

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE November 2008 Edition

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If you have the chance to sit back even for a moment from your daily cares, you might like to think what major issues the profession will be facing over the next year or so. Your representative LMC member should be contacting your practice before Christmas to ask for your views. Those views matter; if adopted by the LMC Conference in Jun 09 those views will be used as a guide to the BMA's GPC Negotiators strategy and tactics in 2010. Take a long view and let your member know what you can see, and what you would like the BMA to do about it.

DDR B UPLIFT – WHAT IS IN IT FOR YOUR PRACTICE?

(with thanks to Cambridgeshire LMC for their advice)

Dr Laurence Buckman sent everyone a letter explaining that any uplift agreed by DDRB next year would be allocated by a 7,2,5,5 formula. As a practice you need to know how this will affect you. Sadly there is no single spreadsheet available to do that calculation for you, but in round terms practices still reliant on an MPIG after this year will have their budget uplifted by about 1/3rd of the headline DDRB figure, and those who float off the MPIG with the rising tide will have more – some much more.

QoF PREVALENCE CHANGES – THE SQUARE ROOT FORMULA

The square root formula was introduced to relate QoF payments to workload and to recognise the fixed costs of running disease management in practices with small numbers of patients on disease registers. It is now seen as unfair and will be removed in stages: the square

rooting will go in 2009/10 and the truncation of prevalence in 2010/11. The exact effect on practices is easy to predict given the right inputs, but those are (we are told) confidential data which the DH cannot release. As a guide, those practices serving deprived or elderly populations, or universities, are likely to be more affected than others; the majority will hardly notice the change. To find out the likely changes to your practice income use the GPC's approved calculator:

<http://www.bma.org.uk/ap.nsf/Content/QoFPrevalence>

Please use the national QoF results not QMAS for your practice points and prevalence data (the sheet tells you how to find them.) Please let us know your practice size and the expected changes to your income for each of the 2 years. PCTs are under instruction from the DH to work with LMCs and practices to identify new services and improvements in care that should be commissioned to address local needs (and thus alleviate this drop in income).

MPIG – REDUCED PAYMENTS

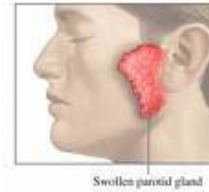
Several practices across the country have reported an inexplicable drop in payments in Oct. This had been ascribed to problems with the Exeter system, but that system has now been proved to be working correctly and the SFE working appropriately. So why the reduced payments? For GMS practices, an increase in the Global Sum of 2.7% was authorised with effect from 1 Apr 08 coupled with a commensurate reduction in the Correction Factor so that for the quarter Apr – Jun the change was cost neutral. The Global Sum is recalculated quarterly, depending on each practice's list size. If on 1 Jul 08 a practice size had increased, its Global Sum would have increased (although the MPIG would have remained reduced but unchanged). Such a practice would have an increased payment in Oct (reflecting an increased Global Sum for Jul – Sep). Should a practice list size have reduced in that quarter the FHS was under instruction not to reduce the payments, but that was a transitional arrangement, and any practice that has a reduced list size on 1 Oct 08 will find it suffers a reduced global sum payment accordingly in Jan 09 when the quarter Oct-Dec comes to be paid. The MPIG, having been reset as at 1 Apr 08, will be smaller but constant all through this year. It follows that if the Global Sum has increased then so too will the 6% deduction for not having out of hours responsibility. What happens on 1 Apr 09 is up to the Government and our GPC Negotiators. If any practice finds that its MPIG has reduced by more than was necessary to counterbalance the increase in the Global Sum as at 1 Apr then they should query this with the FHS. There is also a promise from the DH that if they should find an error in the calculations, even at this late date, any money owed to practices will be paid.

LEARNING DIFFICULTIES DES

There have been perceived ethical problems with releasing the County Council's list of names of those with Learning Difficulties. The PCT has agreed that if a practice uses the 2Gether Trust's list of names then that will satisfy the requirements of the QoF. However that is for this year only; by

next year the County Council should have obtained patients' consent to the release of their names to GPs.

MUMPS



We have been alerted that there is a probable outbreak of mumps in the University. Staff and students under the age of 25 should get in touch with their GP surgery if they have not had 2 MMR vaccinations or if they wish to check to find out if they are in need of a vaccination. And it does not harm to get the vaccination even if your mum says you have had mumps in the past – it may not have been mumps. Please stress to people that this is a potentially serious and highly infectious illness; at least 90% of the population needs to be immune if an epidemic, however minor, is to be averted. Practices will be paid for this as an item of service.

