

---

# THE SECRETARIAT OF THE LOCAL MEDICAL COMMITTEES FOR BERKSHIRE BUCKINGHAMSHIRE AND OXFORDSHIRE

---

**Chairman**  
**Dr Andy Sapsford**  
Rectory Meadow Surgery  
School Lane  
Amersham  
Bucks  
HP7 0HG

**Tel: 01494 727711**  
**Fax: 01494 431790**  
[andrew.sapsford@nhs.net](mailto:andrew.sapsford@nhs.net)

**Treasurer**  
**Dr John Rawlinson**  
Radnor House Surgery  
25 London Road  
Ascot  
Berks  
SL5 7EN

**Tel: 01344 874011**  
**Fax: 01344 628868**  
[John.Rawlinson@GP-K81655.nhs.uk](mailto:John.Rawlinson@GP-K81655.nhs.uk)

**Chief Executive**  
**Dr Paul Roblin**  
Secretariat of Berks Bucks & Oxon LMCs  
Mere House  
Dedmere Road  
Marlow  
Bucks SL7 1PB

**Tel: 01628 475727**  
**Fax: 01628 481173 or 01628 474731**  
[paul.roblin@bbolmc.co.uk](mailto:paul.roblin@bbolmc.co.uk)

safe and ending up with quite large end of year under-spends, used invariably to offset the PCT financial deficit. For 06/07, the GPC and NHS Employers seemed to have agreed that PCTs should spend to last year's floor and fund the new DESs on top of this sum. However, the ES floors were described as "indicative", a term vague enough to raise suspicion of a fudge. The Secretariat has therefore sought clarification from the new South Central SHA. The view of their chief executive Mark Britnell is that "indicative" does not confer a spending obligation on PCTs, for whom coming within budget is a greater priority. The inference is that failure to spend to the new floor will be tolerated by those monitoring PCTs.

My view is that this is a predictable reality for an NHS in deficit and a government sensitive to media criticism. As tax payers, we would want commissioners to prioritise NHS spend within the funding allocated. Obligatory spend on any category is incompatible with this view. GP practices are the obvious first choice provider in many circumstances, and where practices can provide what PCTs want to purchase, LMC will argue the GP case and attempt to get the best deal possible. Again the reality of the current NHS means that profit margins won't always be large; the market will undoubtedly put downward pressure on price.

## **PCTs charging for District Nursing Services**

Several Thames Valley PCTs have recently announced plans to make sure that, without cross charging, their nursing staff do not perform work they believe is funded under the new GP contracts. Many GPs have been upset by this, citing unnecessary interference with the working of harmonious primary care teams, failure to recognise all the free activity practices already give PCTs and the "thin end of the wedge". These are legitimate arguments which the Secretariat will use in its negotiations with PCTs. However, they need to be balanced against the undoubted PCT obligation to ensure the NHS does not pay twice for activity. I hope to reach sensible compromises on where cross charging is appropriate but also avoid a wasteful bureaucracy.

More detailed comment is needed on flu vaccinations given by district nurses. Some PCTs have recently sought to negotiate with the Secretariat on this issue, particularly the size of the charge to practices. Some GPs have expressed surprise that this wasn't vetoed out of hand. I would regard this as an inappropriate response, given that in the absence of an agreement it was clear that PCTs would just have instructed their district nurses not to give any flu vaccinations. Practices would then be responsible for all their housebound immunisations. They still have this option but can also subcontract the work for a sum of approximately £4, leaving £3.50 as payment for ordering and storage.

Historical division of labour within primary care teams was reflected in the pricing of the Global Sum. I do have concerns that the role of district nurses

will be insidiously redefined by PCTs, and tasks they have performed in the past reclassified as being covered by basic practice contracts. I will continue to resist this and will more radically promote discussion on whether practices should take over PCT nursing services to produce an integrated (and fully funded) nursing service for both the housebound and ambulant.

