



Special points of interest:

- ◆ Care Quality Commission
- ◆ Review of Contractor Services
- ◆ The Development of GP Commissioning Consortia in Essex

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# Too Much Information

## The BMA and the Health Bill

The following are key motions agreed at the Special Representative Meeting (SRM) of the BMA held on March 15<sup>th</sup>. These are extracts and a fuller version is available on the BMA website [www.bma.org.uk](http://www.bma.org.uk)

The meeting called on the Government to withdraw the Health and Social Care Bill but it did not call for the BMA to withdraw from discussions over its detail and implementation. In my view this was a sensible and logical outcome as a total rejection by the BMA would have resulted in the government receiving only the more extreme views from those GP groups which are very enthusiastic about the reforms, and this might have been damaging to most practices and to the NHS itself.

**That this Meeting** deplores the government's use of misleading and inaccurate information to denigrate the NHS, and to justify the Health and Social Care Bill reforms, and believes that:-

1. the Health Bill is likely to worsen health outcomes as a result of fragmentation and competition;

**That this Meeting** believes that the current plans for reform are too extreme and too rushed and will negatively impact on patient care. We call upon the Health Secretary to:-

1. call a halt to the proposed top down reorganisation of the NHS;
2. withdraw the Health and Social Care Bill;
3. consider and act on the criticisms and advice from the medical profession that were collected during the White Paper consultation;
4. adopt an approach of evolution not revolution regarding any changes to the NHS in England

**That this Meeting** believes the government's risky plan for wholesale change within the NHS in England should not have been carried out at the same time as trying to save £20bn.

**That this Meeting** believes that the insistence on enforced competition ('Any Willing Provider' or tendering methods) for the provision of health services:-

1. will undermine the ability of local GPs, consultants and public health doctors to work together to create

an efficient local service for the benefit of patients;

2. will inflate the cost of contracting at a time of financial constraint;
3. increases fragmentation of the care pathway for patients;
4. could severely damage the overall financial stability of local NHS hospitals, with the risk of departments or hospitals closing;
5. favours large commercial companies who currently are allowed to cherry pick the profitable services and who will have the financial power to undercut NHS providers

**That this Meeting** believes price competition is a hugely retrograde step and:-

- i) that price competition in healthcare is damaging;

**That this Meeting** supports the principles of clinician-led commissioning with increased medical participation in the organisation and delivery of NHS care for the benefit of patients and believes that this could be achieved without the need for further legislation.

**That this Meeting** believes that successful and effective

## The BMA and the Health Bill Cont'd...



commissioning can only occur through close collaboration between general practitioners, hospital doctors and public health doctors.

**That this Meeting** believes the relationship between doctors and patients in NHS general practice: -

1. is underpinned by the provision, via the GP contract, of Primary Medical Services by independent GP practices;
2. may be undermined by the introduction of commissioning as a requirement of the GP contract;
3. will be threatened if GP practice remuneration is dependent on rationing

decisions, the requirement to balance commissioning budgets or the interests of a commissioning consortium; "

**BB**

"In order to gain registration, practices will be required to show that they are meeting essential standards of quality and safety"

## Care Quality Commission (CQC)

The Health and Social Care Act 2008 introduced a new single registration system across health care and adult social care. NHS Trusts, PCTs and dentists are already registered with CQC. From 1st April 2012, all GP practices will be required by law to be registered with CQC, but practices will be able to apply for registration from October 2011. In order to gain registration, practices will be required to show that they are meeting essential standards of quality and safety. To prepare for registration, it is important that practices familiarise themselves with these standards, which can be found at [www.cqc.org.uk/guidanceaboutcompliance](http://www.cqc.org.uk/guidanceaboutcompliance)

The GPC issued a briefing note to all GP practices in February 2011 and intends to publish a

toolkit for GPs in early Spring 2011. This toolkit will contain guidance on applying for registration and demonstrating compliance. The LMC also hopes to hold several seminars in the Autumn for Practice Managers to assist with the registration process.