HEALTH VISITORS

Though there is much work to do yet, there is some good news on the Health Visitor front. At a director-level meeting with the PCT recently the LMC obtained assurances that the PCT is urgently addressing how best to provide essential health visitor services within primary healthcare teams to the families in greatest need. They have recently appointed Anne Nash, an ex-director of nursing in Swindon, to bring this about. She is now aware of all our major concerns, but says she would appreciate being told of any particular problems you may have. Please send them to this office for consolidation and onward transmission. It may take her a while to unravel all the threads so we have invited her to come to the Feb 09 meeting of the LMC to tell us about the new plans.

CREMATION PAPERWORK

With effect from 1 Jan 09 new regulations will come into force regarding cremations. The main changes are that the application will no longer have to be countersigned, that the applicant can elect on the application form to see the cremation forms within 48 hours and then has a further 24

hours to make representations to the medical referee, so the cremation can be delayed accordingly. Lastly, all the forms have changed. The new form 'Cremation 4' will replace the existing 'Form B'. The new form 'Cremation 5' which replaces 'Form C' omits the words 'seen and', but we would advise any doctor issuing a form Cremation 5 to indicate that the conversation took place by telephone, when appropriate. For those who want a preview of what they will be signing, see Schedule 1 of the Regulations:

http://www.opsi.gov.uk/si/si2008/pdf/uksi_2008_2841_en.pdf. A one-pager guide is attached to this Newsletter.

BMA SERVICE FOR MEMBERS

The BMA Library has just launched a six weeks e-journals trial, providing members with free access to a number of key medical journals. Titles will continue to be added to this list as the trial continues. Log onto the BMA members' home page and follow the links or go directly to

www.bma.org.uk/e-journals. If you have any queries please contact the BMA Library on 020 7383 6564/6452 or by email at e-journals@bma.org.uk.

BMA EMPLOYMENT LAW COURSES 2009

The BMA will be hosting courses on 'Managing Change' (recruitment and selection, contracts of employment, terminating employment, redundancy and change itself) and 'Managing Performance' (absence, staff grievances, disciplinary matters and performance management). For details see:

http://www.bma.org.uk/ap.nsf/Content/gpe_employmentlaw09 or ring them on 020 7383 6605/6923 or email them at confunit@bma.org.uk

Reduced registration fees are available for BMA Members, to whom priority will be given. Practice Managers are also invited to attend and will pay the same registration fee as their GP Partner, depending on whether they are a Member or Non-Member of the BMA.

LIFE LINE SCREENING

There is a private firm called Life Line Screening which is writing to people around the country to offer them

ultrasound screening for Stroke/Carotid Artery, Atrial Fibrillation, Abdominal Aortic Aneurism and Peripheral Arterial Disease, all for £139, with an optional Osteoporosis screening for a further £10. We do not yet know the quality of the tests, and it is always open to patients to consult the practice nurse in the first place, at no cost to themselves. But if they wish to have the tests then that is their choice. The tests may pick up previously undiagnosed problems.

NOVA-CHANNEL AG

We last warned you about this firm in September. They are still sending invitations to practices to have an ostensibly free entry in a directory called the *Physicians and Therapists Guide*. Just be very careful before you agree to take this entry as there is a considerable charge for inserting any additional information. It is not even clear that anyone gets any benefit from the basic entry.

CHANGE4LIFE

In case you missed it, the Government is starting a new initiative to reduce obesity in children so that in the years to come they will not cost the NHS so much. They hope that Change4Life will involve healthcare professionals, social services, businesses and the public in a coordinated drive to make people, particularly children, eat more sensibly and move about more. The website will be developed between now and Christmas and the scheme will go live in the New Year. At this stage practices should just be aware it is happening.

EMPLOYMENT AND SUPPORT ALLOWANCE (ESA)

From 27 October 2008 Employment and Support Allowance replaced Incapacity Benefit and Income Support paid on incapacity grounds for new DWP 'customers'. The new Employment and Support Allowance will require release of medical information from GPs, and for this purpose verbal consent will be sufficient; this has been confirmed by the Information Commissioner and the GMC. GPs should continue to accept assurances from the DWP officer that consent has been given. It will mean that:

- GPs will still be asked to provide statements of incapacity for work (usually on form Med 3) until the Work Capability Assessment is carried out, which is usually within the first 13 weeks of a patient's claim.
- GPs may also be asked to complete form ESA113. This is similar to form IB113. Form ESA113 can be completed from medical records and GPs are not required to carry out a separate examination of their patient.
- GPs may also be asked to complete form DS1500 to provide information about patients who are terminally ill or who are not expected to live longer than 6 months. This is a factual report in which GPs provide details of their condition and any current, planned or future treatment. GPs are not expected to give an opinion on prognosis or life expectancy.
- Your patients will not be denied benefits solely on the information you give. The decision to award Employment and Support Allowance is made by expert decision makers and is based on a range of information, evidence and independent medical advice.

