

BBLMC Secretary's Newsletter

06/08/04

(Paul Roblin)



Editorial

Dear All,

I hope this will be the first of many monthly LMC bulletins. I aim to keep you up to date, and make your life easier without overburdening you with reading!

Could practices managers please distribute this within their practices?

I took over from Chris Tiarks on 1.7.2004. We had 10 days overlap which was invaluable. Chris plainly had a big impact in his 4 years at BBLMC and will be a hard act to follow.

For those that don't know already, I was a full time principal in Summertown, Oxford City for 20 years and part time Oxfordshire LMC secretary for 5 years.

I plan to work one session a week as a locum but otherwise I am full time at the LMC. Call me at the office if I can help with your locum needs.

I am planning to get round all the Local Reference Committees and PCTs as soon as I can. Many of you have already phoned or emailed me about issues. Please keep these contacts coming; we are there to assist with all your problems.

I am keen to use email where possible. This should help to keep our costs down and provide value for the levy you pay.

I realise email use varies and many have IT anxieties, but in reality filling envelopes is time consuming and costly. My philosophy is to work for you rather than push paper.

Below you will find my first joint bulletin for Berks and Bucks. If some points don't seem to relate to your area they are probably still worth reading because the same themes tend to crop up in both counties.

Please give me feedback about what I write and how it is presented.

QMAS Update

The DOH recently sent another QMAS Information Bulletin

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PrimaryCareContractingArticle/fs/en?CONTENT_ID=4084258&chk=bHnHDs

They expect all practices to be connected by 10th September with an improved version due in December.

Once your computer supplier has the NpfiIT nGMS certificate they will install extra software on your system. Uploading of clinical data for QOF will be automated and occur monthly. There will be a web browser interface for chosen people in practices to upload information for the organisational, patient experience and additional services domains.

PCTs will hold seminars for practices and upload your QOF aspirations points total.

What practices should check before employing locums

All practice managers are advised to check the following before employing locums:-

PCT Performers listing.

Berkshire (TVPCA): <http://www.berkshire.nhs.uk/tvpca>

Buckinghamshire:

<http://www.buckshealth.nhs.uk/pcss/supplementary.htm>

1. GMC registration website on www.gmc-uk.org/register/default.htm or 020 7915 3630 or registrationhelp@gmc-uk.org
2. 2 recent clinical references
3. Qualification certificates
4. Defence society certificates
5. JCPTGP number www.jcptgp.org.uk/list/

Request from Bucks Medical Advisors

They have apparently had comments that GPs seem loathe to use 999 when referring in chest pains likely to be of ischaemic origin. They and the LMC secretary agree that 999 is preferable to GPs ordering an ambulance urgently; a subtle but important distinction.

Criminal Record Bureau Enhanced Screening for all GP Performers

Government directed catchup exercise planned for 3 months beginning 1.11.04
Thames Valley Primary Care Agency will be sending forms to GP performers not previously CRB checked.

Ignore these at your peril. You will not be allowed to work without one after 1.2.05

PMS Contracts

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.

<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.

LMC Website

I am keen that this becomes a valued resource for practices, accessed regularly because it is useful, relevant and fun. We are looking at what changes are needed. Any suggestions from practices would be helpful.

Premises

Despite LMC protests Thames Valley PCTs have recently decided they cannot afford all the discretionary flexibilities trumpeted as part of the nGMS.

Government has, however, announced 2 tranches of extra premises growth money for this and next year.

Practices could use this for improvement grants, early project solicitor or architect's fees, or negative equity.

Develop your application for your PCT now and get it in before the end of the financial year.

Referral Hubs

Most areas now have or plan to have these.

Many GPs have been suspicious, predicting delays and restriction of referral freedom.

I feel there are potential counterbalancing benefits such as better tracking of referrals, and closer matching of service delivered to patient need.

All hubs will have teething problems. Please let them settle in before judging too harshly.

The LMC will monitor and troubleshoot where necessary.

Initially most hubs plan just to log referrals and quantify activity turning paperwork around rapidly.

The second phase will extend patient choice at the point of referral. The practicalities of this are vague at the moment. The LMC hopes to be intimately involved with the detail.

QOF Visits to Practices by PCT teams

The LMC has had some reports of practice anxiety about these. By now your PCT should have given you a date. Teams will usually comprise a PCT manager, a GP and a lay person. They will expect to receive information from practices beforehand. Essentially they will be:-

- Looking at your current performance in the 10 disease sections of the Clinical Domain as portrayed by QMAS (the government analysis software that we still have to see).
- Discussing with you reasonable verification of your claims under the domains for Organisation, Patient Experience and Additional Services.

All PCTs I have met with are keen to make this very unthreatening for practices and I hope they have conveyed this to you.

If you require an LMC presence at your QOF visit please contact myself or Jane at the office.

The LMC will monitor the early visits and pass on any lessons. Please keep us informed of your experiences.

Exception Reporting (ER)

One PCT has asked for LMC help in ensuring that exception reporting passes probity tests. They plan to look at practices that seem to exception report excessively. It would be difficult to support GPs who cynically manipulated this system but I have stressed to PCTs that ER has been introduced to ensure that GPs are not penalised for managing patients as individuals. Perverse financial incentives are undesirable where patient care is concerned.

As always the happy middle ground is the best place to be.
Please feedback your views on this.

