

# LMC Secretariat Newsletter (August 2006)

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## **PCT Chief Executives**

On 28.7.06., Mark Britnell (South Central SHA CEO) announced the CEO appointments for two of the four available new PCT vacancies in the Thames Valley.

They are Andrea Young (Oxfordshire) and Janet Fitzgerald (Mid and South Bucks)  
Congratulations to both.

The East and West Berks PCTs decision is still to be made.

At about the same time David Nicholson (CEO for London SHA) was appointed CEO of the NHS in England replacing Sir Nigel Crisp.

## Decommissioning of Enhanced Services

Across the Thames Valley many PCTs are only now finalising their 06/07 Enhanced Services plans and proposals for spend. Due to NHS deficits and differences in ES portfolios between merging PCTs, many are decommissioning some existing LESs. The Secretariat view is that activity not paid for by PCTs should not be performed by practices. We have already helped some practices with in-house notices advising patients of withdrawal of services and who in the PCT to contact.

Phlebotomy has been particularly difficult, partly because of the spread of views amongst GPs and historical differences in where each PCT has placed its service. Where, under the Red Book, phlebotomy has been practice based, funding often sits in the MPIG correction factor (CF). However where a non practice based service existed and is now being withdrawn, there is no mechanism for increasing CF. Understandably practices affected in this way feel resentful. I have tried to get PCTs to see that a one size fits all approach is unfair. However at a time when PCTs are reorganising and people are preparing for job interviews, few seem receptive to this argument.

## Enhanced Services Spend by PCTs

The Secretariat has written to Mark Britnell (South Central SHA CEO) for his view of the widespread PCT practice of only planning to spend to last year's ES Floor. This seems contrary to paragraph 5.18 of "Revisions to GMS 06/07"

[http://www.ehiprimarycare.com/tc\\_domainsBin/Document\\_Library0282/2006\\_Revisions\\_to\\_GMS\\_contract\\_-\\_full.pdf](http://www.ehiprimarycare.com/tc_domainsBin/Document_Library0282/2006_Revisions_to_GMS_contract_-_full.pdf)

*5.18 Enhanced services floors will be frozen at 2005/06 levels. Expenditure on the new 2006/07 DESs will be monitored over and above the 2005/06 floor but as practices may elect not to provide services under these DESs, or they may fail to achieve target payment levels, the 2006/07 enhanced services are only an indicative figure.*

## New NHS Pension Proposals

(Consultation Document published Tuesday, 1 August 2006)

'Moving to the Future: The NHS Pension Scheme Review'

<http://www.nhsemployers.org/pay-conditions/pay-conditions-1256.cfm>

Consultation will commence on 1 September 2006. All NHS staff and employers will be receiving documents about the review that will outline how they can make their views known. It is expected that staff will receive a leaflet with their September payslips; GP Practices will be sent copies for distribution

This is described on the NHS Employers website as: "Terms of agreement between NHS Employers and the NHS trade unions at the Pensions Steering Group for the NHS Pension Scheme Review."

The main proposals are:

- Pensionable age would remain at 60 for current NHS staff
- Final salary pensions for employed staff would be maintained
- Career average schemes for GPs would be maintained

- A new pension scheme would be introduced for future workers with a pension age of 65. This would also be final salary for employed staff and career average for GPs

All NHS staff would pay contributions according to their earning levels. Those earning below £15,107 would pay 5%; those earning between £15,108 and £60,880 would pay 6.5%; those earning between £60,881 and £100,000 would pay 7.5%, and employees on more than £100,000 would pay 8.5%.

More information, including a presentation, is available on the BMA website at <http://www.bma.org.uk/ap.nsf/Content/Hubaskpensionspensionsreview?OpenDocument&Login>

The BMA want to hear your views. You can email your comments to [info.pensionsreview@bma.org.uk](mailto:info.pensionsreview@bma.org.uk)

## **New Childhood Immunisation Schedule Funding**

Details of the agreement reached with NHS Employers on the introduction of the pneumococcal vaccination in the childhood immunisation programme have been published by the CMO.

GPs will be remunerated £15.02 per child for the delivery of the pneumococcal vaccinations and the additional vaccination visit at 12 months to deliver the combined Hib and Men C vaccine.

Payment for the catch-up programme will be £7.51 per child.

