Committee about any issue of concern. LMCs that are not able to resolve local problems, even after taking the above approach, should inform the GPC.



## Quality—QOF Access & PCAS questionnaire—England

The GPC has received a number of enquiries about a new question on the PCAS return for the November survey in England, which asks practices how far in advance patients are able to book an appointment with a GP. The list of potential answers includes allowing for patients to book up to four weeks or longer in advance.

The GPC did not have advance sight of this question and it clearly goes further than the 24/48 hour access covered by the Specification for the Access Directed Enhanced Service. The GPC will be taking this matter up with the Department of Health (England) on the basis that the

answer to this particular question should not affect practices' achievement of the access targets under the Access DES.

Practices should not be obliged to answer this new question on the PCAS return. However, under paragraph 5.26 of the Statement of Financial Entitlements, eligibility for access payments under the Quality and Outcomes Framework depends on a practice's participation in and performance under the survey. Therefore, to avoid any question about whether QOF payments are due to the practice, the GPC would advise practices to fill in the survey but to make it clear this has been

done on the basis that the practice's

response to this question will not affect their achievement of the access targets or their payments.

Further information and guidance will be issued as soon as a response from the Department is received.

## Funding Arrangements—Appraisal

PCOs have received Department of Health guidance on funding for appraisal. 55% of the total funding available for GMS and PMS appraisal is to be retained within PCO Administered Funds. This will be used to make contributions towards the cost of funding appraisers (including recruitment, training and support costs) as well as the appraisees costs of doctors directly employed by PCOs and of locum GP's. It has been agreed with the GPC

that the remaining 45% of GMS appraisal funds be distributed to GMS contractors through an addition (the appraisal premium) to global sum from 1<sup>st</sup> July 2004. The premium delivers a share of the available funds to each GMS contractor using weighted population. The appraisal premium of £0.26 will therefore deliver a payment of £1542 per average GMS contractor over 12 months as a contribution to the costs of

appraisees.

As the premium is being introduced from 1<sup>st</sup> July 2004 it will not have its intended full year effect. Where PCOs have not made a contribution to GMS appraisee costs in the first quarter a local adjustment will be needed.

The full Appraisal Guidance can be found on our website at [www.essexlmcs.org.uk](http://www.essexlmcs.org.uk)



## Quality -Annual Review visits-Timetable

The QOF annual review commenced in October. Feedback received from PCOs indicates that these have started well. However, some PCOs have advised that a small number of Contractors have been submitting pre-visit evidence after the required date, which puts significant pressure on the visiting team to adhere to their deadlines.

The timetable for QOF review visits is as follows:

- \* PCO notifies Contractor of date of visit at least 2 months beforehand;
- \* Contractor submits pre-visit information to PCT 1 month prior to visit;
- \* PCO identifies areas for discussion during visit and agrees agenda with Contractor 2 weeks prior to visit;
- \* PCO sends draft report of visit to contractor for comment within 2 weeks of visit;

- \* PCO finalises report within 4 weeks of visit.

Practices are encouraged to meet all reasonable demands for information within the agreed timetable. Practices who think they may experience difficulty in submitting information within the agreed period are advised to discuss this with their PCO at an early stage.

## Out of Hours

The Out of Hours Period is defined as 6.30pm to 8.00am Mondays to Fridays and all day Saturday, Sunday, Bank Holidays, Good Friday and Christmas Day. (The Out of hours opt out provisions only apply to these specific times)

The remaining hours, namely 8.00am

to 6.30pm are defined as Core Hours

Practices need to ensure (and, if need be, fund cover for) the provision of essential services during these core hours. Practices are reminded that these provisions are no different from the



current arrangements. Practices are only required to have in place arrangements to ensure that any patient whose clinical condition requires it can access essential services during this period.

## Minimum Practice Guarantee (MPIG)

The MPIG ensures that practice income does not drop in the transition from the statement of fees to the Global Sum.

Practices are reminded that the purpose of the MPIG is to prevent destabilisation and protect income for as long as it is needed.



## Premises

No news since Aug/Sept update



## PCO Administered Funds

No news since January update



# Enhanced Services—Pan Essex Agreement

Since reaching agreement at the end of July discussions have now been held with most PCOs to agree arrangements that will be put in place to fund all non core work undertaken by GPs since 1st April 2004.

The majority of PCOs have agreed to commission a basket of services for 2004/5. Castle Point and Rochford have paid practices on the basis of actual activity following a detailed data collection exercise. Detailed discussions have still to be held with Epping Forest, Harlow, Tendring and Uttlesford.

Details of the 'baskets' agreed so far are shown in the table below and opposite.

## Points to note:

- To qualify for at least part of the payment practices will be required to collect activity data
- The payment for the 'basket' of services is in recognition of **existing** work and the cost of data collection by practices.
- Practices **are not** required to provide all of the services in the basket to qualify for payment. As stated above the payment is in respect of **current activity**.
- Activity should be recorded and **monitored** by practices. Any significant increase in workload caused by changes in Hospital practises should be reported to the LMC/PCT

as a matter of urgency.

