

## Letter From The Secretary

May/June

**Inside this issue:**

Letter from the Secretary	1
New Sponsors	1
Motions to LMC	2
The Sale of	2
Where do we go from here?	3
nGMS Contract	4
Non Essential Services	4
Cash to Accruals	5
The Deaneries	5
Hepatitis B & Travel	5
EMIS & Other IT Training Days	5
Basket of Services	5
GPC Regional Representative	6
Message for Practice Managers re	6
Your Secretariat	6

Reminder - LMC Reps 6

**INSERTS:**

Classifieds  
New Oral Cholera Vaccine



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This is my last Newsletter. I leave the organisation in the middle of June after just over four years in the job. Paul Roblin takes office on 1 July.

It certainly has been a very busy time with massive changes both to General Practice as a whole and to the LMC. We have tried to adapt to the rapidly changing political landscape, in particular setting up the Local Reference Committees which do provide local engagement with PCTs, which are still statutorily bound to consult with the profession through this route.

For the most part these Committees work well although the activity waxes and wanes. The relationship with PCTs remains positive on the whole although we naturally have our differences from time to time, some of which are serious.

Enhanced Services and whether the floor defined by each PCT is appropriate is one area where consultation with the LMC has to take place. It is not surprising that the PCTs and the LMC take different views about this. Enhanced Services are pencilled in to account for a significant percentage of your income. If a lot of services are included in the floor which should by rights be funded through the unified budget, when the funding shutters come down your income could be marginalised. Therefore, the LMC is particularly determined to get the right agreements at the start.

If a PCT and an LMC cannot agree about what is in the floor then a dispute has to be recorded by the PCT at the Strategic Health Authority. These negotiations have already caused tensions but are of fundamental importance. PCTs for their part have a difficult balancing act to perform in order to balance their books, with government giving out messages which in the long term put management in an impossible position.

However, the LMC is unashamedly here to represent the interests of its constituents and must rely on the rule book when doing so.

Having been around the NHS for over 40 years, I am well aware that some GPs have no interest in the LMC, some have antipathy and others don't exactly know what it does. However, in the Constituencies where we have had elections recently there has been a better than 50% turnout! This is much better than most GP ballots and considerably better than local council or European elections.

On a serious note, however, the LMC is the only Statutory Body there to represent you no matter how hard a PCT may try to rely on other sources of advice, as a few may do. The fact that some PCTs regard the LMC with suspicion is a healthy sign. No matter how much co-operative working between contractors or the LMC and PCTs is to be welcomed, there will be times when the negotiating table will be rectangular and not round. This is wholly appropriate.

In Bucks and Berks, however, we are fortunate that the majority of our PCTs take a very balanced and co-operative approach to contractors and the LMC in difficult financial circumstances.

Those GPs that are in contract with PCTs where the approach is not so balanced are well aware of the difficulties as is the LMC which will, when appropriate, take the concerns to the Strategic Health Authority.

As Medical Secretary I give support to GPs in difficulty or conflict and will act as a mediator where things are not going smoothly in practices. The complaints procedures are changing with CHIA taking a lead role. Working with doctors subject to a complaint is a major part of my job and I am sure my successor will be as keen to try and help as I hope I have been.

### NEW SPONSORS

**The Secretariat is delighted that Chiron Evans Vaccines have agreed to part-sponsor our Newsletters for the coming year.**



# Motions to LMC Annual Conference

## From Berkshire LMC:

That Conference instructs GPC to negotiate a clear definition of the services that are not Essential but Enhanced which some GPs may historically have been providing to patients under old GMS without identified remuneration.

That Conference requires GPC:

- i) to publish guidance urgently on the implications for NHS GPs of the freeing up of the sale of goodwill in primary care
- ii) to ensure that GPs are able to benefit from this legislation on an equal footing to other providers.

That this Conference believes that Clause 483 of the final (17-3-04) nGMS contract represents an unfair restriction of trade for general practitioners, which has no parallel in the NHS Consultant contract and may be challengeable in the European Courts.

