

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE OCTOBER 2009 Edition

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At this time of year in 1957 Morris Greenberg of the New York City Department of Health said, "It is a little difficult to see why one would try to protect the entire population against an illness so mild." He had to eat his words later. Things may yet change, and quickly too, so we should just be grateful if they do not. In the meantime, planning continues for the administration of mass vaccinations – the latest guidance from the DH is at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106299.pdf. By the time you receive this practices should have received their first box of 500 doses.

TO TAKE OR NOT TO TAKE?

Swine Flu vaccine will begin to arrive in practices on 26.10.09; GPs and all practice staff are prioritized to receive it in the first wave.



However, professional and media opinion varies on both benefit and risk. Some have speculated about possible rushed vaccine development

and safety assessment. The LMC view is that new seasonal flu vaccines are produced each year without such wariness and we are assured that no unsafe production short cuts have been taken.

- The vaccine has already been licensed in Australia and is being used, apparently without a surge of untoward events.
- The illness so far has been largely mild, but there have been fatalities.

- There are recent reports of higher hospitalization and intensive care rates with the autumn illness
- Mutation to a more virulent strain remains a possibility, especially if co-infection by seasonal and swine flu occurs.
- Immunization of clinicians is for protection of patients as well as our own personal health.
- There is also the added benefit that it will maintain workforce numbers at a time of pressure and help with business continuity.

The LMC therefore hopes that primary care frontline staff will want to take up swine flu vaccination but it is for each individual to decide.

CHARGING SESSIONAL GPs FOR FLU VACCINATIONS

Elsewhere in the country some practices are said to be preparing to charge GP colleagues who work for them for being vaccinated against pandemic flu. This is not good practice and should be

condemned. You are reminded that when seeing doctors for a private service it is reasonable to charge to cover directly incurred costs but not a professional fee. Furthermore, the vaccinating practice should inform the appropriate registered GP if a practice vaccinates its employees or visiting locums, (this is both for possible underlying clinical reasons and also so the registered practice gets the £5.25 – as these are front-line staff) and also so that both the vaccinating and registered practices keep proper records and provide a proper occupational health facility for this.

PANDEMIC FLU UPDATE

The GSK (Pandemrix) and now also the Baxter H1N1 Vaccine (Celvapan) have been approved by the European Medicines Agency and the European Commission. Vaccination takes up to 3 weeks to take effect.

The Department of Health is preparing a range of materials for GPs: including a new Immunisation Green Book chapter, fact sheet, Q&A, consent template, Patient Group Directive (PGD) template and patient vaccine invitation letters. Training materials to support NHS staff are also being developed, including a H1N1 vaccination training video at: <http://www.dh.gov.uk/en/PublicHealth/Flu/Swineflu/InformationandGuidance/index.htm>

A new version of the joint GPC/RCGP/DH flu guidance Pandemic influenza – Guidance for GP practices is at:

http://www.bma.org.uk/health_promotion_ethics/influenza/panflugp/index.jsp

MRSA

Pre-operative screening for MRSA is at present a secondary care task. It has not been commissioned from GPs, who are therefore within their rights to refuse to do it.

CONFIDENTIALITY

You may already have received the new GMC guidance pamphlet on 'Confidentiality' and its supporting pamphlet Confidentiality: supplementary guidance'. Be aware that the new pamphlets took effect from 12 Oct 09. You can get an electronic download at: www.gmc-uk.org/confidentiality. They are particularly helpful in such areas as

the reporting of gunshot and knife wounds, communicable diseases etc.

QoF RESULTS

There is a very easy to use, clear webpage that allows you to search on practice and PCT for QoF results. It is www.gpcontract.co.uk. The authors of the website apologise if they have any addresses wrong – they are naturally more concerned that the figures are correct.

