April 2007

Safeguarding patient services, maintaining cost-effectiveness

Guidance for GPs

Safeguarding patient services, maintaining cost-effectiveness

Key points:

- In all cases, ensure that the practice is fulfilling the terms of its contract with the PCO
- Do not take on any new ***non-obligatory*** work that is:
    - unfunded
    - under-funded
    - not funded from the correct resource stream
    - not beneficial for patients
- Consider ceasing involvement, ***after appropriate notice***, in all under-funded (including unfunded) local enhanced services
- Provide appropriate information (for example in the form of posters) to ensure that patients know that any action being taken is because of a decrease in practice funding and a need to protect 'core' services as well as maintain commitments to pay practice staff
- Consider closing the practice list if the potential financial loss of taking on new registrants leads to pressure on the practice which could potentially damage patient access to, or the quality of, the services offered
- Enforce appropriate fees for 'collaborative arrangements' and other non-NHS work, taking into account the actual cost to the practice of providing these services
- In England, evaluate the practice's involvement in practice based commissioning.

This guidance has been produced by the GPC in response to the breakdown in negotiations with the departments of health and NHS Employers, and the Doctors and Dentists Review Body (DDRB's) assertion that there should be no increase in GP principals' pay for 2007/08 on top of last year's zero increase. It is aimed at all practices and, unless stated otherwise in individual PMS contracts, it applies equally to both GMS and PMS contracts.

This guidance has been produced in consultation with the BMA's legal advisers to ensure that the advice complies with the complex legislation concerning trade union and industrial action matters. Practices must not take action that would put them at risk of breaching that legislation. The BMA is not suggesting that practices breach their contracts with PCOs, nor that they breach any of their other legal obligations.

Introduction

GPs are concerned about the financial pressure their practices have been subjected to in 2006/7 and will be further subjected to in 2007/08. Many believe that the decision not to provide an inflationary uplift in both years was unfair, not least because these recommendations were implemented at a time of increasing practice costs as well as rising inflation. Immediately following the publication of the DDRB's report this year many GPs contacted the GPC to express their concern about their practice finances and their growing reluctance to participate in politically-driven initiatives of little proven benefit for patients.

The DDRB's report heralds a second year with no increase in funding to practices for the core elements of the contract, despite rising costs and inflation. Its decision will put practices across the country under considerable financial pressure. There can be no doubt that GPs' first priority will be to safeguard patient services from the effects of a reduced practice income. Despite financial pressures they will also wish to continue to reward practice staff fairly.

While it may not be possible to bridge the gap between rising costs and a zero increase in practice income, it is likely that GPs will want to review their practice workload and costs to explore decisions and actions they could take when trying to balance the practice's books. In much the same way that tight NHS budgets have resulted in pressure on hospitals to review their services, primary care providers will now need to take tough business-minded decisions to minimise the effects on both the practice and patient services. Reaching financial balance and working in alignment with the practice's recovery plan will require the full cooperation of all practice staff including doctors, nurses and practice managers.

The new GMS contract was introduced, among other things, to allow practices to 'control their workload by providing them with the ability to choose the services they will provide'. This was to be achieved through a categorisation of services, in which practices would provide:

- essential services

- a range of additional services from which they could opt out, either temporarily or permanently, when experiencing difficulties, and

- enhanced services, which would provide practices with the opportunity to choose whether or not to increase their workload and income by opting in to the provision of a wider range of services.

The new GMS agreement contained a variety of additional elements designed to support the above approach. These included the out-of-hours opt out and the Quality and Outcomes Framework. At the same time, PCOs became responsible for ensuring that patient access to services was maintained, particularly but not exclusively in the event of practices opting out of additional services. This 'Patient Services Guarantee' was made possible by placing, through primary legislation, a legal duty on PCOs to 'ensure an alternative service is provided'.

The first blue book on new GMS *New GMS Contract 2003 Investing In General Practice* clearly sets out the detail described above and principals and practice managers would do well to reread it. It is now out of print but can be found at
www.bma.org.uk/ap.nsf/Content/investinggp

The GPC has returned to that original agreement in preparing this guidance to GPs and practices. The guidance is part of a wider strategy to help GPs manage their businesses and ensure that their services gain the recognition they deserve.