When practices apply for CQC registration from October 2011 they will be expected to declare compliance with the CQC's standards for the regulated activities that they perform but will not actually have to demonstrate compliance at that point. Only practices that declare non-compliance with any of the standards should be contacted by the CQC before April 2012 about how to become compliant. Otherwise the monitoring of compliance by CQC will not commence until April 2012.

Further guidance can be found on the LMC website, [www.essexlmc.org.uk](http://www.essexlmc.org.uk) and at [www.cqc.org.uk/primarymedicalservices](http://www.cqc.org.uk/primarymedicalservices)



## Payment under section 158 of the Road Traffic Act 1988

### (emergency treatment of traffic casualties)

Following recent enquiries in connection with the rules surrounding payment for GP attendance at Road Traffic Accidents (RTA), the LMC thought it may be useful to remind practices of circumstances when a fee for attendance is payable.

NHS Regulations allow practitioners to charge a fee for emergency treatment at the scene of a RTA in accordance with section 158 of the Road Traffic Act 1988, which is set out below:

#### Section 158

(1) Subsection (2) below applies where —  
 (a) medical or surgical treatment or examination is immediately required as a result of bodily injury (including fatal injury) to a person caused by, or arising out of, the use of a

motor vehicle on a road [or in some other public place], and

(b) the treatment or examination so required (in this Part of this Act referred to as “**emergency treatment**”) is effected by a legally qualified medical practitioner.

(2) The person who was using the vehicle at the time of the event out of which the bodily injury arose must, on a claim being made in accordance with the provisions of section 159 of this Act, pay to the practitioner (or, where emergency treatment is effected by more than one practitioner, to the practitioner by whom it is first effected)—

(a) a fee of [£21.30] in respect of each person in whose case the emergency treatment is

effected by him, and

(b) a sum, in respect of any distance in excess of two miles which he must cover in order—

(i) to proceed from the place from which he is summoned to the place where the emergency treatment is carried out by him, and

(ii) to return to the first mentioned place,

equal to [41 pence] for every complete mile and additional part of a mile of that distance.

The Act confirms payment of £21.30 in respect of each person treated as an emergency and 0.41p per mile for return journey in excess of two miles to the scene of the emergency.



“NHS Regulations allow practitioners to charge a fee for emergency treatment at the scene of a RTA in accordance with section 158 of the Road Traffic Act 1988”

## Review of Essex Contractor Services

In autumn 2010 the PCTs in Essex, through NHS North East Essex as the lead PCT, undertook a review of the functions carried out by Contractor Services. It appeared that PCTs were under pressure from the SHA to transfer these services, with their preferred provider being NHS Shared Business Services.

The LMCs were extremely concerned at what was being proposed. Despite numerous NHS reorganisations, Contractor

Services had continued to provide a high quality service to practices, including managing payments to practices, the transfer of medical records, management of patient lists and call and recall systems.

The LMCs wrote to all practices in Essex highlighting this issue and enclosing a template letter which could be used by practices to raise their concerns individually with NHS North East Essex. PCTs, other Local Representative Committees

and local MPs were also contacted. The response rate from practices and support from local MPs was excellent, and the LMCs are pleased to report that a new contract has been awarded to North East Essex Provider Services, (Now ACE) ensuring that primary care contractors in Essex will continue to receive the same high quality, responsive service for the foreseeable future.

Thank you to all practices that supported this successful campaign.



## The Development of GP Commissioning Consortia in Essex



“Since the publication of these documents GPs in Essex, like their colleagues elsewhere in the country, have begun to consider what the proposals will mean for them and how best they can prepare for the changes that lie ahead”

The Government set out its intentions for the future of commissioning in the White Paper “Equity and Excellence: Liberating the NHS” and the supporting document “Equity and Excellence: Commissioning for Patients”.

Since the publication of these documents GPs in Essex, like their colleagues elsewhere in the country, have begun to consider what the proposals will mean for them and how best they can prepare for the changes that lie ahead.

Discussions have taken place between practices/clusters, PCTs and the LMCs about the future structures that will need to be put in place to support GP commissioning and, in the transition, how best GPs can work with PCTs to facilitate a phased transfer of commissioning responsibilities.

