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## 1. PCTs to seek 'better value' from PMS Contracts

Several PCTs around the country are attempting to renegotiate PMS deals, with many GPs facing the prospect of taking on new work without additional funding.

A directive from the Department of Health on this year's pay deal has made it clear that 'a smaller proportion of PMS practices' should receive an uplift than GMS GPs.

PCTs appear to be looking at a variety of options to help drive up value for money. This includes adding further contractual obligations to PMS practices or asking GPs to justify their funding.

Many PCTs have begun holding meetings and reviewing PMS objectives to discuss how GP's could provide better value with their existing levels of funding.

The attempts to renegotiate terms are likely to cause much concern for GPs with many arguing that they are unable to get any more

value out of their contracts and that there is little scope to take on additional work.

PCTs have traditionally been thought to have the stronger bargaining position in negotiations about PMS terms because the regulations permit them to terminate a PMS agreement on notice if practices do not agree to their proposals.

However, the recent Court of Appeal decision in the dental case of *Crouch v South Birmingham PCT* suggests that the right of a PCT, in the case of Personal Dental Services contracts, to terminate on notice is a procedural provision which is exercisable only when one of the other specified grounds for termination applies. The *Crouch* judgment is very likely to be applicable in the case of PMS and, arguably, significantly reduces PCTs' bargaining power.

Without the threat of termination by notice, practices are more likely to be able to resist attempts to alter their contractual terms. PCTs are only able to impose contract changes where this is required to give effect to legislative changes. Otherwise changes must be by agreement of the parties.

GPC negotiator Dr Peter Holden said: 'It was always a risk with a local contract that when PCTs were strapped for cash they'd want more bang for their buck.'

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## 2. Local NHS funding plans announced

The health secretary Alan Johnson has revealed that NHS primary care trusts are to receive £164 billion in funding for 2009-10 and 2010-11. This amounts to an average increase of 5.5% over both years, thus continuing Government investment that has seen funding treble since 1997.

The announcement will mean a funding rise to an average of £1,612 per person by 2010/11 compared to £426 in 1996/97.

He said: "We will sustain our investment in the health service over the next two years as the NHS continues to deliver significant improvements against key priorities."

Strong financial management has meant that the service is on firm financial footing, but he also warned, "During these tougher economic times the NHS, along with the rest of the public sector, will have to make its contribution to delivering greater efficiency."

PCTs now control a greater proportion of funding, over 80% of the total NHS budget, giving them the freedom and flexibility to spend according to the needs of local people.

The government have stressed that they are intent on "securing high quality care for all, because better care means better value."

It appears that despite the tough economic climate, the NHS is well placed to meet the challenges ahead.

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### 3. Generic Substitution

Pharmacists can, from January 2010, substitute generic drugs for branded drugs even if GPs specify a branded product. This will bring about a 5 per cent year on year saving to the annual NHS drugs bill.

Generic substitution has been put in place as a cost saving exercise. The only method by which a generic substitution cannot be used is if the prescribing doctor ticks a box to insist that the branded medicine is used. However, the Government have warned that if too many GP's tick the box then adjustments would need to be made 'to correct any under or over delivery.' Their 'adjustments' could result in GP's losing the right to prevent pharmacists from overruling their selection.

There will also be exceptions on 'clinical' grounds. However, the proposal has received a cautious response with a call for clear guidance on when generic substitution is appropriate, and relevant advice and reassurance for patients from their pharmacists.

Reassuring and advising patients raises concerns for many, particularly because when patients are ill, confused or cannot read, they may be unable to verify if they have been prescribed the right medication. This is especially true when generic substitutions of medicines are used as they may be packaged differently, be a different shape and colour, and the tablet may look different. The generic medicine may also have a different name.

Another problem can be that the pharmacist will not have a full clinical history of a patient that they decide to use a generic substitution for and the generic substitution may not be comparable, for example by the ingredients used, to the branded medicine. This could cause adverse effects to the patient.

Dr Bill Beeby, Chairman of the GPC Clinical and Prescribing Subcommittee, said the plan represented a 'fundamental shift' that had significant risks for patients.

However, Health Secretary Alan Johnson welcomed the scheme as 'delivering value for money for the NHS and the tax payer.'

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### 4. Photographing and Recording Patients

Whenever you are considering taking a photograph or otherwise making an audio or visual recording of a patient, you must ensure that you follow the GMC guidance in Making and Using Visual and Audio Recordings of Patients 2002.

If you want to take a photograph of a patient you must first obtain permission from that patient and consent for any use or disclosure of the photo. When seeking permission from a patient you must make sure that the patient is given adequate information about the purpose of the photograph and the patient should not be put under any pressure to give permission.

A problem can arise if permission is not obtained as a patient may be identifiable by someone that knows them. You should bear in mind that a feature that you consider to be insignificant may still be capable of

identifying the patient to someone they know.

With some exceptions (please see below), any recordings that are made as part of the assessment or treatment of patients will also require permission; in this case an oral explanation is sufficient. You should make sure that you put in the patient's medical notes that they have given permission.

The same applies for recordings used for public media; however, in this case, written permission must be obtained, even if you think that the patient is not identifiable. The patient must be made aware that once permission is given it may not be possible to withdraw consent for subsequent use. The GMC advises that if a patient would like to restrict use of the recording, permission in writing should be obtained from the owners of the recording before the recording begins.