That this Conference requires the GPC to renegotiate Clause 483 of the nGMS contract to allow GPs to offer services to their patients on a private basis, when such services are either:

- i) not commissioned via the NHS by the PCT
- or
- ii) are provided at the request of the patient outside of core hours (0800 – 1830 weekdays).

That Conference deplores the rapidly increasing spend on management in Primary care as identified by the Audit Commission and urges GPC to pressurise government to ensure:

- i) this trend is reversed
- ii) the funding released goes towards patient care.

## From Buckinghamshire LMC:

That this Conference believes that the new GMS contract has failed to meet the majority of its objectives including:

- i) Encouraging close co-operation between GPs and their PCTs
- ii) Creating an environment high in trust and low in bureaucracy
- iii) Facilitating appropriate remuneration for work done

and instructs the negotiators to address these shortcomings.

That this Conference is dismayed by the failure of the nGMS contract to address the problems of recruitment and retention in general practice and instructs GPC to take urgent action.

That Conference condemns much of the funding arrangements of the new GMS contract and:

- i) reiterates that the value of the global sum must be urgently renegotiated to an amount that reflects the true cost of providing essential and additional services
- ii) insists that (until the value of the global sum is adequate) the correction factor must be uplifted proportional to any growth in practice capitation since 30/6/2003.
- iii) demands that the Government honours its commitment to fully fund the cost of the quality and outcomes payment from central resources
- iv) insists that quality and outcome payments must be based on the actual prevalence of the condition and not reduced by mathematical manipulation.

That Conference believes that the ability to control workload in the new GMS contract by closing a practice list is fatally compromised due to the ability of PCOs in these circumstances to remove enhanced services with their attendant extra funds.

That Conference strongly objects to the Government proposals to revise Section 60 of the Health & Social Care Act 2001 to allow increased access

## The Sale of Goodwill

The Regulation freeing up the sale of Goodwill in Primary Care, came into force on 1 April. The Regulations are quite clear that contractors with a “registered list” are prohibited from taking advantage of these changes. This means that PMS and GMS contractors are excluded. This is clearly unfair and the GPC is considering whether there is a challenge to the Regulation under Human Rights legislation.

Goodwill associated with Essential Services is not a saleable asset but goodwill associated with OOH, Additional and Enhanced Services is.

The principles involved mean that unless the rules change, GPs

will have to split their practices into two separate entities in order to take advantage of the Regulations. One practice would provide Essential Services and the second provide all the other services on a sub-contracted arrangement from the first (Contractor practice).

This is a very rough first attempt to understand the issue and much more sophisticated guidance will hopefully follow from GPC over the next few months.

Opinion is divided as to whether this is a good thing. The entrepreneurs amongst you will seize the opportunities when everything is clear, the GP with a more pastoral focus may find

## Where do we go from here?

When planning for the future it is important to read the political signals. The recent proposal to axe £100 million from the training budget gave out strong signals that the DOH is not interested in the long term future of primary care. This, alongside the closure of the JCPTGP with marginalisation of GP representation on its successor PMETB (which covers all training), does not bode well for traditional general practice.

The GPC achieved a notable success in persuading John Hutton to reverse very rapidly the decision about the training funding. This U-turn should not lull GPs into a false sense of security however.

All of us should take a long hard look at the direction of travel of the development of primary care. The changes have now developed a momentum of their own and will continue notwithstanding the colour of government.

Look at the signals:

- The move to a practice based contract
- The ability to opt out of some services, in particular OOH
- The concept of a Contractor
- The diversity of contractual options
- The ability of PCTs to be providers of services
- The opening up of Goodwill leading to commercial organisations potentially having an interest in the provision of primary care services, eg DTCs
- The clear signposting in the NHS Plan of the intention of government to support the provision of care in a polyclinic environment
- The fragmentation of clinical services
- The contestability of Enhanced Services.

All, or some, or none, of this may be good and supported by the profession but it is essential to read the runes. Practice will be unrecognisable in a few years time and everyone must plan for the changes. It is important to put yourself in the best position possible to deal with these changes in order to have professional fulfilment and continue to live in the style to which you have become accustomed.