The 'basket' arrangement represents a sensible compromise for this year. It is not envisaged that Enhanced Services will be commissioned on this basis in the long term.

The LMC will agree with PCTs a timetable for 2005/6 Enhanced Services Negotiations.

No Negotiation!  
Strictly  
 No Money —No Work



| Maldon/South Chelmsford                       |  |
|---|--|
| 24hr BP Monitoring                            | £1.25 per weighted patient<br><b><u>Not yet agreed</u></b> |
| Cardiac Event Monitoring                      |  |
| Minor Injuries (limited)                      |  |
| Secondary Care Wound Management               |  |
| Pre-Op Assessment                             |  |
| Patient Transport                             |  |
| Investigation at hospital request             |  |
| Certificates for Patients under Hospital Care |  |
| Thurrock                                      |  |
| Pre-Op Assessments                            | 1/4/04 – 30/9/04 25p per patient                           |
| Non urgent patient transport                  |  |
| Certificates for Patients under Hospital Care | 1/10/04 -31/3/05 65p per patient                           |
| Investigations at hospital request            |  |
| Phlebotomy Service                            | PCT agreed underspend to be added to basket                |
| Suture Removal                                |  |

| <b>Basildon</b>                                 |   |
|---|---|
| Secondary Care Wound Management/ Suture Removal | 1/4/04 – 30/9/04<br>25p per patient<br><br>1/10/04 – 31/3/05<br>75p per patient |
| Pre-Op Assessments                              |   |
| Investigations at Hospital Request              |   |
| Certificates for Patients under Hospital Care   |   |
| Non Urgent Patient Transport                    |   |
| Minor Injuries                                  |   |
| 24 hr BP Monitoring                             |   |
| Cardiac Event Monitoring                        |   |
| <b>BBW</b>                                      |   |
| Secondary Care Wound Management                 | £500 per WTE GP<br>No data collection   |
| Pre-Op Assessments                              |   |
| Non Urgent Patient Transport                    |   |
| Certificates for Patients under Hospital Care   |   |
| Investigations at Hospital Request              |   |
| Audiology Screening                             |   |
| Shared Care drugs                               | ? LMC Not in Agreement<br>Clarification to be provided                          |
| Investigation of Hospital DNA                   |   |
| Public Health                                   |   |
| <b>Colchester</b>                               |   |
| Secondary Care Wound Management                 | £500 per WTE GP   |
| Pre-Op Assessments                              |   |
| Non Urgent Patient Transport                    |   |
| Investigations at Hospital Request              |   |
| Domiciliary Vaccinations & Preventative Care    |   |
| Domiciliary Minor Injuries work                 |   |
| <b>Chelmsford PCT/WBH PCO</b>                   |   |
| Minor Injuries (limited list i.e. 3)            | 1/4/04 – 30/9/04<br>50p per patient<br>1/10/04 – 31/3/05<br>75p per patient     |
| Phlebotomy Services (occasional)                |   |
| 24hr BP Monitoring                              |   |
| Cardiac Event Monitoring                        |   |
| Secondary Care Wound Management                 |   |
| Removal of Sutures                              |   |
| Pre-Op Assessments                              |   |
| Investigations at Hospital Request              |   |
| Non Urgent Patient Transport                    |   |
| Certificates for Patients under hospital care   |   |
| Initiating Insulin                              |   |

# Information Management & Technology

Guidance for GP practices on system choice from the GPC and RCGP (September 2004)

The National Programme for IT (NPfIT) has recently issued some 'initial guidance for existing system suppliers' ([www.npfit.nhs.uk/docs/NPFI\\_Tsuppliersguide.pdf](http://www.npfit.nhs.uk/docs/NPFI_Tsuppliersguide.pdf)). The guidance describes the role of existing suppliers in future NHS IT provision.

The GPC has established a joint IT committee with the RCGP (JGPI TC) that has representatives from each of the main system supplier user groups. The joint committee has enabled a more co-ordinated approach so that GPs can stand together and safeguard all their interests. This committee continues to monitor the NPfIT and report back to its parent bodies. As a result of concerns expressed by grassroots GPs this committee reached agreement with the NPfIT earlier in the year and issued a joint statement

([www.bma.org.uk/ap.nsf/Content/NPFI\\_T0404](http://www.bma.org.uk/ap.nsf/Content/NPFI_T0404)) that confirmed that;

- GPs will not be forced to move to any system that has functionality that is less than their existing system.

- That moves to new systems will not be contemplated until data migration issues have been resolved.

- That the JGPI TC is the body that will assess, on behalf of GPs, whether new systems are fit for purpose.

- The GPC has agreed guidance with the Department of Health on funding for general practice IT systems under the new GMS contract. We recommend practices and LMCs make themselves familiar with this guidance, which is available at:

[www.bma.org.uk/ap.nsf/Content/fo cusfundingIMT0404%5Cannexadoh guidance](http://www.bma.org.uk/ap.nsf/Content/fo cusfundingIMT0404%5Cannexadoh guidance).

In addition;

- The National Audit Office has announced that it will review NPfIT. The JGPI TC welcomes this decision. The GPC and the joint IT committee have been assured that they will have an opportunity to input into the official report.