VETTING AND BARRING SCHEME

The GPC will shortly be issuing guidance about the new Vetting and Barring Scheme, which started coming into force on 12 Oct 09. As part of it the new Independent Safeguarding Authority (ISA) will maintain two 'barred lists'. The new barred Lists will replace the existing Protection of Children Act (PoCA) List, List 99 and the Protection of Vulnerable Adults (PoVA) List in England and Wales. As it currently applies, a person on a barred list who seeks or undertakes 'regulated activity' will be committing a criminal offence. The GPC initial guidance is that getting an enhanced CRB check is now mandatory for those taking up a new post as a GP, practice nurse or healthcare assistant (as they undertake 'regulated activity'). This only applies to new recruits and those who are changing jobs who will undertake 'regulated activity'. It does not apply to receptionists, practice managers, cleaners, etc. The NHS also says that a practice will be guilty of an offence if it knowingly appoints a barred person to such a post; we are checking whether this is really so. We believe the onus is on the individual not the employer. Practices should require an enhanced CRB check for all new recruits and for anyone changing jobs within the practice who will be undertaking a 'regulated activity'. (There are no central funds for CRB checks – who pays for them is a matter to be discussed between practices and the applicant.) Practices also have an obligation to inform the ISA if they believe an individual has caused harm, or posed a risk of harm, to children or patients they work with.

Individuals will be able to apply for ISA registration from July 2010, but since 11.3 million people may in the end be covered there will be a 5-year period for registration.

The ISA website is www.isa-gov.org

PAPER PAYMENT STATEMENTS

We note in 'Brocks to Docks' that from 1st January 2010 the PCT will no longer be issuing paper statements; details will have to be accessed via Open Exeter. If you are not one of those practices already doing so, you might like to look into this.



GRITTING THE CAR PARK

With winter approaching it is time to consider staff and patient safety in adverse conditions such as ice and snow. Legal advice from the BMA is that:

'To avoid negligence claims a practice must do all that is reasonable to ensure that the car park is safe. That does not necessarily mean that the practice must expend huge amounts of time and money to keep the place safe – the duty is to be reasonable in the circumstances. If however the practice does not have the time, resource or funding to make safe any car park they may simply choose to close it.'



You could put up a warning sign outside the car park during icy conditions stating that the car park is icy and advising patients to park elsewhere. This may exclude liability for damage to property but will not do so for personal injury or death.

The rule of thumb is to be reasonable and practicable and where this cannot be done then the only safe alternative is to close the car park.

Speaking practically, it may well be possible to arrange for a local gardening contractor to grit/salt your car park and paths on the odd occasions that it is necessary, and for practices to keep a sack of salt in reserve in case the weather is so grim that the contractor is

delayed or even unable to reach you in time.

DISPENSING DOCTORS

Dispensing doctors will already have seen the changing levels of remuneration being imposed. Nationally the GPC is negotiating for sensible rates for prescription of long-term medicines whereby the patient can receive in one go a supply of 2 – 3 months' worth. It is recognised that the current dispensing fees almost force practices into dispensing 28-day amounts, which wastes a lot of time, both for the practice and the patient. It also encourages extra dispensing to the detriment of self-care. In the meantime if any practice feels significantly threatened by the current changes the GPC would like to know about it, in detail.

GPC QUALITY CONFERENCE 4 DEC 09

The GPC is organising a one-day conference on "Quality in modern general practice: Getting ready for the new agenda" on Friday 4 December 2009 at BMA House, London. The LMC Secretary will be attending and will provide an update on registration with the Care Quality Commission and practice accreditation, the likely changes, why they have been introduced, and how these changes will affect GPs.

SESSIONAL GP CONFERENCE

The BMA is holding a one-day educational conference for sessional GPs entitled 'Recognise your Talents, Realise Opportunities: Key steps for sessional GPs' on Friday 13 November 2009.

The aim of the conference is to provide salaried and locum GPs with the tools that they need to succeed in their careers. It will be divided into three key areas:

- Step 1 - Marketing yourself
- Step 2 - Effective planning and career development: making the job work for you
- Step 3 - How to meet the challenges of revalidation.

This event will be of interest to all current salaried GPs (including Retainer Scheme GPs) and GP locums. It will also

be relevant to those considering becoming a salaried or locum GP. The cost to attend is £65 + VAT for BMA members and £225 + VAT for non-members.

For further details, including details about how to book, [please visit the BMA website](#).

GPs STEERING NHS DIRECT?

NHS Direct is recruiting a non-executive director with a medical background and a part-time executive Medical Director. It would surely be better for all GPs if NHS Direct had GPs in these important roles.