The above restrictions do not apply to images from pathology slides, x-rays, internal organs and ultrasounds; although you should ensure that they are anonymised if they are used otherwise than in the course of assessing or treating the patient. The GMC advises that it may still be appropriate 'to explain to the patient, as part of the process of obtaining consent to the treatment, that a recording will be made,' even though express consent is not required for these types of recordings.

For further advice on the information in this article please visit the GMC website on [www.gmc-uk.org](http://www.gmc-uk.org).

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## 5. The Independent Safeguarding Authority (ISA)

This is a follow on article from our Criminal Advice Bureau (CRB) article which was published in the November newsletter. To help prevent harm to children and vulnerable adults, a Vetting and Barring Scheme (VBS) will come into force from October 2009. The VBS will be run by the Independent Safeguarding Authority (ISA). ISA will work with the CRB to ensure that unsuitable people are prevented from working with children and vulnerable adults.

Each applicant will be assessed in accordance with data gathered by CRB. The data will include criminal convictions, cautions, police intelligence and anything else that may be considered appropriate. Everything is decided on a case by case basis. Only applicants who are judged not to pose a risk to vulnerable people can be ISA registered. Individuals can only work with children or vulnerable adults once they are ISA registered.

The CRB will initially receive applications to the ISA and will be involved in gathering and monitoring the information. ISA will assess all the information and will come to a decision on whether to give the applicant ISA registration or to put them on one of the ISA "barred lists".

ISA will keep all information up to date; therefore, if new information is produced about a person they can then be put on a barred list, even if they were previously registered.

The VBS has been set up by the Safeguarding Vulnerable Groups Act 2006. The Act states that certain activities in relation to children and vulnerable adults are regulated. A "regulated activity" is any activity which involves contact with children or vulnerable adults. This could be paid or voluntary work. These activities can include:

- any activity of a specified nature which involves contact with children or vulnerable adults frequently, intensively and/or overnight;
- any activity allowing contact with children or vulnerable adults that is in a specified place frequently or intensively;
- fostering and childcare; or
- any activity that involves people in certain defined positions of responsibility.

In the case of the NHS a specified activity would be any form of treatment or therapy provided to a child or vulnerable person. Further guidance on regulated activities can be found on [www.isa.gov.uk](http://www.isa.gov.uk).

An employer will commit a criminal act if they employ a barred person, employ someone who is not registered with ISA or fail to check

the status of a person if that person works in a regulated activity. In addition, if an individual that is barred takes part in a regulated activity that individual will be committing a criminal offence.

To register on the ISA scheme individuals can go to the ISA website, stated above, and download an application form, or can request an application form from their employer or professional body. There is a charge if the employment is paid.

An individual will still need to get a CRB check as this provides a clearer picture of a person's criminal history.

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## 6. Funding Freeze for Welsh GP Premises

Plans to develop Welsh GP practices have been put on hold until after the NHS reorganisation in Wales.

The Welsh Assembly Government instructed Local Health Boards to cease planning for the modernisation of GP Premises, known as 3PD primary care projects, whilst a reorganisation of Local Health Boards takes place.

BMA Cymru Wales said it is extremely concerned about the delay in the redevelopment of GP practice premises, and that many doctors may have to work in premises that are inadequate and not fit for purpose.

As many as 140 projects could be affected by the decision, and there is a fear that third party developers may become unsettled by the delay and will begin to look elsewhere. Schemes that have already appointed a third party developer may still proceed, but those that have not may have to wait up to a year before the reorganisation actually takes place. Patients who have to visit their doctor in unsuitable surgeries across Wales will now have to wait years before they see an improvement in building standards.

A Welsh Assembly Government spokesperson responded: "With the restructuring of the NHS, the Assembly Government has asked that a prudent approach is taken."

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## 7. Primary Care Privatisation

The Government are considering new plans that could enable Primary Care Trusts (PCTs) to sell their properties to the private sector.

In the pre-Budget report, Alistar Darling announced that the Department of Health will allow PCTs to extend the current Local Improvement Finance Trust (LIFT) programme 'to the management of their entire estate.'

LIFT companies are the public-private partnership investment vehicles, implemented in 2001, to help finance new PCT facilities. Currently, they focus largely on delivery, carrying out schemes given to them by PCTs.

However, the new proposals raise the prospect of LIFT companies playing a much bigger role; this includes, but is not restricted to, deciding how much new building work is carried out and how many old sites are sold off.

Only around a half of PCTs were involved in the original programme and many concerns have been raised over the affordability of the schemes.

The Government recently launched an 'accelerated' version of LIFT, which extended access to other PCTs; the latest decision appears to provide another much needed boost to the flagging scheme.

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## 8. Insolvency of a Provider Company

There are a number of issues raised by the potential insolvency of a private limited company that has formed as a provider vehicle for the provision of healthcare services. One important aspect is the effect that the insolvency could have on the contract of an individual GP with their PCT where the GP is a director of the company.

It is our understanding that, should a company become insolvent, unless the directors of the company have done anything fraudulent or have acted outside of their

powers, the GMS contract or PMS agreement that the director holds with the PCT will remain unaffected. The individual agreement through the directors own practice will not be compromised and will continue to be held by the director.

If you have any questions about this, please contact Michael Barrett at [mb@lockharts.co.uk](mailto:mb@lockharts.co.uk).

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## Previous Issues

If you would like to receive previous issues of the Lockharts Newsletter please contact Kabir Savjani at [csd@lockharts.co.uk](mailto:csd@lockharts.co.uk).

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