A brief overview of the current position in Essex is given below. Six GP Clusters in Essex have so far achieved “Pathfinder” status and further details are provided at the end of the article.

### Mid Essex

A GP Consortia Development Working Group was established to act as a focal point for taking forward the development of GP led commissioning in Mid Essex. The Working Group, which was facilitated by North Essex LMC, met on a number of occasions culminating in the production of a report detailing its proposals and recommendations.

Members of the Working Group supported the idea of a large consortium

covering the whole of Mid Essex, supported by a locality sub-committee structure. The number and boundaries of localities needed further discussion and agreement with practices and clusters. Any structure will need to recognise and support innovations that were already taking place, eg. hard budget pilot run by Essex GP Commissioning (EGPC), which has now achieved Pathfinder status.

In the interim the Working Group agreed that transitional GP leadership arrangements needed to be in place no later than 1<sup>st</sup> April 2011. An election/selection process has been run by North Essex LMC to determine the eight GPs who will act as members of the Mid Essex GP Shadow Commissioning Consortium.

### North East Essex

All practices in the PCT area were previously participating in PBC which was based on the two distinct localities of Colchester and Tendring. The structure was well established and effective. The two locality commissioning groups have successfully influenced commissioning decisions and have achieved freed up resources for reinvestment in services.

Practices agreed that the existing locality structure should continue and should underpin a consortium covering the whole of North East Essex. This has subsequently been agreed with the PCT. Elections of GPs and practice staff to serve as members of the new consortium have

taken place (conducted on their behalf by North Essex LMC) and the transitional leadership therefore has a mandate from colleagues.

North East Essex GP Commissioning Group has recently achieved Pathfinder status.

### South East Essex

Five PBC clusters currently cover the whole of the area. A number of meetings have been held between representatives of the existing clusters and South Essex LMC to discuss transitional GP leadership and future commissioning arrangements.

It has subsequently been agreed that nine GPs from the existing five clusters should form a Clinical Executive Consortium Board (CECB). The CECB and a number of the PCT’s existing Directors will also form the Clinical Executive Committee of the PCT which, during the transition, will have a key role in agreeing the PCT’s direction of travel and overseeing the transfer of commissioning responsibility to GP consortia.

The current cluster leads will form the initial CECB with elections to confirm a mandate from GPs planned for six months time.

One of the existing clusters, Fortis Health, has achieved Pathfinder status.

### South West Essex

Discussions are still ongoing in South West Essex to agree a consortia structure that has the support of the GP community and that covers the whole of the



## The Development of GP Commissioning Consortia in Essex

PCT area.

Under previous PBC arrangements, thirteen clusters were in existence, all of which were at different stages of development. The financial challenges facing this particular PCT are significant and in the short term this is inevitably likely to dictate the extent and the pace at which responsibility for commissioning budgets transfers to GP consortia.

Significant developments so far include:-

The formation of a reconstituted PCT Clinical Executive Committee (CEC). Six GPs have now been elected to serve as

members of the CEC following a selection/election process that, in part, involved South Essex LMC. South West Essex Federation of GPs and South Essex Managed Care Consortium have both recently been granted Pathfinder status.

### West Essex

PBC in West Essex is well established. It consists of three GP clusters covering the localities of Epping, Harlow and Uttlesford. Existing clusters have experience of managing PBC budgets, effectively introducing service redesign and engagement in the delivery of financial efficiencies.

GPs in the area have agreed that this locality based arrangement should continue and underpin a formal consortium covering the whole of West Essex. Initially the existing cluster leads will act as the transitional GP leadership whilst discussions continue with practices/clusters to agree the final commissioning structure and leadership arrangements. North Essex LMC will in due course (probably about six months) conduct an election/selection process to determine the GP leadership.



