

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE APRIL 2008 Edition

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The DDRB report was deeply disappointing. To remind you – all GMS practices in Gloucestershire needed a Minimum Practice Income Guarantee (MPIG) in addition to their Global Sum to ensure they were not disadvantaged by changing contracts in 2003.

We had expected the MPIG to be phased out, but probably over 30 years or so. Under this DDRB report (which only addressed the Global Sum) the Global Sum will be uprated by 2.7%, but the Correction Factor will be reduced by a similar percentage. The net result is that for most GMS practices there will be no gain in income. Only those practices whose global sum is very close to their MPIG, or if they have no MPIG, will gain any benefit. Taking the DDRB approach to its logical conclusion it would seem that the increases to the Global Sum will have to continue for 8 to 10 years before most GPs will see an actual increase in income. In the meantime the DDRB have recommended an increase in pay for salaried doctors of 2.2% which practices will probably feel obliged to pay and there will be other staff with similar requirements. For PMS practices there is no Global Sum and Correction Factor involved so we think they should be getting the full 2.7% and have asked the PCT to institute this.

EXTENDED OPENING HOURS – LES BEFORE DES

The PCT is very conscious of the financial pressures on practices and intend to offer an Interim LES of £1.50 per registered patient to those practices who may wish to take up the Extended Opening Hours DES when it becomes available. The PCT has confirmed that take-up of the Interim LES

does not commit a practice to taking up the DES. In deciding whether to take up the Interim LES while not intending to get involved with extended hours opening you should consider the impact on patients' expectations of carrying out a survey to find out when they would like you to provide these extended opening hours. The form of the questionnaire has not been seen, but we have asked that it contain only open questions and the PCT has agreed to clear the questions with the LMC before publication. The size of the sample to be surveyed is unclear, but is likely to be at large, and practices will bear the cost of postage. The PCT is also asking for 'baseline information' (as yet undefined). They will let you have a copy of the information they hold for your practice and will ask that you confirm or update it. The GPC advice is still that the GMS contract requires a service to be provided, but does not dictate how that service is to be provided, nor does it require you to give information which may perhaps become 'commercial in confidence'. For the moment our advice is that if you are considering taking up the DES and also the Interim LES there is no harm in telling the PCT that the information they have collected about your practice from open sources is correct. The GPC legal advice is that 'requests for information from the PCT are governed by regulation 77 of GMS whereby contractors must produce

information reasonably required by the PCT for the purposes of or in connection with the contract or reasonably required in connection with the PCT's functions. The keyword here is 'reasonable'. If the information is being requested because the PCT wish to ascertain whether, within that practice, the reasonable needs of patients are being met, then this may be considered reasonable. To demand information from practices on the basis of the introduction of a DES that has not yet been agreed or implemented appears to go beyond reasonableness. Please note that Reg 77 is a widely drafted provision and it is likely that most requests for disclosures by the PCT will be caught by it'. If you have not yet declared an interest in taking up the DES you could say:

We have considered your request for information in relation to our obligations of disclosure under our current contract. We do not feel that the PCT in this context is entitled to demand this information from us at this stage. Firstly, the DES has not yet been agreed and we understand that the implementation of it is still subject to legal consultation. Secondly, as we have not indicated that we are minded to take up any DES if one were introduced, then we do not consider that your request is reasonable. On that basis, and in exercise of our rights under our contract, we must decline to produce the information.

Remember that the lost QoF points are being recycled into Extended Hours. The only actual loss is from the Access DES, which was going to end in Mar 08 anyway.

CHOOSE & BOOK LES

The LMC has now negotiated with the PCT for an engagement fee on a pence per patient basis will be paid to all practices aspiring to this LES (the exact amount is now being worked out by the PCT.) The LES will also pay a flat-fee for each converted booking on the C&B system. Practice Based Commissioning Clusters may consider that providing a booking service for their cluster might be effective but the PCT is prepared to provide such a booking service to convert paper referrals into electronic ones if necessary. Under this scheme you would lose the work and of course the rewards.