## Update on Pension Changes

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

The Secretariat recently organised two meetings on 'Pension Changes' at Milton Keynes and Slough. Andrew Dearden, the chair of the BMA Pensions Committee, gave presentations with his renowned mix of good information and entertainment.

For those who couldn't attend, I have tried first to provide my own explanation of how GP pensions work and then to summarise Andrew's key points

### Explanation of GP Pensions (PHR)

The GP pension scheme is known as CARE (Career Average Revalued Earnings). Consultants have a final salary scheme.

During a career, figures representing a GP's annual superannuable profit (partners) or income (sessional) are derived from partnership accounts or P60s. These figures are logged at the NHS Pensions Agency using certificates produced by practice accountants and submitted via PCT support services department.

GPs used to receive an annual SD86 certificate, detailing superannuable income and employee contributions. For partners the SD86 stopped with the new contract because the information is contained in the certificate submitted by the practice accountant

Over time a GP accumulates an annually increasing individual pot representing that doctor's cumulative total of superannuable pay.

To fund this, GPs make a 6% employee contribution on each year's income and the employer contributes 14% (practice partners pay all 20%)

At retirement the annual pension is 1.4% (the accrual rate) of the accumulated pot and the lump sum is three times the annual pension.

An extra adjustment is then made. The annual pension is multiplied by the fraction:

"total length of NHS contributions/total length of contributions as a GP".

This converts a GP's initial years working in hospital into GP years and usually works to a GP's financial advantage.

If retirement occurs before normal retirement age (NRA) which is currently 60, then to allow for pension being payable over a longer period before death, the annual pension is reduced by about 5% for each year below 60.

Since GP income has risen with the new contract, the previously rarely relevant annual pension cap has affected more GPs. Its current value is £108.6K. Potentially superannuable profits above this are not superannuable. Under the new pension scheme proposals this cap will be abolished.

**Threat to the dynamisation formula agreed as part of the new contract.**

Under CARE GPs are credited each year with the superannuable income on which they paid contributions and accumulate a growing pension pot. Inflation means the value of this pot drops every year. Dynamisation is the mechanism that adjusts for inflation and maintains the purchasing power of each GP pension pot.

Under the nGMS contract the dynamisation % was agreed to be the annual average rise in practice profits (ie unrelated to any general inflation index). It seems the government now regrets this agreement, because it underestimated or didn't consider the cost. Lord Warner has repeatedly hinted that he will limit dynamisation to levels the government can afford. Legal opinion obtained by the BMA suggests a breach of contract case on behalf of GPs is likely to succeed.

The table below should enable GPs to see the size of the benefit originally negotiated by the GPC.

Year	Estimated dynamisation %	Actual %
03/04	8.8	12.9
04/05	10.8	?
05/06	12.0	?
3y Total (Compound)	36	?

It is possible that the final 3y total could be 45%, converting a £40K pension before 2004 into one close to £60K now.

**Lifetime Pension Cap**

Doctors may hear of another cap which is usually poorly understood. This is the lifetime cap which currently stands at £1.5m (it rises by about £0.05m/year). Its significance is that contributions taking the calculation above £1.5m are not tax deductible

Government actuaries know that on average people live 20 years after retirement. If future superannuable profits are relatively predictable, then it is possible to work out the likely total pension that will be payable to any doctor of average life expectancy. Just multiply the predicted annual pension by 23. To get close to this cap the estimated pension would have to be £65K (1.5m divided by 23). This equates to a pension pot of 65 x100/1.4 which if it accumulates over 35 years requires an average annual lifetime income

equivalent to a current value of £132.6K. Few doctors are likely to approach this.

At a practical level, because every year of contribution is different, predicting the final pension for those on CARE is very inexact. I cannot therefore see how any GP would know if their contributions were taking them above £1.5m.