This will be introduced on 4 September 2006.

Further details of the changes can be found on the CMO's section of the Department of Health website.

[http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ProfessionalLetters/ChiefMedicalOfficerLetters/ChiefMedicalOfficerLettersArticle/fs/en?CONTENT\\_ID=4137171&chk=vpwQzv](http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/ProfessionalLetters/ChiefMedicalOfficerLetters/ChiefMedicalOfficerLettersArticle/fs/en?CONTENT_ID=4137171&chk=vpwQzv)

## **Healthcare Commission Diabetes Survey**

Many practices have been approached by their PCT to take part in this. Whilst PCTs are likely to be performance managed on uptake, taking part is voluntary for practices.

The Healthcare Commission process seems over-bureaucratic with practices being asked to sign a lengthy contract for Data Protection Act (DPA) purposes.

The GPC legal advice (confirmed with the Deputy Information Commissioner) is that the DPA allows practices to provide names and addresses of Diabetics who might be sent a questionnaire provided the receiving organisation has good confidentiality arrangements and requires the information for health planning.

The questionnaire should only ask about Diabetes. Unfortunately section H is specifically about access for non-diabetes. This needs to be changed.

Miquest queries to extract the data could be run by PCT employees working briefly in practices.

## **Heat wave Alerts from PCTs**

Several Thames Valley practices have contacted the LMC after receiving heat wave emails from their PCT. These usually suggest that GPs and district nurses should jointly compile a list of vulnerable elderly to contact. The PCT initiative is in response to the

Dept. of Health heat wave plan which many privately regard as without an evidence base and impractical. However with PCT mergers and job interviews imminent, feeding back this message to government is impossible.

It is not at all clear to me what GP intervention has been proven to save life in a heat wave. Those most at risk are the cognitively impaired or psychiatrically ill, who might not recognise the dangers of high temperature. The vast majority of these would already have a care package involving environmental risk assessment. For those currently without supervision, what would be the impact of a single phone call or visit from practices?

My view is that it would have been much better to have initiated a national media campaign promoting neighbourliness and temporary increased visiting of the unsupervised elderly. The current campaign seems more a political exercise preparing the way for transfer of blame should the UK experience an epidemic of heat wave deaths similar to that in France a few years ago.

Most PCTs are aware that there is little spare capacity in practices and expect any input to be limited and targeted. I know of no contractual obligation on practices to comply with PCT requests and this is confirmed by the GPC. However, some might feel an obligation to do what they could. My advice is that given baseline practice workload any measures should not consume large amounts of time and effort.

## **Contract negotiations update**

**(Extract from GPC News 21st July)**

Discussions on stage 2 of the GMS contract review, intended for implementation in April 2007, have continued over the past few months. A meeting was held between NHS Employers and GPC negotiators on 13 July 2006.

The GPC entered this round of negotiations with a clear mandate from the LMC Conference about what the profession expected and what it would not accept for 2007/08. The GPC has consistently taken the approach that any deal for 2007/08 must include, as an absolute minimum, an inflationary rise to the contract. It has been made clear that any further release of QOF points for replacement with harder work, or any attempt to erode MPIG by awarding inflationary rises only to practices with no correction factors would be unacceptable.

The GPC has also pressed for negotiation of an expanding practice allowance, a variety of premises issues, revised payments for temporary residents, mechanisms to ensure the continuation of a UK contract and timely implementation of the survey of PCOs on discretionary payments as agreed last year.

Whilst discussions have been held on some of these issues, the search for mutually acceptable solutions is proving a challenge. The GPC has remained firm that the agreement reached for 2006/07 dealt with the perceived value for money issues associated with the 2003 nGMS deal and has resisted any further significant concessions. Negotiations are at a difficult and delicate stage.

## **CRB checks and non-clinical NHS staff**

The Secretariat has been asked to bring this to the attention of practices

It is not a legal requirement for all NHS recruits to undergo CRB Checks at present.

The current law allows the NHS to seek a CRB check for posts that allow access to patients "in the course of normal duties" e.g. doctors, nurses, midwives and porters.

Seeking a CRB check for non clinical staff in general practice would breach the Rehabilitation of Offenders Act and the Data Protection Act.

On 13th October 2004, John Hutton merely announced the government's intentions to introduce Criminal Record Bureau (CRB) checks for all NHS staff by early 2005. However, the necessary legislation was never passed.