The last bullet point is highly topical and exercising the LMC. The PCTs have to try and agree what services are covered by the Enhanced Services floor (a sum of money designated by government that must be spent on Enhanced Services). If the PCT and LMC cannot agree, then a dispute will be reported to the Strategic Health Authority. Resolution may take place there, or referral be made to the central Joint Implementation Group.

Many PCTs are trying to include in their floor many services which the LMC feels are inappropriate:

- Podiatry
- Counselling
- Physiotherapy
- Dietetics
- Services provided to patients in community hospitals

being the main culprits.

All these services are worthy and should be provided, but paid for out of the unified budget. The point is that if the profession concedes these as Enhanced Services, as the funding shutters close these sort of services are likely to survive at the expense of those that GPs currently provide representing a significant minority percentage of their income.

The LMC does not accept that these services form part of the floor according to the Regulations and is continuing to contest the floors with the majority of the 10 PCTs.

This illustrates the need for GPs to predict how their income will grow (or not) and plan the best commercial options for the future. The concept of holistic pastoral care is becoming anomalous as we move inexorably towards that of HMOs and managed care pathways. The American healthcare providers are already sizing up the market. Richard Smith, the editor of the BMJ for many years, is preparing to take a senior position in one such organisation alongside one of the Prime Ministerial advisors.

The patients will not yet notice the difference but will certainly do so when the new underfunded OOH organisations attempt to take over in January at the latest.

So how best to plan?

First there is the issue of Goodwill referred to elsewhere in this Newsletter. As things stand at present, GPs with a registered list cannot sell goodwill associated with Additional and Enhanced Services. In order to do so they would have to separate their practices into two separate organisations, one providing essential services only and the other providing the rest. They would have to be distinct entities. This concept is too difficult at the present and may not hold great advantages.

Should practices consider either amalgamating into much larger units to exercise more clout with PCTs, or enter into confederations with a central organisation, or form units of in hour Co-operatives on the lines of OOH Co-ops? Of course, the Co-ops would not have registered lists.

**DON'T FORGET TO CHECK OUT OUR WEB SITE: [WWW.BBLMC.CO.UK](http://WWW.BBLMC.CO.UK)**

In any event these are all questions worthy of consideration. Economies of scale are going to be increasingly important.

## nGMS Contract Guidance

The following important Guidance on the nGMS contract is available on the GPC web site ([www.bma.org.uk](http://www.bma.org.uk)):

- Partnership Agreements
- Focus on review of the quality & outcomes framework
- Focus on payments for influenza & Pneumococcal vaccinations 2004/05
- Focus on vaccinations & immunisations
- Focus on patient registration
- Focus on funding for IM&T—3rd update
- Focus on premises costs
- Focus on exception reporting
- Focus on the quality & outcomes framework—update
- Focus on postgraduate education after the postgraduate education allowance
- Focus on the financial monitoring of enhanced services
- Focus on standard & default contracts
- Focus on the role of LMCs
- Focus on practice staff under the new contract
- Focus on how to access information
- Focus on GMS indicative contractor budgets
- Focus on choice of nationally accredited systems
- Focus on health service body status
- Focus on enhanced services
- Focus on personal medical services

## Non Essential Services

The LMC has been involved in both counties negotiating payment for services that have traditionally been done in general practice without payment. The so called “Basket of Services”. Although everything seems to have gone quiet all the PCTs have been working hard on it.

In Berkshire, Bracknell Forest are proposing a payment of £2.5K per average practice with activity review, Windsor Ascot and Maidenhead are proposing 54p per patient per year with activity review. The full details are not yet available.

The other 4 Berkshire PCTs are yet to finalise their proposals but have been pressed to do so very shortly.

There is a meeting with the Bucks PCTs on June 7<sup>th</sup>. Full details will be available shortly after that date.

So some progress but not as fast as we would like but at least there is recognition of the principle that the majority of the services raised by the profession are not “essential”. There are still difficulties around secondary care suture removal and the LMC will be pursuing this.

## Cash to Accruals

Everybody, including the negotiators, is upset and exercised by this factor turning out to less than 1.

The negs are urgently seeking clarification from government. Make sure you register a dispute in relation to your final Global Sum and Correction factor.