“Pathfinders in North Essex currently cover 66% of practices and 70% of the population and in South Essex 38% of practices and 39% of the population”

GP Consortia Pathfinders in Essex are as follows:	Practices	Population
<b>North Essex</b>		
Essex GP Commissioning (EGPC)	7	70,000
North East Essex GP Commissioning Group	44	324,184
West Essex Commissioning Consortium	39	288,000
<b>Total</b>	<b>90</b>	<b>682,184</b>
<b>South Essex</b>		
Fortis Health	12	78,409
South Essex Managed Care	10	51,268
South West Essex Federation of GPs	34	179,170
<b>Total</b>	<b>56</b>	<b>308,847</b>

### GP Consortia Pathfinders in Essex

The Government has established a rolling programme of Pathfinders which started in December 2010 and which will work up to the period from April 2012 when consortia will start to be formally established. Pathfinders in North Essex currently cover 66% of practices and 70% of the population and in South Essex 38% of practices

and 39% of the population.

The Shadow NHS Commissioning Board will produce and publish an analysis of the findings of the Pathfinder programme. Pathfinders in the programme will be:

- ◇ Testing out design concepts for GP commissioning and exploring how best emerging consortia will be able to undertake

their future functions.

- ◇ Exploring how consortia can develop effective relationships with constituent practices and local government, patient groups and secondary care clinicians.

- ◇ Embedding and reinforcing the importance of engagement with patients and the public.

- ◇ Exploring how consortia



## The Development of GP Commissioning Consortia in Essex



- can best commission services at different demographic levels.
- ◇ Demonstrating how clinical leadership of commissioning can improve care.
- ◇ Exploring good practice in governance arrangements.
- ◇ Designing their new organisational structures and exploring how best to secure the skills and expertise they need.
- ◇ Taking on increasing delegated responsibility from PCTs.
- ◇ Sharing learning across the GP community.

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## Practice Manager Conference 2011

“The Conference also provided an opportunity for Managers to network with colleagues from across the County and the LMC”



The LMC hosted its 4th Annual Practice Managers Conference on 15<sup>th</sup> February and we were pleased to welcome **61** delegates including colleagues from Suffolk and neighbouring LMCs.

As usual, the day presented an opportunity to hear from a variety of speakers on topical issues. Not surprisingly, GP Commissioning featured quite heavily on the agenda and Scott McKenzie from Scott McKenzie Consultancy started the day with a presentation on “Working in Consortia”. Scott spoke knowledgeably about Consortia approaching change in practical and realistic terms.

Second up were Jill Coote and Mike Heath from “Peninsula”, who provide a specialist Employment Law service to general practice. Jill provided an update on the myriad of employment law legislation recently introduced and an overview of legislation soon to be implemented.

A lively debate then followed, following a presentation from

David Sildown, the East of England Registration Manager for CQC. David advised that the earlier practices start planning for registration, the better! All practices have to be registered with CQC by April 2012 but the application process will open in October 2011. Between July and September CQC will provide practices with information on preparing for registration and they will deal with applications between October and March. “Essential Standards of Quality and Safety” is available on line and describes all of the standards and required outcomes to be compliant.

Following lunch, a lively and interactive presentation was received from Bernadette O'Mahoney on personal impact and we all left the conference much clearer as to whether we were a monkey, a horse, a lion or an owl!

The day ended on the topical subject of GP Commissioning with a very interesting and relevant presentation from Jill

Matthews, Primary Care Implementation Director from the DH.

The Conference also provided an opportunity for Managers to network with colleagues from across the County and the LMC.

Thanks to all of you who attended and for making it a lively and interesting day. We look forward to seeing even more of you at next year's conference.

## Referral Management Centres (RMCs)

North and South Essex LMCs have recently produced some advice for practices which is intended to help deal with a range of questions and issues that may arise as a result of the use of RMCs by PCTs or future commissioning bodies.

This advice summarises the key messages from previous guidance produced by the BMA, GPC and MDU in order to create an accessible, single point of reference for practices. A copy of the advice can be downloaded from the LMCs' website at [www.essexlmc.org.uk](http://www.essexlmc.org.uk)

### **Key Actions for Practices**

The advice contains a number of suggested actions that practices may wish to consider taking as a means of both minimising any potential detriment to patients and properly protecting their own position following the establishment of RMCs as follows:

#### **Information to Patients**

If the PCT operates an RMC locally then explain the process to patients. Consider including relevant information in the practice leaflet and/or waiting room notice.