The **non-executive director** is likely to be a senior doctor with a keen interest in e-health. They are looking for someone who can apply their medical experience to governing NHS Direct and helping to develop its future strategy, in an environment in which pressure on the NHS, rising patient expectations and new technologies are creating opportunities for significant change. The commitment is about two and a half days a month.

The **Medical Director** will focus on joint strategic clinical leadership of the trust with the Clinical Director/Chief Nurse, working with the professions and other external stakeholders to develop the contribution of remotely delivered care to the NHS. They are looking for a dynamic medical practitioner to help shape the national approach to remote and digital health services. The commitment is at least 5 sessions a week, based in London.

For an informal discussion on these vacancies please contact:

- For the non-executive position: Joanne Shaw, Chair of NHS Direct, joanne.shaw@nhsdirect.nhs.uk, tel: 0207 599 4211.
- for the Medical Director position:
 - Roger Rawlinson, Human Resources Director, roger.rawlinson@nhsdirect.nhs.uk, tel: 0207 599 4262.
 - Nick Chapman, Chief Executive, nick.chapman@nhsdirect.nhs.uk, tel: 0207 599 4211.

The closing date for both posts is noon on 9th November 2009.

LMC HIGHLIGHTS

Highlights of October's LMC Meeting are at Annex A.

DDRB SUBMISSIONS

Extracts from the DH's submission to the DDRB is at Annex B. You will not be surprised to hear that while they agree that practice costs may be increasing they are not prepared, in the current economic climate, to support a pay increase for principals, although they are prepared to support a 1% rise for salaried GPs.

MAX'S MUSINGS

My young nephew tells me that if you are a smoker in the Army it is quite the done thing to 'take five' for a cigarette



on a fairly frequent basis. Those who do not smoke do not receive the same level of breaks. It struck him as a

good reason not to give up smoking. Perhaps the generals should insist on 10-minute breaks for the non-smokers? On the other hand, I also read an article the other day extolling the virtues, not of the 'evil weed' but of the benefits to industry of all levels of managers and workers crowding together in porchways and entrances, sharing views from across departments and levels, and perhaps generating new ideas for the benefit of all. There may also be a degree of general bonhomie and conviviality in the face of social expulsion, a feeling more cheaply achieved than by specially organised team-building weekends. After all, it is the smokers themselves who are paying to improve company morale in this way. Furthermore, as Niccolò Machiavelli might have put it, the greater the numbers of workers who smoke the fewer will in the long run be making claims on the company pension funds; about 18% of all deaths in those aged 35 and over are estimated to have been caused by smoking. I am no statistician, but since about a fifth of adults smoke, you could guess that most of them will die of it sooner or later. Companies would have to estimate and offset against these

'advantages' the cost of statutory sick pay and provision of locums during long-term illness while still employed; some 5% of hospital admissions are estimated to be directly due to smoking. *(All statistics used in this paragraph have been extracted from 'Statistics on Smoking, England 2009' published 29 Sep 09 and downloadable from: <http://www.ic.nhs.uk/pubs/smoking09>)* Paradoxically, and rather distastefully, one could argue that it might still be in

the company's interests to encourage their employees to smoke. A suitable subject for the next 'Moral Maze' programme perhaps?

I too have found it illuminating and useful to talk to my staff on a regular basis, and hear what they have to say. I just feel saddened that in most organisations the only recognised venue for this is 'smokers' corner' – usually a windy, wet and unwelcoming bit of the practice car park.

And finally:

'GPs are well-placed to make a positive intervention with patient's addiction problems.'

'The patient was in his usual state of good health until his airplane ran out of fuel and crashed.'

'Between you and me, we ought to be able to get this lady pregnant.'



This newsletter was prepared by Mike Forster, LMC Lay Secretary, & the LMC Office

HIGHLIGHTS OF THE OCTOBER 2009 LMC MEETING

Unscheduled Care Referral Centre (UCRC). There was a review of how this had been going for the first month. Most commented on how helpful the nurses were who manned it, but there was also feedback from the UCRC that some practice staff had been rude to them, which did not help. The passage of most patients through A&E via the UCRC had highlighted a number of previously unidentified problems that were now having to be addressed. Even so, patients were being seen earlier on by consultants despite not all of the consultant vacancies being filled yet. This has reduced internal pressures since many patients are now being treated and discharged within 4 hours who formerly might have stayed in overnight and others are being directed straight to the correct ward, thus saving internal transfers of patients. There is to be a new IT system in Nov 09 which should allow the automated production of discharge summaries, which consultants will back up by letter.