Further information about the Employment and Support Allowance can be found at <http://www.dwp.gov.uk/esa/>

ANTIBIOTIC MANAGEMENT

Dr Philipa Moore, the PCT's director of Infection Prevention and Control plans to visit practices over the next few weeks to provide a chance to ask questions on antibiotics, infection trends and related topics, including Clostridium Difficile. The LMC is pushing for proper reimbursement for practices filling in the CDiff root cause analysis proforma. Updated antibiotic guidelines will soon be distributed to prescribers in a handy desktop flipchart format and as a pocket-sized card.

CHAPERONES

In June 2005 the NHS Clinical Government Support Team published a useful guide to chaperoning which can be accessed at:

http://www.cgsupport.nhs.uk/downloads/Primary_Care/Chaperone_Framework.pdf

This guidance, which is still valid, recommended that practices should:

1. Establish there is a genuine need for an intimate examination and discuss this with the patient.
2. Explain to the patient why an examination is necessary and give the patient an opportunity to ask questions.
3. Offer a chaperone or invite the patient to have a family member/friend present. If the patient does not want a chaperone, record in the patient's notes that the offer was made and declined.
4. Obtain the patient's consent before the examination and be prepared to discontinue the examination at any stage at the patient's request.
5. Record that permission has been obtained in the patient's notes.
6. Once the chaperone has entered the room give the patient privacy to undress and dress. Use drapes where possible to maintain dignity.
7. Explain what you are doing at each stage of the examination, the outcome when it is complete and what you propose to do next. Keep discussion relevant and avoid personal comments.
8. If a chaperone has been present record that fact and the identity of the chaperone in the patient's notes.
9. Record any other relevant issues or concerns immediately following the consultation.

ISA

This ISA has nothing to do with personal savings; it has everything to do with saving persons. The Independent Safeguarding Authority has been set up to make sure that those dealing with children and vulnerable adults are not going to take advantage of them. The new arrangements for 'regulated' activities come into effect a year from now, on 12 Oct **09** and will take a further 5 years to be fully implemented. 'Controlled' activities, as defined under the Act, will not apply until 2014. This all sounds far distant, but you need to plan ahead as it will involve fees, changing of contracts, etc. After 12 Oct 09 any employee that could pose a risk to patients or might have access to records and patients' details would need to be registered. This is likely to include receptionists and cleaning staff and

those who manage and supervise them! Our understanding is that the scheme will initially apply to new applicants with checks for existing staff required at a later date. Full guidance should be available by Spring 09. Current payment arrangements would remain for GPs as they already require CRB checks (which are more thorough than ISA). Theoretically it is up to the employee to bear the £64 cost of one-off registration with ISA, but in practice it is likely that employers will foot the bill, as they will be unable to have the new member of

staff on the premises, even if supervised, until the ISA registration comes through. Because ISA is being introduced by primary legislation (the Safeguarding Vulnerable Groups Act 2006) it takes precedence over existing contracts, but current contracts should still be amended to refer to its effect on the contract, when in force. Note that candidates will still have to receive a standard or enhanced CRB check if the post they are to fill requires it. Duplication? Certainly not! Or so we are told.

MAX'S MUSINGS

I heard recently that the NHS has spent over a quarter of a million pounds on translating NHS Direct into 160 languages, some of which are rarely, if ever, spoken in UK. At first I was angered at the apparent waste. But on reflection I think there are 2 good things about it. One is that our civil service, being extraordinarily persistent, can still create a superbly structured and



coherent mountain out of any molehill, given enough time and money. The second is that it seems to reflect a welcome change in our previously xenophobic national attitude. Yes, common politeness should require any person in a foreign land to find a way of communicating with the natives. But it reflects well on our health service that, when the bodies of visiting foreigners' are sick and their minds are worried, we are prepared to go the extra linguistic mile to make life easier for them. I remember that as a bandy-kneed Boy Scout in a funny hat, scarf and 'woggle' I was often exhorted to 'be prepared' and to 'do my best'. These are excellent character traits, whether personal or national, and should be praised. And the cost was not so very great really, was it?

I see in the Observer that the boys in Bristol have found it cheaper to send obese patients to Weight Watchers and other slimming clubs than to prescribe slimming drugs. The measure of success is the cost per kilogram lost. At a slimming club the cost is about £16 compared with about £50 when using drugs. But of course if you also take

into account the indirect benefits to the NHS and the patient (reduced number of joint replacements, reduced problems with diabetes and probably a longer and healthier life) then the worth of the treatment is greatly increased. I who have had extra-strong springs fitted to my surgery chair; I who normally put more air in the off-side tyres to offset the unbalancing effect of my sitting that side of the car to drive the half mile to my surgery each morning; even I might consider it.