As part of this strategy the GPC intends to conduct a wide-ranging survey of GP opinion which will help accurately gauge current GP attitudes towards present government initiatives. The results of this survey will help inform the GPC's policy and the profession's action over the coming year.

Balancing the practice books – Maintaining financial balance

This guidance will help practices to enable NHS Managers to understand that, like secondary and community providers, practices are responsible for a finite resource. If this resource is reduced, practices will require an appropriate recovery plan to be put in place in order that they can achieve financial balance and safeguard their services to patients, whilst remaining good employers. Practices will also wish to free-up valuable staff resources by directing them away from unnecessary and time-consuming bureaucratic tasks which go beyond the contract/s with the PCO, and redirect them towards frontline services to safeguard patient care and improve practice efficiency.

The GPC strongly encourages practices to review the work they are currently providing beyond the scope of their contracts and to carefully consider requests for new work, particularly work which is already the contractual responsibility of other providers, many of whom will be receiving funding to do it. Work should be assessed in light of the funding available with a view to protecting existing patient services in a way that is cost-effective to practices. As independent contractors, GPs and practices will need to make serious business decisions about which services they intend to continue to provide and those they may wish to cease. Practices should be aware that it is the fact that work is not a contractual obligation upon the practice, and not the fact that work is under-funded, that permits practices to stop doing it,

This guidance identifies a number of measures to help practices with their business planning. Those chosen will vary between practices depending on their unique circumstances and individual GP preferences. **If implemented correctly, none of the measures suggested in this guidance should adversely affect patient care.**

Background - GP expenses

The costs of running a GP practice can be roughly divided into expenditure on the business, premises and staff as well as smaller but still significant expenses such as transport, interest and utility costs. Practice profits are also affected by inflation. As a very rough indicator, applying the forecast rate of inflation for 2007 to average practice expenses with no increase in gross practice income has the effect of reducing practice profits by around 3.3% and a further 3% if one takes into account the reduced purchasing power of that income. The GPC submitted evidence requesting that the DDRB recommended an inflationary uplift in payment across all elements of the contract to restore its value in 2007/08. This inflationary uplift would have had the effect of offsetting rises in practice costs. Without this uplift, while gross practice income may remain unaffected, practice profits will almost certainly fall.

Staff pay is by far the largest cost of running a practice. The Review Body for Nursing and Other Health Professions recommended that staff covered by Agenda for Change should receive a 2.5 per cent increase in income in 2007/08. In addition, the DDRB recommended that salaried GPs employed by PCOs should have the top and bottom points on their salary scale uplifted by £1,000. In accordance with the minimum/model contract for salaried GPs employed by nGMS practices after 1 April 2004, GMS practices will be expected to award their salaried GPs along these lines. For PMS and APMS practices, not withstanding any contractual obligations of the employer regarding pay increases, it will be for the practice to decide whether or how to implement these pay recommendations. The GPC expects that **GPs will wish to reward their staff with fair and appropriate pay increases** along these lines. Any increase in staff costs will need to be met from stationary practice income. It is unlikely that GPs will want to jeopardise the medium to long-term stability of their practices, or the morale of hard-working staff, by failing to award appropriate pay increases.

Suggested strategies for balancing practice's books and protecting patient services

Refuse to accept any new, non-obligatory, under-funded work

Practices are often asked to take on new, under-funded work. As long as this work is new and non-obligatory (ie it does not fall within the explicit or implicit terms of the contract) practices can refuse to take it on. As practices struggle to balance their books in 2007/08 they will be less able and less inclined to take on work transferred from hospitals or other settings. [Practices will be aware that they are often asked to take on such work because the acute provider is carrying out exactly the same cost-limiting exercise that this guidance advises practices to undertake.] Pressure from PCOs to undertake transferred work on the basis of arguments that no-one else will do it should be resisted. In many cases such work could just as easily be done by, for example, community nursing staff or pharmacists. In other cases, where GPs do not wish to take on this work, it will need to remain the responsibility of the traditional provider, often a hospital. This applies to both clinical work and to administrative tasks such as patient transport booking. GPs refusing non-contractual new work should make it clear that it is being refused on the grounds of the financial pressure being felt by the practice. In some cases it may be appropriate to open discussions about the levels of additional funding that would make such work acceptable.

