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### 1. GP Consultations on the rise

New figures show that general practice consultations in England have risen from 217.3 million in 1995 to 300.4 million in 2008.

A typical GP practice in England conducted 34,200 consultations in 2008, compared with 21,100 in 1995, and saw patients an average of 5.5 times a year compared with 3.9 in 1995, shown in data published by the NHS Information Centre.

The study was conducted using the QResearch database of nearly 600 general practices and shows a change in the proportion of patients seen by nurses in primary care.

In 1995, 76% of consultations were with GPs while 21% were given by nurses and 3% by other primary care staff. However by 2008, the proportion of consultations with GPs had fallen to 62%, while nurse consultations rose to 34% and further those with other staff rose by 1%.

Telephone consultations have quadrupled from 3% to 12%, while home visits fell

from 9% to 4%, which may reflect the change in out-of-hours care provision over the period of analysis.

The highest consultation rates were seen in the elderly, at 13.8 and 13.3 consultations per person per year in the 85-89 year old age group.

A more recent comparison shows that GP practices in England conducted an estimated 12 million more consultations in 2008/9 than the previous year. The data show that demand jumped by 4 per cent between 2007/8 and 2008/9.

GPC negotiator Dr Beth McCarron-Nash said most GPs were now working at '100 per cent' as more healthcare moved from hospitals to primary care.

'There is also a growing trend that patients are taking a more active part in their healthcare,' Dr McCarron-Nash said.

'Of course, general practice cannot continue to absorb this demand. I think it is unacceptable that some practices have been penalised financially this year (in the national patient survey) despite this huge demand.'

'We need more resources to employ more staff. As a negotiator I will again be pushing for more resources this year.'

Professor Julia Hippisley-Cox and Dr Yana Vinogradova, researchers at the University of Nottingham who compiled the data, said the study did not take account of the complexity of consultations, prescribing or referral rates, which are all likely to have increased over the last 14 years.

To access the data please visit the NHS Information Centre website at [www.ic.nhs.uk](http://www.ic.nhs.uk).

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## 2. GP catchment areas to be scrapped within a year

Health Secretary Andy Burnham has announced that GP catchment areas are to be abolished within the next year.

Ministers want to introduce more patient choice into the family doctor system, believing it will drive up standards and improve access.

In a speech in London, the Health Secretary said that the current system of fixed practice boundaries would be scrapped within the next year, to allow patients to choose to register with any GP of their choice.

Mr Burnham said: "I want the best to be available to everyone, not according to where they live.

"Too often people's choice of GP practice is unnecessarily limited by practice boundaries, so, with the profession, I want to open up real choice in primary care."

"Many of us lead hectic lives and health services should be there to make things easier."

Politicians of both parties have talked up the prospect of scrapping fixed boundaries in recent months and it was also mentioned by Lord Darzi in his 'Next Stage' review of the health service in 2008. The Conservative party had described fixed boundaries as a 'solid wall of defence against patient choice.'

Roger Goss, of campaign group Patient Concern, said introducing competition might help to improve the overall quality of primary services.

"The less successful surgeries will have to work harder to provide a quality service. It's a good thing if the really incompetent surgery goes out of business."

Dr Laurence Buckman, chairman of the British Medical Association's GPs committee, said the union was willing to work with the Government on how the idea might be implemented.

He said: "We are open to discussing ways of improving choice for patients, and most GPs would be comfortable with flexible boundaries. However, major logistical barriers would need to be overcome. Home visits with a GP a long way away could be costly for the NHS to fund."

Only in May, it was revealed that the Department of Health had given PCTs the all clear to allow patients to register near their place of work but continue receiving care from a GP near their home.

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## 3. The Government's World Class Commissioning Initiative

The Department of Health has developed a national 'balanced scorecard' as part of its World Class Commissioning scheme with the aim of improving GP services. Throughout 2009/10, PCTs will monitor practice performance in a number of areas and manage practice contracts with this new data.

GPs are scored red, amber or green against indicators including the number of GP appointments, response times during opening hours and number of manned phone lines per 2,500 patients during peak hours. The proposals risk subjecting GP practices to an unprecedented level of scrutiny and performance management, as well as the possibility of encouraging patients to change practices.

Many PCTs are already using the scorecards to rate practices, benchmark it against local and national averages, and publish their results online.

Several PCTs have instructed lawyers to work on removing practices judged as the worst performers based on the ratings, initiated disciplinary action against some practices and others have been handed stringent improvement programmes.