Confidentiality when non-clinicians view notes

This crops up in lots of guises. Most recently GPs have contacted the LMC with concerns over Referral Hubs, dispensing probity checks and QOF visits. Local PCTs and Agencies have rigorous procedures and contract obligations binding on their staff.

We have got used to staff performing post payment verification using patient notes without problems. I see no reason why newer practice assessments should cause difficulty provided processes are not relaxed.

TVPCA (Berks) will be writing separately to practices.

Payments for Enhanced Services

I have concerns about how practice work for Enhanced services (particularly local ones) will be translated by PCTs and Agencies into actual payments. Some PCTs seem to have been slow to attend to practical details. There is no one system with few favouring IT over paper.

I am trying to move the situation on and would welcome feedback from practices having difficulty.

Seniority Reckonable Statements

TVPCA (Berks) have now finalised their statements after being messed around by a sequence of contradictory DOH instructions.

All Principals should soon get a statement of how their years working for the NHS have been totalled.

Cervical smears

The Secretariat has raised apparent difficulties with the TVPCA rolling on their recall date after logging a private smear. They promise to look into how this can be altered within their software.

Government plans changes to the cytology recall schedule from 1.4.2005.

Screening will be 3 yearly from 25-50y then 5 yearly from 50-65y and most likely by liquid based cytology (brush and liquid filled bottle).

Patient Assignments

The Secretariat has clarified with TVPCA that patients living outside a practices area cannot be assigned. Occasional error could arise when most of a post code lies within a practice's area but miss-assigned patient lives in a bit which is not. Agency tries to catch this using maps but human error prevents complete recognition. Practices suspecting error should merely tell the agency (and the LMC if things get difficult).

"Full Lists"

Patients tend to contact the TVPCA when faced with being repeatedly told that lists are full (as opposed to closed).

Agency policy is to speak with practice managers to ensure a letter of explanation has been issued and no discrimination has been applied, then inform the PCT of the situation.

New Independent Stage of NHS Complaints Process

On July 30th The Healthcare Commission took over this role.

This can be requested by patients after unsuccessful local resolution.

A case Manager will review the complaint history. Panels (IRPs) may follow this but are not obligatory. As before panels are composed of lay people but they call on professional clinical advice. They make recommendations for complaint resolution and improving services.

It seems government has delayed reforming local resolution procedure until after the Shipman Enquiry.

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](http://www.bma.org.uk/ap.nsf/Content/HubGMScontractguidance)

(download the pdf version because the screen version doesn't have the red Book appendix)

Berkshire Delivery Services

The TVPCA are currently reviewing their delivery services to Berkshire practices.

The agency have asked the LMC to remind practices that if they are returning large numbers of notes they should be placed in a suitably sized box, clearly secured and addressed to the agency.

If this is not adhered to the driver has instructions to refuse to take them.

Pneumococcal vaccination

Flu vaccine under nGMS is now a NES.

Remember that attached to this is a government instruction to offer pneumococcal vaccine to all over 75s not previously immunised.

Most PCTs seem to have forgotten this in their NES specifications.

The LMC is on the case!

PCT Administered Funds

In Berkshire the LMC has successfully argued that sickness and pregnancy absence attract non discretionary locum reimbursement according to SFE ("the new red book") rules.

Berkshire PCTs are probably ahead of the game but some issues still need to be sorted.

Rolling over the red book residual list size arithmetic rules was just sloppiness on behalf of the GPC/negotiators.

I am actively working on alternative mathematics to define the threshold for reimbursement.

What do practices think about full wte being defined as 9 sessions a week each session being 4hours i.e. $wte = 36h$ per week for the total of all GP work not just patient contact?

All GP performers could calculate what percentage of 36h they worked and this would go into the total practice workforce total and be used to calculate the drop when they were absent.

The only question is how we deal with modern workforce planning and skill mix.

My feeling is that practice nurses should not contribute to this workforce calculation but nurse practitioners probably should where they have been employed in place of doctors.

2004 NHS Performance Ratings

These were published recently and can be found on:

http://ratings2004.healthcarecommission.org.uk/reviewing_your_rating.asp

All 6 Berkshire PCTs got 2 stars and all 4 Bucks PCTs got 3.
The gradings for secondary care trusts were

Trust	Stars
Buckinghamshire Hospital Trust	1
Milton Keynes General	2
Royal Berks and Battle	3
Frimley Park	3
Heatherwood and Wexham	3
Berkshire Health Care Trust	1
Buckinghamshire Mental Health	0
Royal Berks Ambulance	2
Two Shires Ambulance	3

Not having worked in Berks and Bucks as a clinician I am not sure if I have captured all the trusts that are used by the practices I represent. Please feedback to me the gaps in the list.

Interestingly for Bucks GPs the Healthcare Commission Chair, Sir Ian Kennedy, expressed concern about the performance of mental healthcare trusts in general across the UK

New Childhood Vaccination Preparations announced 10th August

DOH letter sent to all practices.

- Injectable polio (IPV) now replaces oral
- Acellular pertussis replaces whole cell
- No more thiomersal

First year of life primary course will now be 5-component (DTaP/IPV/Hib) jab x3.
Preschool injection will be 4 component (dTaP/IPV) and teenage injection 3 component (Td/IPV).
New deliveries begin w/c 27th September.

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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