There is no obligation to engage in the provision of enhanced services and they should not be undertaken if they are not felt to be cost-effective for the practice or if the practice feels that the benefits to patients do not justify the workload involved. Costing the provision of any enhanced services will require an evaluation of all the components of the service, including the expense of acquiring and maintaining relevant skills, the time and resources incurred by GPs and other practice staff in organising and providing the service and the premises and equipment needed to deliver the service. Practices will also need to consider any additional opportunity costs of enhanced services provision if other commitments are dropped or sidelined to accommodate the extra work. Practices should cost staff time on the basis of routine appointments lost to such activity and price accordingly. In deciding an appropriate cost for enhanced services, practices will also need to have regard to the prevailing market costs.

Drawing the line – saying no

PCOs and secondary and community providers often try to persuade GPs and their practices that it is *their* responsibility, not the PCO's, to comply with PCO performance management targets, or to take on work which the PCO or other services state they are no longer able to provide. Practices should be aware that they have had, since the introduction of nGMS in 2004, the right under their contract to manage their workload effectively, and they have the right to say no.

The GPC is aware that saying no to PCO's and secondary and community providers is difficult for many practices, particularly when they are made to feel that it is the practice's responsibility to pick up patient services dropped by other organisations. Understanding where to draw the contractual line is important and practices should ensure that GP colleagues, practice managers, nurses and administrative staff are appropriately trained to say no to PCOs, secondary and community providers and other organisations.

The GPC is anxious to learn of circumstances where, as a result of ignorance of the regulations, pressures on PCO systems, or other reasons, GPs or their practices feel they are being subjected to intimidation and/or bullying by the PCO as an organisation, or by any individual working for a PCO. It can be difficult to identify at what point PCO attempts at reasonable persuasion become intimidation or bullying, or whether such behaviours have been so insidious as to have become part of the local management culture. Such behaviour is always unacceptable. Through GPC Wales, the BMA has previously circulated *Bullying and harassment in the workplace* to assist LMCs and practices in dealing with it. This can be found on the BMA website www.bma.org.uk/ap.nsf/Content/bullyingWales?OpenDocument&Highlight=2,bullying.

Should it be impossible to reach agreement about services with the PCO, GPs should be aware of the dispute resolution procedure which is set out in Schedule 6 Part 7 of the GMS regulations.

Review involvement in enhanced services

Practices should identify the funding for all enhanced services already provided by the practice. In particular, they should consider the workload implications of, and remuneration for, engagement in enhanced services, whether directed or local. Where an enhanced service is not properly funded (for example, where the PCO is not offering an inflationary uplift to the price of the contract in 2007/08, where a PCO has chosen to dispute the running or funding of it, or where the monitoring of the service is excessive) practices may wish to consider ceasing provision. Practices should be aware that the cost of providing enhanced services will change over time. For example, if appropriate, practices should consider the additional cost of either using disposable instruments, or sending re-usable ones for off-site decontamination.

It is important that practices only withdraw enhanced services after the correct notice period, usually three months, has been completed. The notice period and method for terminating enhanced services varies and should be carefully adhered to. Practices will need to be aware that where such contracts are terminated, PCOs will be free to contract the services elsewhere and that there is no guarantee that they will get them back.

Conversely, practices may be able to identify new services that they could provide through an adequately funded local enhanced services arrangement to help balance the practice's books. The GPC maintains a list and examples of local enhanced services provided by practices around the country (see appendix 1).

Practices should be aware of the status of recently negotiated Directed Enhanced Services (DESs) (see appendix 2). The funding for several DESs is now coming to an end and, as with local enhanced services, practices may wish to consider whether or not to remain involved in the work associated with these arrangements beyond the end of the earmarked funding. Where practices are keen to continue with the service but where centrally negotiated DESs are no longer available, it may be possible for the LMC or practice to negotiate a local enhanced service. Practices must ensure that any action taken in relation to DESs is in accordance not only with the initial DES but also with any additional contract agreed at a local level in relation to that DES.