▪ **The new Pension Proposals**

To access the 'Proposals at a Glance' copy and paste the following into your web browser <http://www.bma.org.uk/ap.nsf/Content/pensionsreview0806>

The government says it can no longer afford the current system of public sector pensions. The main reasons given are population demographics and increasing longevity. It first put forward proposals for change in 2004. These were revised and put out for further consultation in September 2006.

Tiered employee contribution rates

Salary or Profit Band	Employee Contribution %
under £15,107pa	5%
£15,108 - £60,880	6.5%
£60,881 - £100,000	7.5%
£100,001pa and above	8.5%

What do the increased contributions mean?

- If earning £49,000      Extra £245 pa      (£147pa after tax relief)
- If earning £90,000      Extra £1,350 pa      (£810 after tax relief)
- If earning £110,000      Extra £2,750 pa      (£1,650 after tax relief)

Both government and GPC justify tiering on the grounds of fairness. At the moment higher earners are subsidised by lower earners. To view a detailed explanation of this by copy and paste the following into your web browser

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

The whole NHS pension scheme has to be self financing, but is not subdivided into staff classes. BMA actuaries estimate that the real % level of contributions necessary to deliver pensions for higher earners is about 24-25% not the current 20%. What the proposals do is lessen the cross subsidy by lower earning staff, but not abolish it completely.

Improvements for existing NHS workers

- Increased flexibility for lump sum
  - Up to 5.25 x pension as cash - tax free
  - A correspondingly smaller annual pension
- Removal of the annual earnings cap

- Introduction of partner pensions
- Removal of spouses pension cessation on re-marriage
- Standardised short term survivors pension at 6 months regardless of child dependants
- Children's pensions payable until 23 for all
- Revised abatement definition – less abatement
- New guaranteed AVC arrangement (Added years will stop)
- Possible improved benefits for those without partners

#### Likely Timescales

- Decisions taken December 2006/January 2007
- 31 December 2007: New Scheme starts  
(Those not currently in the NHS pension scheme will see their NRA move to 65y and the accrual rate to 1.87%.)
- 1 April 2008: Changes to existing scheme
- Beyond 2008 - Choice exercise starts?  
(Those already contributing will have the option to move irreversibly to the new scheme or continue in a modified current scheme)

#### Dearden Advice to every GP

- Obtain a Pension Estimate and a Service Record (it takes 6 months)  
See <http://www.nhs.uk/nhsplanet/index.cfm>
- Obtain a State Pension Estimate (0845 3000/68)  
(£87/wk)

### **GDC Requirement for GP medicals on new dentists**

The GDC (General Dental Council) has recently decided that prospective registrants with them must have a medical and then completion of health reference forms

The issue came to the attention of the GPC about a month ago but no dialogue had taken place before the GDC imposed their requirement.

Some Thames Valley practices have been presented with requests for dental medicals and have contacted the LMC for advice.

The Professional Fees Committee of the GPC advises that completion of health reference forms does not form part of a GP's terms and conditions and therefore an appropriate fee may be levied by the GP to the patient concerned.

### **NHS Reorganisation**

From October 1st the Thames Valley has 5 PCTs compared to the previous 13.

The new Chief Executives are:

Berkshire East: Lise Llewellyn

Berkshire West: Charles Waddicor

Buckinghamshire: Janet Fitzgerald

Oxfordshire: Andrea Young  
Milton Keynes: Barbara Kennedy

The contact details for the new organisations can be found at:

<http://www.southcentral.nhs.uk/page.php?id=65>

All are currently announcing their directory structures and choosing key directors.

Once the appointments are known the Secretariat will be making contact to organise Liaison meetings.

The current plan is to maintain existing Local Reference Committees (LRCs) as a means of obtaining local GP views and then for the Secretariat to take selected issues to Liaison. In order to keep the timetabling of these meetings flexible, they will probably be routinely attended only by local LRC chairs, but the dates will all be in the public domain and any rep could attend for selected items or sessions. We will adapt to circumstances and modify arrangements in the light of experience.