OTHER LESs

The Smoking Cessation and Miscellaneous LESs will continue in 2008/09.



There may be an Access LES to take forward the best points of the 2007/08 DES.

Components 2 and 3 of the IM&T DES will be continued locally this year and be completed. Component 4 will continue this year and may have to stretch into next financial year, depending on progress and availability.

Details of the PBC funding availability will be issued by the PCT during April.

What do competitors' contracts look like?

With the relaxation on who could provide primary care services besides general practices, private providers have successfully been gaining a foothold in this area. Often in competition with GP-owned practices and often very little is known of what the APMS contract actually looks like in comparison with the nGMS contract.

However, contracts can be accessed under the Freedom of Information Act and many journalists in doing so indicate that the APMS contracts are tougher overall. The key target for APMS practices is Access. They have to open 8am to 8pm on weekdays and 10am to 2pm on Saturdays. They also have maximum waiting times for home visits of between one and six hours, dependent on the urgency. They face targets of a high percentage of generic prescribing rate. They must reach a quality score of at least 950 points. They must use C&B and have involvement in PBC. Emergency admissions and sick notes issued must be within 10% of the best performing practices in their PCT area. They are expected to meet targets on smoking cessation and reduction of pregnant smokers.

As for the customers... there's a limit on numbers and generally they have to keep within their boundaries.

Although one could say this is micro-management of an APMS contract, as it is for a nGMS contract by the PCT, the difference is that in the APMS contract there are outright, clear requirements expected by the PCT – non negotiable, as part of what an APMS practice signs up to.

Where an nGMS practice can opt out of enhanced services, APMS contractors are also expected to provide a certain number of enhanced services which include looking after patients in care homes; drugs misuse and sexual health services. One of the main differences in legal terms is that an APMS contractor is not deemed to have an NHS contract, whereas an nGMS contractor is seen as having an NHS contract unless it states otherwise. The difference is that where an NHS contractor is involved in a dispute it is referred to the Secretary of State and in most cases resolved via mediation and if that eventually fails then the courts have to intervene.

An Opt-out such as that allowed for nGMS contracted services is unlikely.

Like nGMS, APMS contractors can't sub-contract without permission from the PCT, so you'd find the NHS supplies its drugs and appliances and GPs act as clinical advisers and so forth. Of course in commercial contracts, the supplier has to deliver the contract and can sub-contract out, as long as it delivers the service it signed up to.

If the APMS contractor fails to deliver then there would be financial penalties and even termination of the contract, with a six-month notice period. Whereas with an nGMS contract the PCT can't just terminate a contract, it has to go through a set process. An nGMS contractor would have opportunities to remedy any breaches and avoid contract termination but the APMS contract could be terminated without reason.

One could argue that GPs could tender for an APMS contract but would need to bear in mind the investment of time and money in bidding for a contract and the financial penalties if targets were not met. Also because of EU procurement regulations, once contract terms have been set, it is very difficult to alter these once put out to tender.

General Practice already does, or can offer services that would make a difference to the local population, not always being seen as wanting to make a fast buck, services such as vasectomies; community dermatology; private flu and other vaccinations; retinal photography and anti coagulation treatment; private minor surgery and as experts in their field offer to provide a training vehicle for other clinicians.

Overall, the existing general practice model may need to look outside the box to see what it can provide that the competitors can't.

The question here is, is it likely all England general practice contracts will be APMS contracts?

ISSUE OF SICK NOTES BY HOSPITALS

The duty to provide a statement rests with the doctor who has clinical responsibility for the patient at the time. If the patient is in the clinical responsibility of the hospital, then the hospital is responsible for issuing all certificates for social security and sick pay purposes for both in-patients and outpatients who are incapable of work. They should issue the Med 3 on discharge from hospital where a hospital doctor advises a patient to refrain from work, and the doctor was attending and had clinical responsibility for the patient at the time this advice was given. Once the GP resumes clinical responsibility for the patient's treatment the onus returns to the GP. The reference is IB204 – a Guide for Registered Medical Practitioners which was issued by the Department of Work and Pensions in Aug 2004 which you can find at http://www.dwp.gov.uk/medical/guides_detailed.asp and by clicking on IB204 in the left column and reading at page 7.

