BBLMC Secretary's Newsletter
(Paul Roblin 15.9.04)

New Secretariat Office Hours

The Secretariat Office's opening hours are currently 8.30 am - 5.00 pm. However, the majority of GP telephone calls are received during the late morning, or over the lunchtime period, and very few are received between 4.00 pm and 5.00 pm.

It has been decided, therefore, that, with effect from Monday, 20 September 2004, the Secretariat Office opening hours will change to 8.00 am - 4.30 pm.

It is hoped that this will provide an enhanced service to our constituent GPs, who will now have the added option of being able to contact the office before beginning their morning surgeries, rather than having to try and ring between patients or wait until the end of surgery.

Paul Roblin and Jane Solomon are also available on their mobile telephones (numbers below) should you need to speak to them and the Office answerphone, giving contact details for use in an emergency, is also available outside office hours.

Paul Roblin: 0779 911 6597
Jane Solomon: 0773 935 6254.

QOF and Patient Confidentiality

New DOH Guidelines were released on 1.9.04.
They seem to impose on QOF visit teams a requirement to get specific patient consent to view non-anonymised notes. This contrasts with what has applied historically to Training Practice Visits or Post Payment Verification.
Secretary is taking this up with GPC
Berkshire PCTs QOF visit protocols vary between

- Practices asking a cohort of patients 2 weeks pre visit to sign a specific consent form
- Visiting team to sign a tight binding confidentiality agreement with no specific patient consent being sought

New GPC PMS Guidance (September 2004)

www.bma.org.uk/ap.nsf/Content/pmsagreements0904

PMS Contracts (item repeated from August)

All PMS pilots ended on 1.4.04. By 1.10.04 practices need to have agreed a new one compliant with new NHS PMS regulations 2004.
See http://www.legislation.hmso.gov.uk/si/si2004/20040627.htm
I have seen a variety of PCT contract drafts of varying quality. Although many PCTs are doing their own, there is an alternative.

Andrew Lockhart-Mirams is a solicitor who has worked for the GPC. His firm have developed a PMS contract which they are selling to practices via LMCs.
We can send you without charge an electronic copy for viewing and internal discussion within your practice. However as soon as you start using it in discussions with your PCT then a charge of £225 + vat becomes payable. You pay the LMC and we pass it onto Lockharts.

PMS Agreements Alert from Lockharts

Lockharts are concerned about reports nationally of some PCTs presenting practices with "take it or leave it" (ie agree or return to nGMS) agreements for signing by 1.10.04.

What actually is the legal situation?

- By 1st October PCT and Practice need to agree variations to their existing Pilot PMS Agreement to bring it into line with new PMS Regulations.
- Where agreement proves impossible PCTs can impose only those changes necessary for compliance with regulations.
- PCTs have no authority to impose other variations or insist on reversion to nGMS

Salaried PMS GP performers

(Extract from new GPC PMS Guidance)
Salaried GPs who became or in future become PMS GP performers for the first time in PMS, will accrue NHSPS membership on an assistant practitioner basis on or after 1 April 2004.

PMS practices who currently hold forms SD55 for salaried GPs accruing NHSPS membership on an officer (non-practitioner) basis, because they became GPs for the first time in pilot PMS, should liaise with their PCO and send a terminal form SD55 to the Pensions Agency showing the "last day of pensionable membership as an officer", as 31 March 2004. The PCO should then send a joiner form SS14 to the Pensions Agency, showing a "commencement date of membership" as an assistance practitioner, of 1 April 2004.

PMS Staff superannuation

(Extract from new GPC PMS Guidance)
A sum has been made available nationally, and passed on to PCTs in their primary medical services allocations, to cover the increase in employers contributions from 7% to 14% for PMS practice staff.
It is up to local negotiation to determine how this funding is distributed to practices, although the GPC has been pressing the DoH to provide clear guidance to PCOs and practices.

Ideally, this money should have been added to PMS staff budgets as part of their 04/05 uplift, but it has become evident that many PCTs did not pass it on or were not aware they had received it.