## TPBC C2 Reward and the SFE Amendment

Last month the Secretariat alerted practices and PCTs to the apparent perverse wording of the Amendment to the Statement of Financial Entitlement (SFE). It seemed to indicate that the C2 reward would be reduced by any savings. Several PCTs have now confirmed that provided practices achieve their TPBC plan objectives, they will receive into their account, the full C2 without deduction. Seventy% of Savings (FUR) less the value of C2 will sit in a PCT account for practices to use on agreed patient services conforming to the LDP

## PBC Collaboratives or Consortia

The TPBC DES seems to have accelerated involvement in PBC. Most areas now have practices working together under collaboratives or consortia.

The Secretariat has had difficulty tracking these, and discovering how they are contacted.

The table below represents our present knowledge.

Feedback on where the details are incorrect or incomplete would be appreciated

County	Known organisations
Berkshire	<ul style="list-style-type: none"><li>- EBPCC (Peter Roberts and Julius Parker)</li><li>- Two large Reading collaboratives and three smaller ones</li></ul>

	(Jackie Bidos at the PCT) <ul style="list-style-type: none"> <li>- Three Newbury collaboratives             <ul style="list-style-type: none"> <li>▪ Kennet (Rob Tayton)</li> <li>▪ Best (Paul Harris)</li> <li>▪ Rural group (James Cave)</li> </ul> </li> </ul>
Buckinghamshire	<ul style="list-style-type: none"> <li>- CSB Collaborative (Tilly Siva and Hilary McDermott)</li> <li>- MK Collaborative (Peter Berkin)</li> <li>- Wycombe Collaborative (Annet Gammell)</li> <li>- United Commissioning (Johnny Marshall)</li> </ul>
Oxfordshire	<ul style="list-style-type: none"> <li>- North Oxfordshire Commissioning Consortium (Martyn Chambers)</li> <li>- NE Oxfordshire Consortium (John Galuszka)</li> <li>- Oxford City (Helen Groom)</li> <li>- West Oxfordshire Locality Group (Stephen Smith)</li> <li>- Vale PBC Consortium (Philip Ambler)</li> <li>- SE Oxfordshire PBC Consortium (Andrew Burnett)</li> </ul>

The relationship between PCTs and PBC consortia is evolving. I hear different views on who in future will make decisions on spend or alteration to services. It seems clear to me that PCTs hold ultimate responsibility. Otherwise why would they exist? Practices or consortia will be powerful advisors on change but will not be the final decision makers. To avoid conflicts of interest there will be checks and balance to ensure that NHS money is used to best effect and without patronage. Building in safeguards without producing a stifling bureaucracy will be a difficult balancing act.

## Healthcare Commission Performance Ratings 2005

See

<http://www.healthcarecommission.org.uk/homepage.cfm>

### PCTs

County	Trust	Quality of Services	Use of Resources
Oxfordshire	Oxford City	Fair	Fair

	NE Oxfordshire	Good	Weak
	Cherwell Vale	Good	Weak
	SE Oxfordshire	Fair	Fair
	SW Oxfordshire	Good	Weak
Berkshire	Newbury	Good	Weak
	Reading	Excellent	Fair
	Wokingham	Good	Weak
	Bracknell Forest	Good	Weak
	WAM	Fair	Weak
	Slough	Fair	Weak
Buckinghamshire	CSB	Fair	Weak
	Wycombe	Fair	Weak
	Vale of Aylesbury	Fair	Weak
	Milton Keynes	Good	Weak

### Secondary Care Trusts

County	Trust	Quality of Service	Use of Resources
Oxfordshire	ORH	Good	Weak
	NOC	Weak	Good
	Oxfordshire MH	Fair	Fair
	Learning Disabilities	Excellent	Good
Berkshire	RBH	Good	Good
	Healthcare (MH)	Good	Fair
	HWPH	Excellent	Weak
Buckinghamshire	BHT	Weak	Fair
	Bucks Mental	Weak	Weak

	Health		
	Milton Keynes	Fair	Fair

## Profit or Loss on Personally Administered Drugs

Drugs and appliances administered personally attract reimbursements. On 1<sup>st</sup> April 2006 changes were made to the payment of these reimbursements. Whilst these changes were aimed primarily at dispensing doctors it is apparent that all contractors will be affected and that some PA items will now be non profitable or even loss making.