Gutenberg, Caxton and Pynson were early printers who changed the world of letters and learning completely by mass-producing books that almost anyone could buy. The inventor of the typewriter



probably thought he was onto a good thing too, helping any unskilled person to commit their thoughts to paper. Even the word processor and the microfiche reader and the laptop computer were steps in the same general direction. But the other day I saw a wonder. It was an electronic 'book', no thicker than one of my cigarette cases and about the same size as a large paperback, but much less heavy. On its internal memory it could hold nearly 200 complete books; its battery lasted for ages. Comparing Caxton's printing press with a modern one, I feel this must be only the first step in a new direction. The day cannot be far off when that capacity will be vastly extended: it will be fitted with a search engine, and made from a material that can be rolled up and stuck in a convenient housecoat pocket; all the

medical textbooks and Department of Health papers you ever heard of; all the idiot's guides you ever wished you had to hand; all the leisure reading you could ever hope for; all the newspapers of the world downloaded while you sleep; possibly even an interactive device for filling in the crossword, and rubbing out the wrong numbers you put into the Sudoku puzzle. And it was so easy to use. When you bookmark a passage it even looks as though it is turning over

the corner of the page. Not, I hasten to add, that anyone in my family would dream of being so cavalier with a valuable book. Its main limitation is that you still need a torch to read it under the bedclothes. My young nephew, grounded in Muscat for 3 days (aircraft reliability still has a way to go), used his electronic book to read 12 'books', so did not feel the time to be wasted.



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

GLOUCESTERSHIRE LMC DOCUMENT SUMMARY

Document Title: New Cremation Forms	
Document Originator: Parliament	Document Date: 3 Nov 08
Remarks: Statutory Instrument 2008 No 2841	Date of Summary: 26 Nov 08
Download Full Doc from: http://www.opsi.gov.uk/si/si2008/pdf/uksi_20082841_en.pdf	
Document Summary written by: Mike Forster	
<i>N.B. This summary was correct when issued. Its accuracy cannot be guaranteed in the long term, since policies and organisations change. Although every effort will be made to ensure that it is updated the Reader is urged to exercise caution if the document at the time of reading is more than a year old.</i>	
<p>Bottom Line: These changes are a product of the Shipman enquiry, and are designed to ensure that the evidence of wrongdoing is not too hurriedly burned. Form B is replaced by form Cremation 4, and Form C by form Cremation 5, with effect from 1 Jan 09. Some extra questions have been added and much more space given to show supporting detail. Note that the confirming medical practitioner no longer has to 'see and question' people, but merely 'question' them.</p> <p>The regulations now also allow the applicant 48 hours to see the forms Cremation 4 and Cremation 5 and a further 24 hours to make representations to the medical referee.</p>	

You will mainly notice that the forms have increased in size; the content is largely the same, but there are a few significant changes.

Cremation Form 4 changes. Several questions have been rephrased or given minor amendment. Significant changes and additions are:

- You now have to say the date and time you saw the body, not when the deceased died.
- New Questions:
 - (13) 'Do you have any reason to believe that the operation(s) shortened the life of the deceased?'
 - (15) Additional to the usual question of whether other persons were present at the moment of death you now have to state 'whether you have spoken to them about the death'.
 - (16) 'If there were persons present at the moment of death, did those persons have any concern regarding the cause of death?'
 - (21) In addition to the normal question asking whether the coroner has been informed there is an additional question: 'Has there been any discussion with the coroner's office about the death of the deceased?'

Cremation Form 5 changes.

- It now requires the name, address and occupation of the deceased!
- In all the normal following questions the words 'seen and' have been deleted. This opens up the possibilities of questioning the people concerned other than face to face – by telephone conversation perhaps, but also perhaps by e-mail or even by letter. We would recommend that where possible face-to-face should remain the norm and if done over the telephone this should be stated on the form.
- (7) now specifically asks you to confirm that you agree with the cause of death given in Question 11 of Part 2 of form Cremation 4 and allows you to insert full details if you do disagree.

Note that under clause 22 of the SI the person applying for cremation of the deceased will from 1 Jan 09 have the right to inspect both forms Cremation 4 and Cremation 5, or to authorise another to do so on their behalf. This examination has to take place within 48 hours of being telephoned by the cremation authority that the forms are available for inspection. They then have 24 hours to make representations to the medical referee. So cremations could be delayed by up to 3 days in such circumstances.