#### **Initial Referrals**

Ensure referrals are appropriate. All referrals should state as a minimum, the urgency requested, the problem, appropriate history, the type of clinic required and what is wanted from secondary care.

GPs are responsible for

ensuring as far as possible, that the referral reaches the RMC.

#### **Returned Referrals**

In the event that a referral is returned without being actioned by the RMC, the practice should have in place an effective system to ensure that the referral is actioned as expected by the referring GP.

Practices may wish to adapt the Model letter in Appendix 1 of the LMC document to follow up any returned referrals.

#### **Inappropriately Returned Referrals**

Where referrals are returned without good reason the practice should inform the Medical Director of the PCT and the LMC as a matter of urgency.

GPs should alert their patients (with care), the PCT and the LMC if they believe that patients' health will suffer as a direct consequence of decisions made by the RMC.

#### **Tracking Systems**

GPs may retain some responsibility to ensure that their patient is seen by the appropriate person.

Whether or not GPs are held liable for referrals that do not reach the RMC will depend largely on the circumstances of the case.

It is therefore advisable for practices to have in place their own system for tracking referrals.

GPs should also consider suggesting to patients that they contact the RMC if they

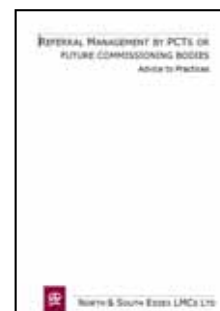
have not received confirmation of an appropriate date within 2 weeks of referral.

#### **Patient Confidentiality**

Inform patients if their referrals are going through an RMC. Consider producing a leaflet that could be given to patients during the consultation. A suggested form of words is included in Appendix 2 of the document.

Seek express consent from patients for their data to be sent via the RMC.

In instances where a patient declines to have personal information shared, make clear to the RMC that the patient has restricted the sharing of data and stipulate that such details, where agreed by the patient will be supplied to the Consultant personally by the patient, either verbally or in letter form.



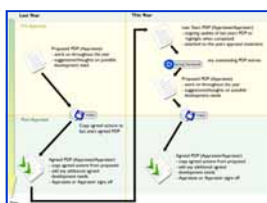
“This advice summarises the key messages from previous guidance produced by the BMA, GPC and MDU in order to create an accessible, single point of reference for practices”



## Patient Group Directions and Patient Specific Directions in General Practice



"..until a replacement system can be identified, GPs are advised to either use the electronic Microsoft Word versions of the appraisal forms available on the EQUIP website or pay the £50 subscription to continue to use the NHS Appraisal Toolkit"



The GPC has recently reviewed what is very complex legislation surrounding the administration of medicines. As a consequence its advice on the use of Patient Group Directions (PGDs) in general practice has been changed.

Clarity was essential because in recent years there has been a fundamental difference of opinion on the place of PGDs in a general practice setting between the GPC and that of the Royal College of Nurses and the Nursing and Midwifery Council in their advice given to Practice Nurses.

After receiving an up to date legal opinion on this matter, the GPC's advice has changed as

follows:-

Practices should use PGDs to authorise registered nurses to administer or supply prescription only medicines, unless they are independent prescribers.

The Medicines Act 1968 does not permit nurses who are not qualified prescribers to administer or supply prescription only medicines (POMs) unless one of three types of instruction are in place:-

- ◇ A signed prescription.
- ◇ A signed Patient Specific Direction (PSD).
- ◇ A Patient Group Direction (PGD).

If non-prescribing health care professionals are to administer a

medicine on the instruction of a GP, the GP must be able to show that they have appropriate mechanisms in place to ensure that their practice meets statutory requirements.

Since these mechanisms for supply and administration are statutory, the fact that a practice has followed them is mitigation to any ensuing liability.

Practices are advised to familiarise themselves with this latest guidance which can be downloaded from the LMCs' website at [www.essexlmc.org.uk](http://www.essexlmc.org.uk)

## NHS Appraisal Toolkit

The contract between the Department of Health and SCHIN for the provision of the NHS Appraisal Toolkit (ATK) which had been running since 2002 expired on 31<sup>st</sup> October 2010. Following the publication of The White Paper, "*Equity and Excellence: Liberating the NHS*", it was deemed inappropriate for the DH to continue to hold/fund one particular system centrally.