The government assumes that all practices negotiate discounts on the drugs they purchase and therefore reduces the reimbursement it gives.

The assumed discount for reimbursement and the tiered dispensing fees change as monthly drug expenditure increases. They can both be found on pages 242/3 (Annex G) of the Statement of Financial Entitlements (SFE). The actual discount to be applied is in Part 1 and the relevant dispensing fee is in Parts 2 or 3

See <http://snipurl.com/y8qv> **then** click on the hyperlink text: "Download GMS Statement of Financial Entitlements: 2005 onwards- Post amendment [Current] (PDF, 609K) Page 245"

### Explanation of the Changes

#### 1. Calculation of reimbursement pre 1<sup>st</sup> April 2006:

- Basic cost of drug less discount (clawback)
- ADD on cost of 10.5% of basic price
- ADD 3.8p container allowance
- ADD dispensing fee
- ADD VAT on the basic price **before** deduction of discount

#### 2. Calculation of reimbursement post 1<sup>st</sup> April 2006:

- Basic cost of drug less discount from p242 of SFE
- ADD dispensing fee
- ADD VAT on the basic price **after** deduction of discount

The changes to be noted are:

- Removal of the on cost
- Removal of container allowance
- VAT is reimbursed on the figure produced when the tariff price is adjusted for the presumed discount obtained on page 242 of the SFE

### Worked Example

Personal administration of Zoladex 10.8mg

(The assumption has been made that the lowest levels of discount at 3.17% and the maximum dispensing fee of £2.406 apply)

<b>Cost to practice</b>	<b>Practice Income</b>	<b>pre 1/4/06</b>	<b>post 1/4/06</b>
Purchase price: 267.48 (with any discount) VAT on discounted price: £46.81	Price in drug tariff: Less 3.17% discount: Net price: On cost (10.5%): Container fee: VAT on net price: VAT on gross price: Dispensing fee:	£267.48 £8.48 £259 £28.01 £0.38  £46.81 £1.27    	£267.48 £8.48 £259   £45.32  £2.41    
<b>Total cost: £314.29</b>	<b>Total income:</b>	<b>£335.47</b>	<b>£306.72</b>
<b>Loss/Profit</b>		<b>Profit £21.18</b>	<b>Loss £7.57</b>

Many practices negotiate a discount on the purchase price either by themselves or through the LMC

I have devised an Excel calculator for practices to use.

See <http://www.bbolmc.co.uk> (under heading Latest 1/10/06)

If the LMC negotiated price is put into the table above, then the £7.57 loss becomes a £15.33 profit

#### Additional Text after Feedback on our Hot Topic Email

- Finding the Basic Price for all bought in drugs

I had thought the drug tariff would list all drugs prescribable on the NHS but it doesn't.

The BNF lists drug prices but I have not been able to discover if these are the true basic price (ie NHS reimbursement before presumed discount). If anyone knows of a more reliable listing could they please let me know

- Unrecognised omission from the SFE

Email to GPC 29.9.06

"The profit or loss calculation on PA Drugs involves looking up annex G on pages 242/3 of the SFE (tables labelled parts 1,2,3)

Practices need to choose which discount rate (part 1) and which dispensing band (part 2 or 3) applies to them

Whereas part 1 explicitly says the bands are calculated per month, no such "per month" statement appears in parts 2 and 3

I therefore phoned the PPA today and they confirmed that the calculation is made monthly

It seems there is an omission in tables 2 and 3 that will make it more difficult for practices to understand them

I have asked the GPC if this could be corrected.