Many have suggested that balanced scorecards may risk becoming crude practice league tables that will deceive the public, and potentially distort the local

health economy by encouraging patients to erroneously interpret the practice data.

GPC negotiator Dr Chaand Nagpaul expressed his concerns about the scheme: "It's a nonsensical way of judging doctors. Many are working in practices where poor performance is not a reflection on the GPs, but a host of factors, including poor premises and lack of staffing. Using threats of termination is completely wrong."

At Lockharts, we are considerably troubled by the PCT proposals to take legal action to remove practices that score poorly under the initiative. In particular our concern relates to the extent to which PCTs can terminate GMS Contracts/PMS Agreements, etc. of practices judged as poor/the worst performers under the 'balanced' scorecard system.

Should you discover that your practice has been rated red or amber, or is under pressure from your PCT, we will be happy to assist you in dealing with a PCT and restricting or removing the threat of the PCT to modify your contractual arrangement.

If we can assist please contact Victoria Wheeler in the first instance at [vw@lockharts.co.uk](mailto:vw@lockharts.co.uk).

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#### **4. PCTs to tighten GP drug budget funding**

In 2006, the NHS has just slipped into more than £500 million of deficit and then health secretary Patricia Hewitt was not a happy woman. She ordered PCTs in no uncertain terms to get their financial act together – and so the era of drug budget cutbacks began in earnest. Fast forward to the present and there is no sign of an end to the drive for low-cost prescribing.

GP drug budgets will bear the brunt of strict PCT cost controls for the next two years amid evidence of a growing disquiet over the rationing decisions made by trusts.

PCTs in England are, on average, freezing their GP prescribing budgets for the current financial year. Data from 76 trusts reveals

that they are only uplifting them by 3% for next year.

The budget squeeze comes at a time when primary care prescribing is rising (an increase of 5.8% in prescriptions issued last year) and despite large rises in funding planned for other areas such as smoking cessation and sexual health.

The fact that a third of trusts have already reduced their prescribing budgets this financial year, by an average of £1.6m each, and with others planning reductions the year after further highlights the extent of the cuts.

A survey of 200 GPs conducted by Pulse found widespread concern over rationing of treatments by PCTs, with 51% saying it adversely affected the care of their patients.

Another survey of over 400 GPs found that 65% said they were placed under pressure from their PCT to co-operate with drug switching schemes. A third thought their freedom to do the best for their patients was compromised.

PCTs insist that savings will come through more efficient prescribing. NHS Sefton is cutting its GP prescribing budget by £1.1m this year and next year and a spokesperson said the cuts would be balanced by GPs prescribing cheaper medicines: 'The PCT will be making savings by supporting GP practices to achieve an increase in generic prescribing, particularly in practices with a low rate of generic use.'

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#### **5. GPs banned from charging patients for premium rate 084 numbers**

The Government has banned GPs from charging patients for premium rate phone numbers, insisting that patients should never be charged more than the price of a local phone call when contacting their practice.

Health minister Mike O'Brien announced the decision on the use of phone numbers beginning with the prefix 084 in England, and said the decision had been made on the basis

of the strength of feeling expressed in more than 90% of the 3,000 responses to a public consultation.

The 084 numbers will not be banned but calls to hospitals or GP surgeries must cost no more than a standard call.

Calling 084 numbers can cost patients up to 40p a minute as telephone providers normally charge a premium, known as revenue sharing, a proportion of which goes towards covering the cost of additional services such as queuing systems and automated answering services.

The Government stopped short of outlawing revenue sharing arrangements, suggesting telephone companies will either have to bring call charges for 084 numbers in line with those of local calls, or include calls to 084 numbers in call packages.

The ban will be enforced through negotiated changes to the GP contract, and would be put in place 'as soon as practicable', Mr O'Brien said.

Mr O'Brien added: 'It is clear from the feedback we have received that patients support the banning of any number or tariff which is more expensive to call.

'It is not our intention to prohibit 'revenue sharing' as part of our proposals – the important thing is to ensure that patients are not being made to pay more than the equivalent cost of calling an 01 or 02 number.'

Campaigners against higher tariff 084 numbers, increasingly used within the NHS, say they go against the founding principles of the NHS which is that it is "free at the point of need".

The GPC also welcomed the ban, which it said would be fairer to patients. Deputy chair Dr Richard Vautrey said: 'We're pleased that the phone companies who supply these lines to practices have agreed to ensure that their tariffs are in line with local charges.'

'There are many added benefits that telephone systems using these numbers have and which patients find helpful, for example better and quicker access, so it's good to see that the government has

recognised this and has not gone for a complete ban on the use of these numbers.'