SCHIN will continue to provide the ATK until 31<sup>st</sup> March 2012. Whilst PCTs will no longer fund the system, an on-line subscription function became available in November 2010, at a cost of £50 per annum for GPs. Users who do not wish to subscribe will be able to download their appraisal forms and uploaded documents free of charge whilst the ATK remains

available. SCHIN will provide free access for a period of seven consecutive days to allow for such documentation to be downloaded. GPs are strongly advised to download copies of all important information/evidence stored on the system as early as possible. Further information can be accessed at [www.appraisals.nhs.uk](http://www.appraisals.nhs.uk) or [www.revalidationsupport.nhs.uk](http://www.revalidationsupport.nhs.uk)

In an effort to secure a replacement system, EQUIP received presentations from various toolkit providers at its Steering Group meeting in December 2010 and agreed to recommend the Medical Appraisal and Revalidation System (MARS), currently used in Wales, as the preferred system for use in Essex.

Unfortunately, MARS have since been unable to commit to the original terms quoted and EQUIP has concluded that there is currently no alternative single system that would be appropriate to be recommended for use by all GPs in Essex. Therefore, until a replacement system can be identified, GPs are advised to either use the electronic Microsoft Word versions of the appraisal forms available on the EQUIP website, [www.essexequip.nhs.uk](http://www.essexequip.nhs.uk) or pay the £50 subscription to continue to use the NHS Appraisal Toolkit.

Further advice will be issued to practices as it becomes available.

## Common Assessment Framework (CAF)

In recent months the LMCs have been contacted by a number of constituent practices who have expressed concerns at the way that the CAF is being used. In some cases referrals are being returned to practices and agencies are insisting on referrals being made using the CAF.

The matter has since been considered by both LMCs. Members had a number of legitimate concerns which have been brought to the attention of Essex County Council:-

- ◇ The CAF is not a referral form. Trying to use it as such may delay or even deny referrals.

- ◇ The CAF was designed to act as a single point of reference for the person nominated to lead the co-ordination of care.

- ◇ GPs are not contractually required to use the form.

- ◇ In the unusual circumstances where a GP identifies a clear need then the form can be used, but for a referral it is clear that a referral letter is required.

The LMC does not accept that referrals can or should be rejected as this potentially obscures the responsibility of the recipient of the referral.

The legal consequences of any rejection may be legitimately pursued by practices.

The County Council is keen to resolve these issues and agree a mutually acceptable process for referrals. Representatives from Essex County Council have offered to attend meetings of both LMCs over the coming months. Practices will be updated as soon as further information is available.



"There is no obligation under the Regulations for a GP practice to administer Hepatitis B vaccinations for occupational reasons. Patients should be referred to the Employer's Occupational Health Department."

## Hepatitis B Immunisation and Charges for Pathology Tests Outside of GMS

Following the imposition of charges by phlebotomy departments for certain tests, the LMC has sought clarification on Hepatitis B immunisation and related blood tests for occupational reasons. GPC Guidance (Updated November 2005) states:-

There is no obligation under the Regulations for a GP practice to administer Hepatitis B vaccinations for occupational reasons. Patients should be referred to the Employer's Occupational Health Department. Under Health and Safety Legislation, it is the employer who has responsibility for undertaking an Occupational Health assessment and taking action as appropriate. It is therefore the employer's duty, rather than the GP's responsibility to ensure that an 'at risk' employee does not work

unless they have been appropriately vaccinated.

If a practice does administer Hepatitis B vaccination for occupational health purposes, any associated costs, including phlebotomy or laboratory fees to establish immune status, should be charged to the employer.

Practices are advised to refer patients who request Hepatitis B vaccination for occupational reasons back to their employer in the first instance, using the template letters provided in the GPC guidance. If the employer then chooses to secure a non-NHS vaccination service through the practice, any fees should be invoiced back to the employer accordingly.

In the case of practice staff requiring investigation/vaccination, the responsibility for any charges would remain with

the practice as the employer.