If there are steps to introduce such legislation, the financial implications to practices will be raised by the GPC.

## **Apollo Software**

The GPC IT team has recently reviewed the QOF assessor toolkit Apollo software. Some LMCs and GPs have expressed concern about patient identifiable data leaving practices. GPC has confirmed this is not the case and LMCs and GPs can be reassured that the software is safe to use.

## **Flu pandemic planning**

Practices might like to look at a practical guide to planning for the threat of pandemic flu

This has been produced by the joint RCGP/GPC Emergency Planning Group and can be found at:

[http://www.rcgp.org.uk/service\\_continuity/service\\_continuity\\_home.aspx](http://www.rcgp.org.uk/service_continuity/service_continuity_home.aspx)

The GPC is continuing work to ensure that, should a pandemic arise, practices are clear what policies and procedures are in place. Issues raised include prescribing and availability of anti-viral drugs, availability and effectiveness of flu vaccines, repeat prescribing and dispensing of regular medication, indemnity for GPs following government directives and the protection of GP income.

GPC (Peter Holden) has raised these issues with NHS Employers, with view to reaching agreements particularly around GP terms and conditions of service, and also with the various Emergency Planning Committees that are in existence to formulate such plans.

## **Maternity Locum Reimbursement**

The 06/07 SFE increased the maximum amount payable to £1,500 for locum costs from week three of potential entitlement for maternity, paternity and adoptive leave for GP principals and their salaried GPs.

The GPC has received reports from various areas where PCTs are imposing a blanket refusal to pay the new maximum payment of £1500, and in some cases nothing at all.

The issue was raised directly with NHS Employers who have confirmed that PCTs cannot issue blanket refusals to pay up to the maximum.

They have agreed to ask the Department to write to PCTs to ensure that this is made clear.

Please continue to make the Secretariat aware of problems you encounter.

A key GPC priority for the forthcoming year is to ensure that, as detailed in the revisions to the GMS contract 2006/07 guidance, the level of reimbursement for

maternity is monitored and reviewed to determine the level of PCO discretion that is being exerted. If the results determine that discretion is not being applied appropriately, the GPC will take this up with NHS Employers accordingly.

## **CMO's report on GMC and Medical Regulation**

Last week the CMO Liam Donaldson published a major review of medical regulation, prompted by the Shipman inquiry.

The document "Good Doctors, Safer Patients" contains 44 recommendations including proposed devolution of some of the GMC's powers to a local level and the creation of a new framework for revalidation.

It can be found online at

[www.dh.gov.uk/assetRoot/04/13/70/78/04137078.pdf](http://www.dh.gov.uk/assetRoot/04/13/70/78/04137078.pdf)

## **General Medical Practitioners Annual Census**

Practices have recently been asked to complete an annual practice staff census. The GPC regards this as essential to the work of the Technical Steering Committee (TSC)

They wish to encourage all practices to participate as the results could have an important influence on future negotiations.

## **Dovedale Counselling for GP, staff and family**

(Oxon and Berks practices only)

### **New wellbeing focus for GP-CARE**

The GP-CARE support service for GPs and their immediate families has been extended to include a broad range of advice and guidance on general wellbeing issues. This is in addition to the helpline support and face to face counselling services already provided, and is in response to the needs of GPs, as they have developed over the years. The service is provided for Oxford and Berks GPs by Dovedale Counselling Ltd., a leading provider of counselling and support services for GPs and practice staff.

To find out more about this new extension to the service, check the GP-CARE user pages on Dovedale's website. These can be accessed by visiting

[www.dovedale.co.uk/GP-CARE](http://www.dovedale.co.uk/GP-CARE)

On these pages you'll find information about improving the way you manage relationships, both at home and in the practice; on healthier eating; on how to manage alcohol better; on managing your personal finances and on many more topics. They also contain more information on the Dovedale service and how to access it, including how to make use of the **secure, on-line service request facility**.

The user pages are in addition to the telephonic support and face to face counselling services Dovedale already provides through its 24/7 helpline on freephone **0800 214 307**.

## **GP Workload Survey**

Practices may soon be asked by the technical steering committee of "The Information Centre For Health and Social Care" to take part in a GP workload survey. Again this work is a vital part of GPC preparation for contract negotiations. The GPC need to monitor the

workload of all staff groups in general practice, to ensure that resources keep pace with any changes.