COMPLAINTS PROCEDURE

A reminder of the proper complaints procedure has been agreed between the PCT and the LMC, and will shortly be on the website. The essence is that every practice



needs a designated complaints manager (often the practice manager) and that the vast majority of complaints can normally be dealt with at local level by the practice, if

necessary with conciliation help from the PCT.

C&B – NAMED CLINICIAN REFERRALS

C&B allows you to select a Named Clinician from an ellipsis button. All you then have to do is enter his surname and speciality (nothing else). If you click 'Search', and if their details are on the system, their name

will appear. Click on the line to highlight it in orange and then click 'Done'. Click 'Suggest Services' and then carry on as normal. You may need to select a clinic type after clicking 'Request'.

Note please do not send a named referral letter unless you have used the Named Clinician box in the C&B system. It confuses the recipient!

GP Systems of Choice (GPSoC)

The PCT is aiming to sign up the majority of practices to the GPSoC agreement. Practices will need to agree to this.

Among the advantages are:

- Cash savings in the PCT to be spent elsewhere in primary care.
- Standardisation of costing and service according to national service.
- Future development of primary care systems.

Practices do have a choice, and the decision to sign up, even if it is for the same system, should be a positive one after consideration of the option of changing system supplier. The agreement has been made with the full support of the BMA. Full details are at www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/gpsoc including a summary page!

Within the agreement that practices have to sign is an element about the support that IT Services supply. Primarily this is for support of the hardware (excluding servers), networking, PCs and printers as well as the county wide email. This support will continue to be purchased on behalf of practices by the PCT.

The PCT is keen to know of deficiencies (perceived or actual!) in this service and would like feedback from practices where they feel that the service has not come up to scratch. It would be helpful to include brief details of the problem as well as the incident number to enable a fuller investigation. Feedback of this sort is vital if we are to improve the service to primary care. Dan Corfield or Dr Andrew Rigby would be happy to receive information about such problems. Future developments may include a user satisfaction survey, but until then the PCT would like individual feedback, please.

IT services provide a service during the working day, which may not coincide with practice working hours at present and

certainly will not if any practice wishes to work additional hours. The PCT are considering how support can be extended to cover the whole of the time practices are functional.

IM&T

The PCT is aiming to complete the assessments for component 2 by the end of July in 90% of practices. Dan Corfield will be sending you some further information about this. The timing is good from a practice point of view as after the summer QOF and Flu jabs occupy their energies to the exclusion of most other things and it would be a good thing to get it out of the way ASAP. The PCT would find it helpful if practices could be as flexible as possible in arranging appointments for the assessors to visit.

The DES is worth 44p per patient, and accreditation will last for 3 years.

Any practice not meeting the standard will be given appropriate advice and recommendations, and once this complete reaccreditation will take place only for the 'bad' bits and will be for 3 years as before.

One practice (using Vision) has successfully moved to a hosted service I'm told, making them compliant with component 4 of the DES. Other systems are still developing their hosted service.

Component 2 is about data quality and will help to improve the GP2GP record service amongst other things.

GP EMPLOYMENT LAW COURSES 2008

BMA Regional Services are offering a series of one-day courses on employment law for GP Partners. Running throughout the year in venues across England, these courses will help you to keep track of employment legislation, best practice and human resources issues. Four different courses are available:

- **Managing change** will include recruitment and selection, contracts of employment, terminating employment, and redundancy and will help you to handle change among staff fairly and consistently.
- **Managing performance** will help you to get the most from your staff and will include performance management, dealing with staff grievances, handling disciplinary matters and absence.

- **Managing equal opportunities** will include the development of an Equal Opportunities Policy, flexible working, managing diversity and avoiding discrimination and will help you to ensure that your staff are treated fairly and with respect.
- **Managing health and safety** will help you to understand your legal duties as an employer to minimise health and safety risks. The course will include the development of a Health and Safety Policy, creating a safe working environment and protecting staff who work on your premises but are not employed by you.