Further information and template letters can be found on the LMC website and at [http://www.bma.org.uk/images/HepBNov05\\_tcm41-20601.pdf](http://www.bma.org.uk/images/HepBNov05_tcm41-20601.pdf)



## ESSEX LMCS LTD – BUYING GROUP - Challenge Gary

In this period of financial uncertainty, we'd like to remind you about an opportunity for your practice to save thousands of pounds a year.

We hope that all GPs and practice staff in Essex are aware of our **LMC Buying Group**, which offers practices discounts on office stationery and equipment (including catering supplies), medical consumables, surgery and locum insurance, medical equipment testing and calibration, utilities brokerage, staff uniforms, fire and security equipment, confidential information shredding and health and safety systems. Practices

can save thousands of pounds just by switching to buying group suppliers.

### Challenge Gary

The Buying Group's procurement consultant, Gary Burns, offers practices a free cost analysis to demonstrate the huge savings they could be making. All you have to do is send him an email detailing which areas you want him to analyse (e.g. office supplies, medical consumables, utilities etc) and he will work out how much you could save by switching suppliers.

**Example: This mid-sized practice asked Gary Burns to analyse**

**their expenditure in five areas:**

**TOTAL SAVINGS: £4,401**

If you want to find out how much your practice could save email:

[g.burns321@btinternet.com](mailto:g.burns321@btinternet.com)

or visit our website at

[www.lmcbuyinggroups.co.uk](http://www.lmcbuyinggroups.co.uk)

If Gary can't save your practice money we will enter you into a free prize draw to win £50 of M&S vouchers.



Product/Service	Buying Group Saving	Annual Saving	Buying Group Supplier
Office stationery	18%	£535	Whittaker Office Solutions
Medical Consumables	15%	£705	MidMeds
Equipment Calibration	43%	£387	TAG Medical
Electricity	43%	£2,472	Untied Utilities
Gas	21%	£302	Untied Utilities

## LMC Levy 2011/12



The Board of Directors of North and South Essex LMCs Limited considered the proposed LMC budget for 2011/12 at its meeting on 15<sup>th</sup> February 2011 which was subsequently adopted by both Committees at their March meetings.

In view of the increasing pressures faced by practices, Directors were strongly of the view that every effort should

be made to keep costs as low as possible when producing the 2011/12 budget. However, they acknowledged that a significant amount of additional work was being generated for the LMCs as a result of the new Health Bill. Directors were therefore pleased to be able to report only a minimal increase in the LMC levy for the year 2011/12. The new costs per

patient are detailed below:-

### North Essex

**2011/12 37.72p**  
(36.73p in 2010/11)

### South Essex

**2011/12 38.71p**  
(38.05p in 2010/11)

## New Tax Brackets

The Finance Act 2009 introduced significant changes affecting those earning over £100,000, which came into effect on 6 April 2010, including: -

- ◊ A new additional rate of income tax of 50% on total income (including all income, not just wages, salaries and profits) over £150,000;
- ◊ The gradual withdrawal of the personal allowance for those whose adjusted net income exceeds £100,000.

The personal allowance will be reduced by £1 for every £2 of income in excess of the £100,000 threshold.

Guidance has been produced by the General Practitioners Committee (GPC) to highlight the effects of the tax changes which will affect doctors earning over £100,000, and other financial considerations arising as a result. The guidance has been revised following the emergency budget on 22 June 2010 and is available on the BMA website at <http://www.bma.org.uk/employmentandcontracts/tax/focustaxbrackets.jsp>

[employmentandcontracts/tax/focustaxbrackets.jsp](http://www.bma.org.uk/employmentandcontracts/tax/focustaxbrackets.jsp)



## NHS Cervical Screening Programme

South Essex LMC recently considered Best Practice Guidance produced by NHS Cancer Screening Programmes which will be used by PCTs when developing protocols with local cytology laboratories for managing and monitoring rejected samples.

National guidance confirms the following eligibility criteria for cervical screening: -

**Aged 25 -**

First screening

**Aged 25 – 49**

Screening at three yearly intervals

**Aged 50 – 64**

Screening at five yearly intervals

**Aged 64 +**

Only screen if not screened since age 50 or if recent abnormal tests

Any samples submitted for patients falling outside the

specified age criteria will be rejected. Patients outside the age range presenting with symptoms should be referred to a consultant for further investigation.