- Progress on extending the functionality of our existing systems to include support for GP2GP transfer, electronic prescribing and e-booking is ongoing.

- Representatives nominated by the



"For that problem, sir, you need to contact the wizard of DOS."

JGPI TC have begun to have meaningful discussions with LSPs about the development of general practice computing.

- Finally the 'initial guidance for existing system suppliers' referred to above states that existing systems may not necessarily be replaced but could be integrated into future LSP offerings.

Given the above it is sensible that users of systems are aware of their rights under the nGMS contract and under the agreed position with NPfIT. It is inconceivable that the GPC or the RCGP would stand by and allow the rich functionality of the systems currently in use in general practice, nor the enormous investment GP users have made in pushing these developments, nor the data they contain, to be squandered. The GPC will continue to demand the rights it has been granted under the nGMS agreement with the Government but it will do so on the principles above and without favouring any specific commercial interest.

## PMS—The PMS regulatory framework

Like GMS contracts, PMS agreements are now subject to a set of consolidated regulations - *The National Health Service (Personal Medical Services Agreements) Regulations 2004*, with which all agreements must comply.

Agreements signed after 1 April 2004 must be drawn up to comply

with these regulations. Existing agreements must, under transitional arrangements, have been brought into line with the regulations by 30 September 2004, either by introducing the necessary variations, or by signing completely new contracts. There are a number of model contracts available.

If the necessary variations have not been made by then or no new agreement signed by 30 September 2004, the PCT may (under the *General Medical Services and Personal Medical Services Transitional and Consequential Provisions Order 2004*) vary the agreement without the consent of

## PMS—The PMS regulatory framework Cont'd

the contractor **but only to the extent that is required to make the existing agreement compliant with the new PMS Agreements Regulations.**

The PMS agreements regulations carry across a great deal of the content of the *National Health Service (General Medical Services) Contracts Regulations 2004*. They deal with such matters as the OOH opt-out procedure, list closure procedure, restrictions on private practice, removal of patients from lists, prescribing and complaints procedures.

### List of patients

The regulations require that it is the contractor who has the list and patients now register with a contractor rather than individual GPs, i.e. it is a practice list as in the case of GMS.

### PMS Provider Status

The following are eligible to become PMS providers, i.e. enter into a PMS contract:

- medical practitioners who meet the conditions set out in the new PMS regulations;
- health care professionals (including General Dental Practitioners) who meet the conditions set out in the new PMS regulations;
- NHS employees;
- employees of PMS or PDS providers
- individuals providing services under a GMS, GDS, PMS or PDS contract
- PCTs or Local Health Boards (LHB);
- NHS Trusts (including NHS Foundation Trusts).

**Right to refuse to register new patients**

This is a controversial area in both GMS and PMS. The GPC has produced a guidance note, *Focus on Patient Registration*, which gives its legal interpretation of the regulations.

The relevant paragraph of the PMS Agreements Regulations is Regulation 16 of Part 2 of Schedule 5, as opposed to Regulation 17 of Part 2 of Schedule 6 of the GMS Regulations.

### Dispute resolution

Part 7 of Schedule 5 of the Regulations sets out the procedure for dispute and appeals. Note that the function of the Secretary of State with regard to disputes over proposed or actual PMS agreements has been delegated to the Family Health Services Appeals Authority (FHSAA)

### NHS body status

**Unlike in GMS, PMS practices must opt not to have health service body status.** They must do so by written notice before the agreement is made. If the agreement has already been signed, the contractor can request a variation to the contract to remove the health service body status provision. The choice should be entirely a matter for the contractors and PCTs should not exert pressure on them either way.

### Movement to GMS

Before 1 April 2004, individual doctors had a right of return to PMS. Under the PMS Agreements Regulations, this right now applies to contractors, rather than individual doctors. Return to GMS is therefore now a practice decision (see part 6, Regulation 19). The contractor must notify the PCO that it wants to enter into a GMS contract three months before the date on which it wants the GMS contract to take

effect.

There is no agreed formal mechanism for determining the financial position of PMS practices who wish to enter into a GMS contract. Whilst these practices have no statutory right to a Minimum Practice Income Guarantee (the income protection guarantee that GMS practices had on transfer from the old to new GMS contract), John Hutton's October 2003 letter to PMS GPs stated

*"A PMS pilot practice could make a strong and robust case for having an MPIG from 1 April in discussion with the PCT. The practice would be expected to provide the data which could be assessed by the PCT using:*

*\* the local data on payments for Global Sum Equivalent items that they may have available for the pilot; this might include some or all of growth monies relating to contract variations forming part of the practice's Global Sum Equivalent*

*\* a national average calculation (if the supporting data are not robust enough to do the calculation) based on PMS earnings and GSE".*

There is no automatic entitlement to retain growth monies on movement to GMS. However, the Hutton letter stressed that this should be allowed *"where a practice provides evidence that some growth should form part of the GSE"*. If the growth money is retained, the PCO may use it for the benefit of patients across GMS and PMS practices.