For further information about the courses, including registration fees, please visit the BMA website at:

<http://www.bma.org.uk/ap.nsf/Content/qpemploymentlaw08>. Places are strictly limited and will be allocated on a first come, first served basis. Reduced registration fees are available for BMA Members, to whom priority will be given. If you should have any questions about the courses or are unable to access the website, please contact BMA Conferences on 020 7383 6923 or by email at confunit@bma.org.uk

TRAINING COURSES

You may wish to consider attendance at one of these courses:

An RCGP Business and PBC Study Day on 22 Apr 08, see:

<http://www.gloslmc.com/link%20documents/Business%20and%20PBC%20220408.pdf>

and another on Quality, see:

<http://www.gloslmc.com/link%20documents/Quality%20%20Severn.pdf>

GP RETURNERS

For those who leave the PCT's performers' list for more than 2 years and then wish to rejoin it there is now going to be a nationally agreed written assessment. Depending on the results of the assessment and the efforts that the individual has taken to keep up to date in the interim, the Deanery may impose a period of retraining, from as little as a week to as much as a year. During that time the Deanery will pay the practice to which the Returner is attached for retraining but will not pay the Returner (the argument being that he/she could have made the effort to keep up to date). There should be less than a handful of cases a year to which this applies. This scheme also applies to those who go off to work abroad, but not, we believe, those working with the Services. The moral is: if

you leave a practice, stay on the list and keep your hand in.

REVALIDATION AND RELICENSING

In a similar vein, you should note that there are changes in the wind to do with revalidation (an RCGP responsibility) and relicensing (for which the PCT is responsible). The general idea is that one portfolio will serve both purposes, with annual appraisals for relicensing and a 5-yearly submission for revalidation. The exact terms of what will be required are still being worked on, but the flavour is that we are entering the Age of Inspection: not only must you do a good job, and prove that you are doing so, but you will probably have to photocopy it as well.

DARZI UPDATE

Part of the Darzi review has been work by a series of Review Groups in each SHA area that have come up with a profusion of bright ideas. Many of these are very worthy but a fair few are also impractical. There were a few GPs involved in these groups but one gets the feeling that at times the GP was outvoted. We are putting a short(ish) précis of these ideas on our website, but it is too early to say which of them, if any, will be taken forward for serious consideration. There is going to be a second interim Darzi report in May and a final one, probably to be released at the 60th anniversary of the NHS in July. Let us hope that it is well-considered.

DARZI CLINICS

The likely place for a Darzi Clinic in this county, if the PCT decides to open one, would be in Gloucester City. With that in mind the LMC is establishing a small working group of its members, mostly from Gloucester City but also with representation from Tewkesbury and the Freelance fraternity, to monitor developments and help to mould them in such a way that existing practices are not destabilised.

PRIORITY FOR VETERANS

A letter from the DH dated 12 Dec 07 has just reached us. It says that for patients of equal clinical need, veterans should have priority referral to secondary care for conditions which in the opinion of the GP or other healthcare professional could be related to their service. This guidance

covers all ex-servicemen, not just war pensioners. Typical conditions that might apply are hearing loss, mental health and orthopaedics. Patients need to be reminded that even if they get priority referral this does not equate to enough evidence to support the need for a war pension.

THE PHARMACY WHITE PAPER

"Pharmacy in England Building on strengths – delivering the future" published on 3 Apr 08 has a sting in the tail. It proposes to allow a surgery to dispense to all its patients, and sell over-the-counter medicines to them, provided the nearest pharmacy is more than a mile away. But this is not often true. The proposal is at present only that, and will be discussed more fully over the coming months. The dispensing practices must be protected. You can access the white paper on <http://www.official-documents.gov.uk/document/cm73/7341/7341.asp>

PRE-OP ANTIBIOTICS

Just a reminder – there is a long-standing practice that, particularly in cases of operations on the chest, the anaesthetist has the right to delay an operation if, in his clinical judgement, the influence of a current or recent course of antibiotics could adversely affect the success of the operation.