The GPC is aware that many practices in England are seriously considering their involvement in Choose and Book (C&B). Whilst most practices have tried to use C&B to some degree, fewer than 35 per cent of referrals are currently made in this way as many GPs have found the system an ineffective, time-consuming burden on staff and doctors' time and one that has not

improved the service to patients. In some areas there is also evidence that PCTs abuse the system by using it to restrict access to certain services, simply by removing them from the C&B menu. The one-year (2006/07) 'Choice and Booking' DES came to an end on 31 March 2007. Although the status of the Choice and Booking DES for 2007/08 is uncertain at present, it is likely that many GPs will evaluate their involvement in C&B over the next year, particularly where they feel the use of the software offers no real benefit for patients and takes up too much time. Whether or not Choice and Booking continues as an English DES, there are local enhanced services arrangements in some areas to incentivise participation in the C&B. Practices will need to consider the available funding as well as the factors discussed above when deciding whether or not to become involved in the scheme.

It is important that everyone in the practice is able to explain to patients, if asked, why the practice is making changes to its services and inform them who they should speak to if they have any concerns.

Consider whether to take on new patients

Most practices (ie most GMS practices on MPIG) currently take on new patients below, and often substantially below, the sum intended under the global sum funding formula. Under these circumstances, there can come a point where the registration of new patients creates an unacceptable pressure on the practice in view of the funds available and can, ultimately, threaten the quality of patient care. If taking on new patients is not economical, the practice may wish to consider moving to a closed or an 'open but full' list. This is a strategy that requires careful consideration and full compliance with the regulations, as set out below. In some cases, taking on new patients will still make financial sense. Where it does not, practices will need to weigh up the desire of all GPs to offer patients good access and ease of registration with the financial problems caused by the fact that adequate money does not always follow new patients. GPs considering this course of action to protect the quality of patient services should be aware of the potential for increasing opportunities for Alternative Provider Medical Services (APMS) to enter the market, particularly in under-doctored areas. It is of course also the case that PCOs can assign patients to practices until or unless they formally close their lists and that there are procedures in place to assign patients in areas with closed lists.

Closed and 'open but full' lists

Under the new contract, GMS practices which do not wish to have patients assigned to their list by the Primary Care Organisation (PCO) must go through the list closure procedures set out in paragraphs 29-31 of Part 2 of Schedule 6 of the National Health Service (General Medical Services Contracts) Regulations 2004 or their equivalents in the other three countries of the UK. If the PCO or the assessment panel approves the closure notice, the contractor's list is officially closed to assignments. The closure period will then be either for a maximum of 12 months or if a range was specified in the closure notice until such earlier time when the number of patients falls below the bottom figure of the range.

As a completely separate issue, and no matter whether or not it has gone through the list closure procedure mentioned above, a GMS contractor retains its freedom under the new contract not to register new patients, *provided it has reasonable and non-discriminatory grounds for doing so*, such as protecting the quality of patient services. In such cases, it may refuse to register new patients under paragraph 17 of Part 2 of Schedule 6, which is reproduced below, or its equivalent in the other three countries.

"(1) The contractor shall only refuse an application made under paragraph 15 or 16 if it has reasonable grounds for doing so which do not relate to the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.
(2) The reasonable grounds referred to in paragraph (1) shall, in the case of applications made under paragraph 15, include the ground that the applicant does not live in the contractor's practice area.
(3) A contractor which refuses an application made under paragraph 15 or 16 shall, within 14 days of its decision, notify the applicant (or, in the case of a child or incapable adult, the person making the application on their behalf) in writing of the refusal and the reason for it.
(4) The contractor shall keep a written record of refusals of applications made under paragraph 15 and of the reasons for them and shall make this record available to the Primary Care Trust on request".

Should a practice be unable to accept patients routinely, a discussion between the practice and the PCO could take place to allow the situation to be resolved. This may involve, for example, additional support being given by the PCO or a formal closure of the list.

The contractor 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 as in paragraph 3 of the extract above. The PCO may still assign patients to the contractor's list under paragraph 32 of Part 2 of Schedule 6, as its list is open to assignments within the meaning of the Regulations. There are equivalent procedures in the Regulations of the other three countries of the UK.

An open but "full" list reflects a) the legal status of the list with regard to assignments under the new Regulations and b) the contractor's discretion to refuse to register new patients if it has reasonable grounds to do so. A contractor should bear in mind that the PCO may ask it to justify the reasonable grounds that it has used to refuse to register a patient. Practices must ensure that their actions do not discriminate between patients on the grounds of the applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. A written acceptance policy will enable practices to refute any suggestion of improper rejection of applications.