Despite pressure from the GPC, the DoH has so far been reluctant to direct PCTs to do so. It is important for LMCs and PMS practices to be aware that a transfer of money was made to PCTs, whether they are aware of this or not.

NHS body status for PMS Practices

(Extract from new GPC PMS Guidance)
Unlike in GMS, PMS practices must opt not to have health service body status. They must do so by written notice before the agreement is made. If the agreement has already been signed, the contractor can request a variation to the contract to remove the health service body status provision. The choice should be entirely a matter for the contractors and PCTs should not exert pressure on them either way.

For information on what health service body status entails, see GPC guidance, Focus on NHS Body Status, which is available at
http://www.bma.org.uk/ap.nsf/Content/__HubGMScontractguidance

Part Two Cremation Forms

The Secretariat has received reports from practices and undertakers about recent difficulties in getting GPs to sign part two cremation forms. This may be in response to the GMC announcing its post Shipman investigation of GPs in Hyde. The anger at the GMC action is understandable and GPs might think that the risk of signing is no longer worth it. However, for two reasons, I would ask colleagues to consider whether “downing tools” is the best response.

1. The main losers through GPs not signing cremation forms are distressed patient relatives. Is this something GPs wish to be responsible for?
2. If the media were to hear of this change in GP behaviour might their reporting of it harm the collective reputation of GPs?

Berks and Bucks LMC Buying Group

This is the 3rd year that Berks and Bucks LMC has been negotiating with Flu vaccine companies for the purchase of vaccines at a discounted price for their GP constituents.

The LMC is also acting on behalf of the Essex LMCs and the same offer will also be made available to GPs in Essex.

In 2002 Wyeth and Solvay were the two companies that provided the most competitive discounts and in 2003 it was Wyeth and Chiron. This year we are going out again to tender and will be looking for the following ;-

- Competitive Discounts
- Reliability
- Sale or return of 5%
- 120 days credit
- Named day delivery
- Product information and support materials for Practices

Charging for Hepatitis B Vaccination

Many practices have asked the LMC for guidance on this issue. The first NHS principle is that practices can only charge their registered patients for services defined on page 38 of the nGMS (schedule 5, paragraph 1g).

In the case of vaccinations, practices can only charge for travel vaccines that the NHS will not fund. So if the indications for Hepatitis B are for foreign travel, then practices can charge. However, most Hepatitis B requests tend to be for occupational risk (nurses, dentists, policemen, firemen etc). Vaccine provision in these circumstances is the responsibility of the employer by whatever occupational health arrangements they have put in place. In reality, many patients come to their GP. The practice then has two options;

1. Refer back to the employer
2. Provide vaccination themselves, free of charge on the NHS as part of a duty of care.

Travel vaccines under nGMS

The Secretariat has received several queries about when to charge.
Basically the Red Book Rules have been carried forward. So much for the much requested modernisation!!
Where you used to claim an item of service the vaccine is now covered within your Global Sum (or equivalent).
Where you used to charge because the NHS would not pay, you carry on doing this.
Practices may need to ensure that their classification of which vaccines cannot be charged for is correct.
Provided you have a BMA username and password the useful GPC Focus On Vaccinations and Immunisations can be found at
http://www.bma.org.uk/ap.nsf/Content/__HubGMScontractguidance
(download the pdf version because the screen version doesn't have the red Book appendix)

Travel Vaccines and MPIG

The LMC is aware that historically some practices, confused over the charging rules, may have charged for travel vaccines that should have been provided for free on the NHS.
Unfortunately this presents a possibly irredeemable problem with MPIG, which of course is smaller by an amount equivalent to the income that was charged to the patient rather than the NHS during the MPIG reference year. Under nGMS, the NHS pays for vaccines either in the global sum or global sum equivalent (MPIG). If Practices correct their charging policy so that it is line with my first paragraph, then unfortunately MPIG cannot be altered to take account of this. I gather this is the line PCTs are taking and it is difficult to argue that they are wrong.

NPfIT and EMIS.