Contact is likely to be made in two phases (September and December)

## **Temporary Residents: Communication with Usual GP**

The Secretariat has sought clarification from the TVPCA about how this is best done in the new world of computerised consultation records.

Their reply is copied below in italics.

*TRs are not transferred across the LINK so the TVPCA is not aware of them.*

*We are not aware of any national guidance or procedures for temporary resident transfer of clinical details but no doubt this will be solved as we move towards the National Care Record System and we will raise it with Connecting for Health staff.*

*The best practice process for TR forms is that the TR form is filled in at the Practice and the flimsy is kept, with the cardboard copy being given to the patient to give to their own GP.*

*If a Practice is not using the TR forms but entering the detail onto their Practice computer system then one can only suggest that this is printed and given to the patient to give to their GP.*

*Your email has prompted me to action in terms of the need to re-energise all round best practice in primary care. I will of course share any proposals with you beforehand.*

## **PMS Funding**

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT\\_ID=4127552&chk=bQ7VEs](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4127552&chk=bQ7VEs)

Paragraph 3.31 of this year's White Paper (URL above) states that the government intends to carry out a fundamental review of financial arrangements for PMS practices

The GPC has asked all LMCs to notify them of attempts by PCTs to negotiate or impose less advantageous PMS contract terms.

Please keep the Secretariat informed of developments at practice level.

## **Screening for Cystic Fibrosis and Haemoglobinopathies**

It has been announced that from 1.7.06. Valley all neonatal bloodspot tests across the Thames will also be tested for the above

Details can be found at

<http://www.ich.ucl.ac.uk/newborn/cf/index.htm>

and

<http://www.kcl-phs.org.uk/haemscreening/>

## **Commissioning Framework for England**

The Department of Health published a commissioning framework on 13 July 2006, 'Health reform in England: update and commissioning framework', which can be accessed at the following website address:

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4137226&chk=D2YSig](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4137226&chk=D2YSig)

The annex of the framework contains the bulk of information relevant to LMCs and GP practices and appendices D-E of the annex are open for consultation.

## **New Access DES Reward Table**

An updated table of threshold targets and associated rewards, which replaces that which was published as Appendix A of Annex 4 in "Revisions to the GMS contract 2006/07", has been agreed.

This is published in section 7B of the revised SFE.

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4107508&chk=dc/lzz](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4107508&chk=dc/lzz)

This table provides details of the financial rewards payable to practices for patient satisfaction levels between the minimum and maximum access thresholds, as measured by the results of the national patient survey. This has moved the percentage satisfaction levels to 1% intervals rather than 2%.

## **Altered Choice and Booking DES**

[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT\\_ID=4136869&chk=pZaxRJ](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4136869&chk=pZaxRJ)

There is no reference in the DES Directions (see above) or the SFE to the 25% aspiration target in June 2006 booking.

Therefore, the only target the contractor has to meet to retain the aspiration payment is to reach the minimum year-end standard of at least 50% of its referrals (converted Unique Booking Reference Numbers) through Choose and Book in the period 1 September 2006 to 28 February 2007.

The June target was intended to ensure that practices started using Choose and Book early enough to be able to reach the minimum level in the measurement period of September to February. With the payment thresholds starting at 50% and the full value of the booking component only payable if a practice achieves 90% or more, any practice hoping to achieve the maximum payment needs to start using Choose and Book as soon as possible.

Both aspiration payments in the C&B DES are recoverable if the relevant targets are not reached, but the two components of the DES are not linked. So if a practice fails to meet its 50% C&B bookings target for Sept-Feb, its booking aspiration payment can be recovered, but its choice aspiration payments cannot, as long as the practice reaches the 60% survey result target.

GPC is aware that attainability of component 2 of the DES is being questioned, due to the lack of functionality with C&B systems that are in place and hospitals not accepting C&B referrals. The DES specification makes provision for system fall down which allows for payments to be made where a practice has not been able to implement a particular programme due to circumstances beyond its control.

LMC will discuss the situation with Thames Valley PCTs and we are continuing to discuss the criteria for determining this. In the meantime, practices should be keeping records of when they could not use the system through no fault of their own so that they can make a case at the end of the year should it be required.