Evaluate involvement in practice based commissioning (PBC) in England

Practices are not obliged to undertake any commissioning activity if they do not wish, or are inadequately resourced, to do so. However, Practice Based Commissioning (PBC), where implemented correctly, offers GPs the potential to gain greater influence and control over local health services, thereby improving patient care and experience, as well as the possibility to generate resources for primary care. Further, through service redesign PBC offers the potential to invest in primary care infrastructure, including premises, in the context of scarce, if any, funding from other income streams. Practices should therefore consider involvement in PBC as a business and service decision, and will need to weigh-up the short-term costs and workload of involvement in PBC with the longer-term benefits – including the prospect of control over income-generating provision of services – and the risk of allowing commissioning of behalf of their patients to be done by others.

The Department of Health's own guidance on PBC strongly encourages PCOs to hand over local health budgets to practices and consortia, in order that services can be delivered closer to patients' homes in accordance with government policy, and in a way which enables practices to develop the services in primary care necessary to deliver that policy. Recent guidance also details the arrangements for PBC in 2007/08, including the mechanism for practices to secure adequate management resources for their involvement, their entitlement to freed up resources, the process to apply for service redesign costs, as well as the ability to provide new services in

primary care without the need for tendering. It is vital that practices are aware of and demand these entitlements. To aid local negotiation, we have summarised the key points in a series of GPC guidance notes.

With only a few exceptions, PCTs have failed to promote the Department of Health's PBC policy, and SHAs, which are supposed to have performance managed the process, have by and large been complicit with that failure. Moreover, the government has signalled its preparedness to hand commissioning over to the private sector through the introduction of a national framework under which PCTs will be able to buy-in the necessary services in order to fulfil their commissioning function. Because PBC is the process that defines which services are commissioned, it is important for practices to understand the risks to practices of such a handover as well as the opportunities if PBC is controlled by NHS practices already in contract with the PCT. Despite the inertia of PCTs and SHAs, and even in the face of the barriers placed in front of PBC by those organisations, in the light of the risk from the private sector, practices should evaluate:

a) whether they and their LMCs should continue to tolerate such inertia and barriers
b) whether they and their LMCs should publicise their PCT's failures in this area
c) the risk of pulling away from the commissioning process

Practices or consortia considering involvement in PBC will need to define and cost their management requirements according to their commissioning activity. These costs will include:

- practice-level clinician and/or management/administrative time, taking into account full locum costs to allow for backfill as necessary
- consortium-level clinician and/or management/administrative time, taking into account full locum costs to allow for backfill as necessary
- any necessary training or research costs
- specialist advice where necessary
- costs arising from data management, IT or administrative functions.

The DoH guidance on PBC affirms practices' rights to adequate resources and PCT support for PBC, and further that as commissioners they have some control over the use of the PCT's management resource, with the ability to use this resource for independent support if the PCT is unable to meet its commitment. There is additional provision for practices to receive funding via local incentive schemes in 2007/08 to replace the PBC DES which ended in March 2007.

The GPC urges practices to negotiate with PCTs on these terms, to ensure that involvement is matched with commensurate resources. The Department's guidance also specifies involving SHAs to arbitrate should practices feel their PCT is failing to honour its commitment to PBC.

Unfortunately, if after all negotiation, the PCT fails to provide requisite management costs, practices may be forced to reconsider the level of commissioning they wish to take on based on a judgement that involvement should be limited to match the resources on offer from the PCT. Practices considering limiting their involvement in PBC should have strict regard for any contractual arrangements already entered into. Practices would be well advised to attempt to negotiate adequate support for PBC (through LMCs where appropriate) before resolving to limit their participation based on funding considerations.

The Department of Health guidance encourages practices and/or PBC consortia to develop their provider services in line with their PBC plans, via submission of a business case to the PCT. Practices and consortia must ensure that the business case includes the management resources required to deliver the service, the up-front costs required for the proposals and their recovery period. Again, practices should ensure that they seek and receive adequate funding for such services. It should be noted there is no need to tender under a new 'any willing provider' model, however under these arrangements practices should be aware that PCTs' contracts with practices will not set any level of guaranteed income/payment or activity/volume (sophisticated contractual terms should minimise such risks).