GWAS. The ambulance service is proposing to institute a number of grade qualifications for its OOH doctors. The LMC was concerned that this meant that GPs doing house visits by day would not be deemed qualified to provide exactly the same service when employed by the GWAS out of hours. There was also concern that their proposed accreditation panel did not include GP representation, nor was there mention of the GP Support Panel. The LMC office will follow up these and other concerns with GWAS. It was agreed that the PCT medical lead would also consider it.

Choose and Book. Glos PCT is now the 5th best in NHS SouthWest, which itself is the lead SHA in the country, so the pressure is off. Concern was expressed that consultants were booking their leave at short notice, leading to cancelled appointments. There was also a feeling that the official confidence in the system was not matched by the experience of GPs and their patients.

QoF. Rather quiet as a result of all the Swine Flu preparations. Important to find an equally suitable co-ordinator before momentum was lost.

Revalidation. There were still many important issues to sort out, all of which meant that it would not get going until 2011, although qualifying data might have to be gathered in 2010. A General Election was unlikely to deflect the course of revalidation.

CRB Checks. There was still a back-log of CRB checks not completed. The PCT was planning for CRB checks to be redone on a 3-year rolling basis.

GPC Negotiators Update. It is likely that a 'ratio formula' will be applied to any uplift that is negotiated (as last year) in order to move as quickly as possible towards a state where no practice has an MPIG. There appears to have been an underspend on the 5 clinical DESs, so the GPC is seeking their extension for another year. Swine Flu continues to dominate many of the discussions, so substantive issues such as changes to QoF are being slipped by a year. 'Bright ideas' like the abolition of practice boundaries (which threatens a considerable change in the way primary care operates) are being handled tactfully and slowly. The potential change of government will also see some 'bright ideas' and it is not clear yet whether they will have to be handled similarly.

GMS GP PAY REVIEW 2010

Extract from the NHS Employers' Submission to DDRB.

5.8 Following higher than expected increases in GMP contractor pay resulting from the new GP contract, the Department has sought action to direct more of the Government's additional investment in primary care into improving services. Through a combination of negotiated changes and DDRB recommendations, proportionately more money is being re-invested in services and GMP net earnings (as a proportion of gross investment) are moving back towards expected levels.

5.9 The Department considers that, in order to contribute to the financial discipline and efficiency improvements essential to respond to wider fiscal and economic challenges, the Review Body recommend an increase in average gross income sufficient to cover likely increases in expenses in 2010/11 with no uplift in GMP net income.

5.10 Given that the wider NHS is required to deliver 3% cash releasing efficiency savings in 2010/11, it is the Department's belief that, to be fair and equitable, any uplift to GMP contractor payments should also assume efficiency improvements can be made in general practice. The Department considers a 1% cash releasing efficiency assumption to be realistic in the current climate. Paragraph 5.48 discusses how GPs have previously been able to generate efficiency savings.

5.11 The Department believes this represents a fair deal, particularly as GPs can increase their net income from other potential NHS earnings outwith the DDRB remit.

5.12 The Department believes **a gross uplift of 0.5%** in GMS contract payments would deliver sufficient increases to overall investment to cover the expected average increase in expenses. This estimate takes into account the fact that, under existing contractual arrangements, GPs are directly reimbursed by the NHS for expenses such as premises and IT systems, so the gross uplift does not encompass increases in those reimbursable expenses.

5.13 For salaried GPs employed by PCTs or other NHS organisations, the Department recommends an uplift of up to 1%, in line with (non-consultant) hospital doctors.

5.14 The Department recommends that the Review Body holds the GMP registrar supplement at 45% for 2010/11.

5.15 The Department recommends that any uplift to the GP trainers' grant should be no more than the increase which is proposed for (non-consultant) hospital doctors.

5.16 The Department recommends that GP educators should not receive any uplift to their pay scale. This is in accordance with what is proposed for consultant doctors, and in line with the Government's wider approach to senior pay in the public sector this year.

GPC Position

Still negotiating for a 2% uplift.