Katherine Murphy, director of the Patients' Association, said: "It's great that the Department of Health has listened to patients. Asking them to pay extra costs for phone calls was unreasonable."

The Department of Health response to the 084 numbers consultation is available online [here](#).

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## 6. NHS to launch GP comparison site

The precursor to the new online service that allows the public to rate and compare GP practices on issues such as patient care, cleanliness and waiting times has been launched.

The facility, available on [www.nhs.uk](http://www.nhs.uk), will work in a similar way to internet comparison websites, and means patients will be able to compare a range of surgeries and their ratings in one place, allowing them to make an informed choice.

Patients will be encouraged to leave feedback from their experiences with GP surgeries on the NHS website, and there should also be responses from staff at the surgeries in a bid to drive up standards.

It is hoped the feedback given by patients will help other patients make more informed choices about where to go for treatment by giving helpful and relevant information.

A similar system that allows hospital patients to rate their treatment has been launched and should help to ensure the GP surgery version is a success when it goes live.

Users will also be able to read patient reviews on staff performance, how involved patients felt in decisions around their treatment and if they would recommend the surgery to friends and family.

Health Secretary Andy Burnham, who unveiled the service, said: "The service also

offers an unparalleled opportunity for managers to be made aware of any issues and act to improve their services, helping to drive up standards across the board, and become more patient focused."

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## 7. Life Assurance for Partnerships

A partner will acquire and accumulate capital during the time he is a member-death (or disability), or simply planned retirement, will terminate the membership.

The partner, naturally, would wish the value of his capital account to pass to his family; the continuing partners will desire to secure the interest in the partnership assets itself. Generally provision to cater for retirement can be planned; invariably, it is the aspect of sudden death (or serious illness) that may result in financial pressure arising against fellow partners (by the deceased's members family) if appropriate arrangements are not in place.

Life assurance can be a suitable vehicle to alleviate such pressure.

Examining the death situation firstly - there are two methods:

- (a) each of the partners should take out a policy on his own life, ensuring the policy benefits are in trust for the surviving partners; or
- (b) each partner would take out a life policy on the lives of his fellow partners.

The aim, in either case, is to provide a source of funds to buy out the family of the deceased partner.

Method (a) is usually preferred as (b) is administratively complex and suitable only for very small partnerships.

The type of life assurance is known as term (cheaper than whole of life). It is important to demonstrate that funding the premiums on such life cover is on commercial terms to avoid any Inheritance Tax (IHT) transfer of value complications. It would be expected

that premiums payable by an older (possibly less healthy) partner should be less than premiums payable for similar life cover by a younger partner colleague.

On maturity: (e.g. death claim) the proceeds should be free of income tax (a qualifying life policy) and CGT should not be an issue. In relation to the all important IHT considerations, it is essential that the existence of life assurance arrangements do not jeopardise Business Property Relief (BPR) – i.e. there is no binding contract for sale in relation to "relevant business property".

As the policy is written with benefits exclusively passing to surviving partners, inter alia the member taking out the life policy term contract cannot benefit - (i.e. surrender the policy), then the IHT gifts with reservation rules (GWR) should be avoided.

With the above structure arrangements in place – untimely death would mean that the value of the member's partnership interest would attract BPR and so pass to the family. The surviving partners would have the benefit of liquid funds immediately available (from the life policy) – passing without any requirement for title determination (other than a death certificate) as the policy is subject to a trust nomination.

Life companies can provide suitable flexible trust wording documentation; however as benefits are to accrue to fellow partnership members (and the likely quantum of benefit not being insignificant); it would be recommended that solicitor's advice be sought as to the required policy trust provisions.

Typically, the partnership agreement will require the continuing partners to pay out the retiring partner – possibly by instalments over a term of years. The main consideration here is funding; it is possible to use a series of endowment policies (with predetermined maturity dates) to provide a source of funds so that liquidity can be available at set dates in the future.

Any arrangements should include a provision where a partner may have to withdraw from the business (either wholly or partly) through accident or illness.

The appropriate policy is critical illness, with terms underwritten, on similar to those set out above (viz term cover applicable on death).

The aspect of sudden death, or serious illness of a partner, can result in financial obligations arising against surviving partners concurrent with their having to replace the loss of an income earning partner at short notice.

If suitable life assurance arrangements have been put in place beforehand, then the partnership will have both flexibility and liquidity available to operate the partnership in a timely manner.

For further information please contact Associate Solicitor Andrew Murdoch at [am@lockharts.co.uk](mailto:am@lockharts.co.uk).

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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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