A potential drawback of ceasing to provide enhanced services, stopping the registration of new patients or deciding to opt-out of practice based commissioning is that it opens the market to the involvement of alternative providers. In particular, non-cooperation with PBC will reduce the role GPs play in the local health service and could encourage APMS providers to assume this role instead. Properly supported, continuing or fresh involvement in PBC may increase practices' influence and help generate additional income during these challenging times.

Ensure the practice costs, sets and charges appropriate fees for work undertaken under the 'collaborative arrangements'

Practices should ensure that they are costing fully and charging appropriate fees for non-contractual work, whether for the NHS or other bodies, and particularly for work done under the collaborative arrangements.

The collaborative arrangements encompass medical services provided by PCOs (through GPs) to local authorities to enable local authorities to carry out their responsibilities in the fields of education, social services and public health. The collaborative arrangements are not part of the GP contract. Examples of work done by GPs under collaborative arrangements include housing reports, certificates produced in relation to parking permits for disabled patients and attendance at case conferences and other meetings arranged by social services. In many areas the collaborative arrangements cover most of the work commissioned by local authorities in the fields of education, social services and public health.

Until 2005/06, (with the exception of 1996/97) the rates for work under collaborative arrangements were set by the DDRB and issued via an NHS circular. For many years the GPC argued that these fees were too low and did not reflect the true cost to the practice of performing this work. Since April 2006, however, the DDRB has advised doctors to set their own fees for work performed under collaborative arrangements. It is important to note that it is for individual GPs and their practices to decide whether or not to continue carrying out this work based on the rates published for 2005/06 or whether to set their own / practice fees. Should a practice decide to decline work it has customarily provided under collaborative arrangements, it should give an appropriate notice period (three months) to relevant contracting bodies It is the BMA's opinion that practices have no obligation to accept collaborative fee rates unilaterally issued by PCOs.

Setting fee rates under the collaborative arrangements

As a general rule, if a doctor no longer wants to undertake the work under the collaborative arrangements based on the 2005/06 rates, the doctor may withdraw from any existing arrangements by giving reasonable written notice. The BMA believes that three months' notice would be reasonable. [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.]

GPs who wish to change their fees for collaborative work should notify their PCO in writing that, as there is no longer a DDRB recommended fee, any request for collaborative work received after a set date will be charged at their own fee rate (the BMA recommends that a notice period of at least three months be set). In setting the appropriate fee, GPs will need to ensure that their remuneration levels and overheads are charged on a time basis. Fee levels must be reasonable, transparent and subject to scrutiny where necessary. It is important to

note that Competition legislation and the Office of Fair Trading prohibit the BMA, or local medical committees (LMCs) from advising on or negotiating collectively such fees.

Individual practices are free to advertise their rates in publicly accessible locations such as the internet but *under no circumstances* should practices discuss their fees with one another as otherwise it would be extremely difficult to rebut any charge of cartel creation. The penalties for such activities are very severe indeed and would bankrupt many practices, possibly also leading to imprisonment of the perpetrators.

Further information on collaborative fees arrangements can be found at:
www.bma.org.uk/ap.nsf/content/CollabArrange

Charge appropriate fees for all non-NHS work

The BMA (through its professional fees and forensic medicine committees) negotiates a range of fees to cover many non-NHS services and is currently preparing detailed advice for members on how doctors should go about setting their own fees where the work is not covered by national agreements. Fee agreements are listed in a series of BMA fees guidance schedules available on the BMA web site; they relate to local and central government work, medico-legal work, insurance work and a wide range of reports, examinations and certificates for patients or third parties. They also cover areas such as cremation certificates, work for coroners and work as forensic physicians (police surgeons).

A key consideration in taking on non-NHS work will be to cover the expenses incurred in doing it and to ensure a reasonable profit margin. Expenses will include elements of the GP's practice staff, premises and equipment as well as medical indemnity and professional subscriptions. If mileage or travelling expenses are incurred these should be included. Once these calculations have been made, the doctor needs to consider the 'professional' element of the charge. This should reflect not only the time devoted to providing the service but also the doctor's assessment of the value of the professional training, skills and clinical experience he/she brings to the work in question. In determining what, if any, fee to charge, a doctor should be aware of the extent of the responsibility they are undertaking and should decide what they consider to be a fair and reasonable fee in the light of the time and effort needed.