## **2006/07 Interim Dynamising Factor**

The GPC, NHS Employers and the Health Departments have now agreed the interim dynamising factor for 2006-07.

The interim figure for 2006-07 will be 1.0 per cent (NB, it can never be less than 1.0). The final figure for 2006-07 is judged likely to be around 2.6 per cent.

As with 2005-06, the 1.0 per cent interim figure was agreed according to the statistical analysis provided by the Technical Steering Committee (TSC), which determined there was 90 per cent confidence that the final figure would be higher than 1.0 per cent.

The interim figure announced will only affect those GPs who receive their pension between 1 April 2006 and 31 March 2007. This provides retiring GPs with a more realistic pension. All other GPs will have their earnings increased by the final figure that will be announced in 2008. Pensions taken between 1 April 2006 and 31 March 2007 will be recalculated by the NHS Pensions Agency once the final factor is determined and they will arrange for the amended pension (with any arrears due) to be paid.

## **Interim Seniority Figure 2006/07**

To determine the proportion of the full annual seniority payment GPs are entitled to, GPs need to take the Average Adjusted Superannuable Income and from this calculate the Superannuable Income Fraction which will determine the proportion of the seniority payment received.

Because the aggregate of all NHS profits of all GP providers (that determines the Average Adjusted Superannuable Income) cannot be determined until after the end of the financial year, an interim average superannuable income figure is agreed between the GPC and the Departments of Health.

For 2006/07 the interim average superannuable figure for England, Wales and Northern Ireland is £95,335. This figure will be used in interim calculations of Superannuable Income Fractions. There will be retrospective adjustment of underpayment or overpayments after the actual Average Adjusted Superannuable Income has been determined, as per paragraph 21.11 of the SFE.

## **24 hour retirement**

The GPC is still trying to get further information following the changes to the requirements for GPs who wish to return to work after retirement.

In the meantime, GPs should be aware that although it is confirmed that the required period of retirement has been reduced to twenty-four hours, the process remains the same and the same problems, particularly for single-handed doctors, remain.

24h retirement requires retirement from the GMS or PMS contract with the PCT, but not the Performers List. For single-handed doctors the risk is that the PCT might not offer the contract back.

## **Medical reports provided to the prison service**

An issue has come to light about whether GPs are still able to charge for medical reports provided to the prison service.

Now that prisons have been transferred over to PCTs, the Prison Health Service believe that prisoners should be treated as patients and therefore a charge should not be applicable on request for a report on a prisoner.

On Prison Service Order number 3050, paragraph 2.4 Charging for Information states:

*NHS bodies should not normally charge each other and information necessary for the purposes of continuing patient care should not be delayed. Although there has been some uncertainty about whether a fee can legally be charged, as the responsibility for prison health in the public sector comes directly under the umbrella of the NHS, the British Medical Association (BMA) advises that demanding a fee is inadvisable. Further information can be obtained from the BMA's handbook of ethics and law. NHS bodies are expected to extend this to include private sector prisons in order to ensure continuity of care for patients.*

This is in concordance with the advice of the BMA's Professional Fees Committee and the Civil and Public Services Committee. In practice GPs should provide reports for the prison service free of charge but ensure that these reports contain only information related to the direct clinical care of the patient and to ensure continuity of care, for example a brief note asking for medication details, drug abuse history or note of any outstanding hospital appointments known.

## **Targeted insurance reports**

There have been reports from a few areas of practices receiving requests from insurance companies for a 'targeted' insurance report, and offering set fees for the work. This is not a negotiated or agreed BMA fee. The BMA's Professional Fees Committee (PFC) has clarified the situation as follows:

"The PFC has been informed by the Association of British Insurers of their intention to introduce targeted reports and are aware that the reports are being piloted. PFC has received a number of queries recently, indicating that they are now in wider use. The Committee has not supported the introduction of these targeted reports, and therefore there is no fee agreement with the ABI. Whilst the BMA-ABI agreement remains in place for the GP and supplementary reports, PFC would suggest that doctors charge at their own rate for undertaking targeted reports - although, there is no obligation on the doctor to undertake the work."

## **GMC Consultation on "Good medical Practice"**

The GMC is currently reviewing Good medical Practice, with a view to publishing the new version in November 2006.

To take part in the consultation, go to: <http://www.e-consultation.net/gmc>