MS OFFICE ENTERPRISE 2007

Provided you have an e-mail that ends in 'nhs.net' or 'nhs.uk' you can order a free version of Microsoft Office Enterprise 2007 (although you do pay for the cost of the media and p&p – approx £19). You should check first with your system supplier of medical software to make sure it will not be incompatible. To order a copy, go to: http://www.microsoft.com/uk/nhs/pages/nhs_licensing_home_user_programme.aspx

MAX'S MUSINGS

The Americans have been researching the effects of obesity (they need to) and have come up with the interesting finding that

the wider your waist at middle age the more likely you are to go down with dementia some years later. Listening to some of their broadcasts and reading some of their publications I also wonder whether a narrowing of the mind accompanies an increase in girth. Are the narrow-minded doomed to be absent-minded also? An interesting thought. Another recent long-term US study of 900 Catholic clergy shows that about a fifth of them went down with dementia. I wonder if they were obese. Since it is about 20 years since I was last able to see my shoelaces while doing them up, I can only suppose that the onset of dementia in my case is disguised by my immense erudition, or something. Mind you, a further study suggests that injection into the back of the neck of a drug normally used to treat arthritis can increase connections between the brain cells, thereby helping the demented. 'Bring it on!' as I sometimes here my younger patients say when I suggest a rectal examination.

Continuing the North American theme, my cousin has come back from Alberta. He tells me that GPs out there earn £150,000 a year and are paid by the appointment rather than the registered patient. The cost of living is lower; the police, and even the criminals, are polite; the houses are huge; the land is positively flowing with milk and honey. And there is a shortage of doctors. 'Why not go there?' he asked. I know he only wants to get rid of me so that he can take over the family estate (car). But I will not be suborned. Why should I swap the crowded, smelly, litter-infested streets of my beloved city and the penny-pinching attitude of an uncaring Labour government for the wide open boulevards and distant Rocky Mountains of Calgary and a jolly decent salary befitting my skills and aspirations, to say nothing of a good education system? Hmm. Perhaps I am still young enough to learn to ice-skate down the canals to work in winter carrying my trusty Gladstone bag? I could always send you these musings from there...



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



SERVICES AVAILABLE TO ASSIST GPs WITH HEALTH & OTHER PROBLEMS

Nationally available services:

Irwin Mitchell (Solicitors)
(Contact Paul Bourne IRO Project Manager)
(Solicitors dealing with allegations of unlawful
discrimination & other complex law cases)

Tel: 0114 2721705

National Counselling Service for Sick Doctors

1 Park Square, London NW1 4LJ

Tel: 0870 241 05351

Doctors Support Network

Tel: 07071 223 372

Doctors for Doctors

Tel: 020 7383 6739

Doctors' Support Line

Tel: 0870 765 0001

The BMA Counselling Service (24-hour support)

Tel: 0645 200 169

BMJ Careers Chronic Illness Matching Scheme
Opportunity for doctors who have a chronic
illness or disability to receive informal careers
advice from another doctor.

www.bma.org.uk/public/chill.nsf

Sick Doctors Trust

Tel: 0870 444 5163

Website: www.sick-doctors-trust.co.uk

The British Doctors & Dentists Group
Doctors recovering from chemical dependency
Monthly group meetings.

Tel: 01252 316976 or 020 7487 4445

National Clinical Assessment Authority (investigates performance of doctors)

Telephone: 0870 267 0850

www.ncaa.nhs.uk

One to One (counselling service for training grade doctors in the South West Deanery)

Telephone: 0845 130 5354

The Maudsley Hospital provides an acute referral service for severely ill health professionals under the auspices of Professor Ann Farmer and Dr. Tony Clare. In the first instance Phone 020 3228 4696 (after hours 4693)

FINANCIAL HELP

BMA Charities

Tel: 020 7387 4499 including Cameron Fund

Royal Medical Benevolent Fund

Tel: 020 8450 9194

Royal Medical Foundation

Tel: 01372 821011

www.epsomcollege.org.uk/rmf

Gloucestershire LMC