Clearly the expenses and reimbursement for services vary from GP practice to GP practice. Individual charges may also vary and consideration must be given to such matters as the

variable length of consultation, which may be determined by the complexity of the case or difficulties in communication. Where doctors charge patients directly for services, the BMA advises them to forewarn patients, before agreeing to provide services, of the likely level of fees, including the fees of other doctors who might be involved. Where the work is not covered by a national agreement, an estimate of the time it would take to complete the work should also be given. The BMA Professional Fees Committee advises members that, where a third party commissions a medical report or examination which it requires for its own purposes, that third party is liable for the costs involved; fees for providing a service to a third party should always be agreed before any work is undertaken. Larger practices and all those practices which dispense must remember that VAT may be applicable in many cases and the BMA recommends that all fee quotations should include the phrase 'VAT, where applicable will be levied at the current rate in ADDITION to the fee quoted'.

General practitioners should always ensure before levying a charge for a service that they do not have an obligation to provide the service without charge under their contract for primary medical services; similarly employed doctors, or those providing services to community hospitals, must ensure that they are not required to provide the service under their contract of employment or terms and conditions of service. Some services must be provided without charge by statute. General practitioners must also ensure that when setting their fees that they are aware of the obligations of the 1998 Competition Act and do not act in an anti-competitive manner. **Doctors should always ensure that their fees for providing a service are agreed before any work is undertaken.**

Summary

In summary, in view of rising practice expenses and the DDRB's recommendation, endorsed by the government, that GPs receive no increase in their pay in 2007/08, the GPC recommends that practices seek to safeguard patient services through the following measures:

1. Refuse to accept any new, non-obligatory, under-funded work
2. Review involvement in enhanced services
3. Consider whether to take on new patients
4. Evaluate involvement in practice based commissioning (PBC) (in England)
5. Ensure the practice charges appropriate fees for work undertaken under collaborative arrangements
6. Charge appropriate fees for all non-NHS work
7. Always ensure, in taking the above steps, that practices continue to comply with contractual and other legal obligations.

Appendix 1 – Examples of local enhanced services

The GPC maintains a central database of LESs to share with LMCs, GPs and other interested parties when requested - it should be noted however that we have not reviewed the agreements and do not necessarily circulate them as models of good practice. Copies of individual LESs can be requested by emailing myahaya@bma.org.uk

- Access
- Asylum seekers and immigrant services
- Basket LESs
- Cancer
- Contraceptive implant fitting and removal
- Diabetes management
- Diagnostic services
  - Sigmoidoscopy
  - Spirometry
- Drug services
- ECG
- Health promotion
- Holidays and weekend services
- Insulin initiation
- Intermediate care facility
- Learning disability services
- Mental health
- Minor injuries
- Minor surgery
- Near patient testing and drug monitoring
- Neonatal checks
- Nursing homes
- One-off services
  - 24 hour ambulatory blood pressure monitoring
  - Child protection
  - Community dermatology
  - Hormonal implant services
  - Immediate and first response care
  - Palliative care
  - Patients resident in women's refuge
  - Vasectomy
  - Violent patients
  - Weight management brief intervention
- Other chronic disease management
  - Chronic disease management LESs
  - HIV
  - Leg ulcer
  - COPD
  - Heart failure
- Phlebotomy
- Practice support LESs
- Service continuity
- Smoking cessation
- Student and university services
- Teenage and young person services
- Treatment room
- Vaccinations and immunisations
- Wound care
- Zoladex injections and prostate cancer follow up

[List updated: 22 February 2007]

Appendix 2 – status of recent Directed Enhanced Services

Here is a list of all the DESs and details of their status as of April 2007.

UK

1) Childhood immunisations

The original DES, including the agreed funding, will still apply and PCOs continue to be legally obliged to commission the service from all GMS and PMS contractors in the area.

2) Influenza and pneumococcal immunisation

The original DES, including the agreed funding, will still apply and PCOs continue to be legally obliged to commission the service from primary medical services contractors in the area. Note that the DES has not been amended to include any other at risk groups, such as poultry workers, but this group may be covered by a local enhanced service (LES), for which the same rates as stipulated in the DES should apply.