(Email from Paul Cundy GPC IT lead re EMIS, ENUG and NPfIT)
Sorry this is a bit long but there is a lot of chatter/misinformation about this issue which requires this length of response

I am continually reality checking and to my mind it all remains scare-mongering. Forget what all the guidance says and what is in black and white in the various agreements / contracts and guidance and the bottom line is that no one will be able to impose any new systems on us if they are not better than the ones we've already got. If they are better – and I remain open on this – then it won't be an imposition. Also the matching of the old coding systems to the new SNOMED coding system on a 1:1 basis virtually removes the data migration issue, providing your data is not all in free text and that its correctly coded.

The last time the EMIS user group wrote to MPs they got a clear statement about the future of their systems and it helped get a statement from NPfIT drafted with GPC and signed off by both that no GP would be expected to move to a new system; it said verbatim;

"In some parts of the country there have been suggestions that the Programme will require the rapid replacement of existing GP systems, which are currently serving GP practices and their patients well and on which the current delivery of patient services depends. While such an approach may be amongst the options being considered by LSPs, it is our firmly held view and that of the National Programme that such replacement should NOT occur unless, and until, a clearly better alternative is available along with a tested and agreed process for safe migration to it. Practices will be reassured that paragraph 4.31 of the new GMS contract 2003 'Investing in General Practice' guarantees a role for the GPC in the assessment of any new alternative systems."

Therefore we are in a position of "wait and see". If they develop better systems then I for one am happy to have a look and will change if I think its better. If they are not we will say so.

Lets re-cap where we are at the moment, suppliers of current systems are guaranteed funding of their current systems via the 100% re-imbursement agreement. The only reason current suppliers will go down the drain is if they fail to develop their systems to keep one step ahead of what the NPfIT is doing. EMIS are very well aware of this and are doing it and doing it in a very public way – see the recent press coverage of their on line appointment booking. Current suppliers have a massive advantage in this arrangement. They have guaranteed income plus protection of their client base plus the benefit of an implemented and loyal client base. The hurdle that LSPs and the NPfIT has to overcome is enormous. EMIS are not the only system that is on its own commercially. IPS, who are "inside" NPfIT, nevertheless only has a status as the second choice and is thus under exactly the same pressure to innovate to keep customers. If IPS do not keep ahead of the game they will loose out to the LSP solutions. This applies to all the suppliers except perhaps for Torex who are much closer to their LSPs. Manpreet's claim that this arrangement will stifle innovation simply does not hold up, especially for a company

that is as commercially astute as EMIS. He states that it has been user group driven competition that has kept UK GP computing at the forefront, well the competitive element is still there, all that's changed is that GPs no longer pay any of the costs. EMIS's rolling out of their appointment booking is manifest proof of their continuing to innovate. Quite the opposite to his assertions in his letter.

Finally there are some things I want to see added to all systems, whether old or new, inside NPfIT or out, they are electronic prescribing, GP2GP transfer of patient records and hospital links. All of these are being pursued actively and all current suppliers are going to be compliant and EMIS have said they will also be joining up with this work. So just what is the need to go banging on MPs doors again? Not only are we promised better new systems but we know we are going to have the functionality of our current systems extended.

Whilst I understand the need to support the EMIS users neither should we add weight to inappropriate panic being whipped up by the EMIS user group. Remember that as chair of the IT committee in the days immediately prior to NPfIT I spent most of my time stopping PCTs imposing EMIS on everyone. Manpreet's letter which quotes that 56% of GPs chose EMIS is I believe open to question. I do not think it is correct to suggest that 56% of GPs chose EMIS. A significant number had EMIS imposed on them.

Then there's the political angle – lobbying MPs twice in one year when they've already been told all of the above and just after an announcement that the NAO is to investigate the NPfIT – just what will it achieve? A pro-forma letter stating "thanks for the enquiry – the NAO is investigating, you've already be given the reassurances when you last wrote – wait and see".

Its very difficult to keep a balance but the more the EMIS users up the volume the more we have to pour oil on the turbulent sloppings in the brewery, sorry mixed my metaphors; get down of my horse to pull the skin of the rice pudding under their feet.

Feedback Needed

Please let us know if you find this bulletin helpful
If we can help with any enquiries please contact us on 01628 475727 or

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