Further information can be found at <http://www.cancerscreening.nhs.uk/cervical/about-cervical-screening.html#eligible>

“Any samples submitted for patients falling outside the specified age criteria will be rejected.”

## Taking on New Partners

The GPC has recently issued guidance for GPs highlighting the benefits of taking on new partners.

The guidance looks at the increasing move away from the traditional partnership model in favour of employing salaried GPs and the implications of the tax changes introduced in the Finance Bill 2008/9.

Topics covered include: -

- ◊ The cost of employing a salaried GP, including National Insurance contributions and employer's superannuation.
- ◊ The impact of the tax burden for existing partners earning over £100,000.
- ◊ The benefits of taking

on a new partner.

The GPC guidance, “Focus on Taking on New Partners”, can be found on the LMC website and at [http://www.bma.org.uk/employmentandcontracts/independent\\_contractors/managing\\_your\\_practice/focusnewpartners.jsp](http://www.bma.org.uk/employmentandcontracts/independent_contractors/managing_your_practice/focusnewpartners.jsp)





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Promoting the interests, aspirations and welfare of general practitioners

## Health Protection Agency Launches Migrant Health Guide

A new, free on-line resource for GPs and nurses working in primary care was launched by the Health Protection Agency (HPA) in January 2011. The Migrant Health Guide has been developed in consultation with GPs and health professionals from around the country, and is endorsed by both the RCGP and RCN.

It is intended to be a 'one stop shop' for information to support GPs and nurses in assessing and treating migrant patients, in recognition of the fact that these patients

sometimes have health needs which are more complex than those of UK born patients. It will provide health professionals with the information they require quickly and easily and it is hoped that this will, in turn, improve patient care and quality of life.

The new resource will support health care practitioners in diagnosing and managing a range of infectious and other conditions that may be relevant to migrants from different countries. Early diagnosis and prompt

treatment is important for the health of the individual patient and also to reduce the risk of onward transmission of some infections. Practitioners are encouraged to register with the site so that they can be alerted when there are significant changes to the resource of issues that they should be aware of in relation to migrant health.

The Migrant Health Guide can be accessed at [www.hpa.org.uk/migranthealthguide](http://www.hpa.org.uk/migranthealthguide)

## Focus on Clinical Waste and Clinical Waste Self Audit Tool

The GPC has recently issued guidance detailing the responsibilities of GP practices in relation to the disposal of clinical waste.

Following the introduction of the Environment Agency (EA) guidance for waste management companies in 2007 and 2011, disposal facilities are required to obtain detailed information on the composition of waste before they accept it. This information forms part of their 'pre-acceptance checks', which are a condition of their operating permits.

To allow for disposal facility operators to complete their pre-

acceptance checks, waste collection companies will now be asking GP practices to provide certain information about the types of clinical waste that they produce. As a result, all producers of clinical waste, including GP practices, must provide audits of their waste to their waste management contractors if they are to continue to have their waste accepted for incineration or treatment. This audit is an Environmental Agency legal requirement and failure to provide an audit report by 1 July 2011 could result in the EA prohibiting waste collecting companies from collecting the waste from GP practices.

In order to assist practices in completing the pre-acceptance requirements for waste disposal, the GPC has developed a self-audit tool with the support of the Environment Agency. The tool asks a number of questions to help determine the most appropriate way to dispose of your waste.

The GPC guidance and self audit tool can be found on the LMC website and at <http://www.bma.org.uk/employmentandcontracts/independentcontractors/practicepremises/clinicalwasteaudit.jsp>

## Thornfields Event - Understanding GP Commissioning

The LMC still has a few places left on the Understanding GP Commissioning Event. This course has been specifically designed for

Practice Managers and the last of these courses is to be held on the 24th May at Pontlands Park Hotel, Chelmsford.

Further information and a

booking form are available via the LMC website. <http://www.essexlmc.org.uk/whatson/index.html>