3) Minor surgery

The original DES, including the agreed funding, will still apply and PCOs continue to be legally obliged to commission the service from primary medical services contractors in the area.

4) Service to support staff dealing with violent patients

The original DES, including the agreed funding, will still apply and PCOs continue to be legally obliged to commission the service from primary medical services contractors in the area.

5) Quality information preparation

The original one-year 2004-05 DES ceased to apply from 1 April 2005.

For further information, refer to the following website addresses:

Primary Medical Services (Directed Enhanced Services) (England) Directions 2006
www.dh.gov.uk/assetRoot/04/13/68/70/04136870.pdf

DES specifications
www.bma.org.uk/ap.nsf/Content/Hubdirectedenhancedservices

England

1) Access to primary care

The original UK-wide access DES was replaced with a new, one-year 2006-07 DES specific to England; this came to an end on 31 March 2007. The status of the intended review of the access DES for 2007-08 is uncertain at present. LMCs will be informed of any developments accordingly.

2) Towards practice based commissioning (TPBC)

This one-year 2006-07 DES came to an end on 31 March 2007. There will be no national successor, however unlike the other one-year DESs, there is a definite proposal from the Department of Health to enable GP practices to continue this work in 2007-08, via locally agreed incentive schemes (see paragraphs 4.10-4.13 of the latest Department of Health guidance on PBC, 'Practical implementation').

3) Choice and booking

This one-year 2006-07 DES came to an end on 31 March 2007. The status of the intended review of the choice and booking DES for 2007-08 is uncertain at present. LMCs will be informed of any developments accordingly.

4) Information management and technology

This two-year DES, 2006-08, has one year remaining.

For further information, refer to the following website addresses:

Primary Medical Services (Directed Enhanced Services) (England) Directions 2006
www.dh.gov.uk/assetRoot/04/13/68/70/04136870.pdf

Revisions to the GMS contract, 2006/07 - delivering investment in general practice, February 2006
www.bma.org.uk/ap.nsf/Content/revisionnGMSFeb20062

Northern Ireland

1) Access to primary care

The original UK-wide access DES was replaced with a new, one-year 2006-07 DES specific to Northern Ireland; this came to an end on 31 March 2007.

2) Long-term condition management

This one-year 2006-07 DES came to an end on 31 March 2007. However, as this DES was funded with recurrent money, it is possible that it will be rolled over to 2007-08; clarification on this point is being sought at present.

For further information, refer to the Primary Medical Services (Directed Enhanced Services) (Northern Ireland) Directions 2006 as follows:
www.dhsspsni.gov.uk/pms_des_directions_ni_2006.pdf

Scotland

1) Access to contractor-based primary care services.

The original UK-wide access DES was replaced with a new, one-year 2006-07 DES specific to Scotland. This DES will continue unchanged in 2007-08.

2) Cardio-vascular disease (CVD) risk dataset

This one-year 2006-07 DES came to an end on 31 March 2007.

3) Cancer referral

This one-year 2006-07 DES came to an end on 31 March 2007.

4) Adults with learning disabilities

This one-year 2006-07 DES came to an end on 31 March 2007.

5) Carers

This one-year 2006-07 DES came to an end on 31 March 2007.

Discussion is currently taking place on a programme of services that Health Boards will be funded to commission through local negotiation in 2007-8.

For further information, refer to the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2006 as follows: www.sehd.scot.nhs.uk/pca/PCA2006(M)03.pdf

Wales

At the time of publication, national negotiations in Wales regarding DESs were on hold. Welsh GPs will be kept informed of any developments.

1) Access

The original UK-wide access DES was replaced with a new, one-year 2006-07 DES specific to Wales; this came to an end on 31 March 2007.

2) Severe mental illness

This one-year 2006-07 DES came to an end on 31 March 2007.

3) Learning disabilities

This one-year 2006-07 DES came to an end on 31 March 2007.

4) Information management and technology

This one-year 2006-07 DES came to an end on 31 March 2007. The future of this DES is being considered at present.

For further information, refer to the Primary Medical Services (Directed Enhanced Services) (Wales) Directions 2006 as follows:
www.wales.nhs.uk/sites3/Documents/480/DES%5F%28Wales%29%5FDirectionsv2%5F4%5F%4030%2D3%2D06%2Epdf