## The Deaneries

Despite what I wrote in an earlier piece, and John Hutton's assurances, it is becoming clear that the Deaneries are still being starved of funds. This means that recruitment and training for general practice is being undermined. The Deaneries are extremely upset.

A decrease in the number of GPs being the goal seems to be becoming clearer. All the more reason to do some careful workforce planning for your businesses.

## Hepatitis B & Travel Vaccines

We get a lot of enquiries at the office about this.

The Global Sum includes payments for travel vaccines that were an item of public policy and for which there was a fee under the old Red Book. You must continue to do these and not charge, although you may still claim for a personally administered item. If the CMO designates a travel vaccine as an item of public policy in the future, you must provide that free of charge.

Any travel vaccine which is not covered by this principle, or was not in the old Red Book, you may charge for. In this case you may not also give an NHS prescription, or claim a personally administered item.

Hepatitis B has always been a contentious issue for GPs. This is an occupational health matter. As such, it is not included in the transfer from the SFA to the Global Sum. This means you do not have to provide it. If you do provide it, though, **you cannot charge the patient**. The new Regulations are quite clear and you would be in breach of your contract if you attempted to make the patient pay.

## EMIS & Other IT Training Days

The LMC has heard that some PCTs are arranging costly training events for IT. Some of these have been extremely poorly attended, which not only gives a very bad impression but is a waste of money.

It will be difficult for the LMC or GPs to complain in the future if we do not make the most of the opportunities on offer.

## Basket of Services

Latest Latest News: Slough is offering 42ppy for their basket of services.

## GPC Regional Representative

Are you struggling to understand the new contract? Were you puzzled by the first monthly payment from the PCT searching in vain to find what it does and doesn't cover? Are you confused about the way in which superannuation for staff is (or isn't) being funded let alone that for doctors? Do you have a dispute with your PCT about Enhanced Services? Are you now left wondering whether you will ever get funding for surgery development?

All of these are problems which have been raised in the last few weeks on the LMC List Server. I would like to be able to tell you that the GPC has the answers but our own list server has been crammed for weeks with similar questions. Indeed part of every monthly meeting is now devoted to BOGs or Break out Groups where we have a chance to put problems and questions related to the new contract to one or two of the negotiating team.

This is of course a form of group therapy and some members

have been so overcome by the opportunity to say something that I fear they may have forgotten that GPC as a whole is supposed to make policy for the profession not just respond to what is being handed down by others.

Alas for the last 3 years or more the GPC dog has been wagged by the tail – the chairman and negotiating team; not a happy or healthy state of affairs. All I can say is that your bit of the dog has done a good deal of barking on your behalf and is proud to have earned the title of Dr Angry of Milton Keynes.

Hopefully after the LMC Conference we will see a change of leadership and direction and can get down to addressing the many flaws in nGMS and in particular the crazy funding formula.

Dr Eric Rose is the GPC Regional Representative for both counties. You can contact him by telephone on 01908 393979, or by email at:

### MESSAGE FOR PRACTICE MANAGERS SECRETARIAT LIST SERVER

We are increasingly using our List Server to facilitate the rapid dissemination of key information and guidance re the nGMS contract and would urge all Practice Managers to sign up to ensure they keep abreast of important developments.

If you would like to join, you can do so via our web site ([www.bblmc.co.uk](http://www.bblmc.co.uk)), or by emailing

### YOUR SECRETARIAT TEAM

Dr Christopher Tiarks, Medical Secretary (email: [christopher.tiarks@bblmc.co.uk](mailto:christopher.tiarks@bblmc.co.uk))

Ms Jane Solomon, Director of Development & Liaison (email: [jane.solomon@bblmc.co.uk](mailto:jane.solomon@bblmc.co.uk))

Mrs Pauline Green, Administration & Information Manager (email: [pauline.green@bblmc.co.uk](mailto:pauline.green@bblmc.co.uk))

Mrs Michelle Walker, Administrative Officer (email: [michelle.walker@bblmc.co.uk](mailto:michelle.walker@bblmc.co.uk))

### Your LMC Representatives Are There For You – Please Use Them

They are there to help and advise you and can be contacted with:

- ⇒ queries;
- ⇒ topics you would like raised at the LMCs' County or Local Reference Committee meetings;