



Will anything be different when GPs and practices are in Clinical Commissioning Groups (CCGs)?

The NHS reforms are under way and are starting to take shape. Fledgling commissioning groups are currently engaging with PCT clusters and gradually having more influence over commissioning. They are starting to be assessed by the SHA and this will continue until the Authorisation process begins around October 2012. This may seem to be some distance into the future but, if the Government agenda is to be followed, all of us will be affected very soon. There are many details as yet unknown, and the Health and Social Care Bill has not yet completed its passage through Parliament, but it is clear that CCGs will have an increasingly important role in primary care and across the wider NHS.

CCGs might become stifled by bureaucracy and merely have token GPs at their centre, but this is not the stated option of the Government and such a scenario would fail. It is important that CCGs are not reincarnations of PCTs, as a genuine link to practices, which will allow reciprocal accountability, is the only way to guarantee a new way to commission

services and produce real change.

The LMCs have recently produced guidance on how CCGs can be accountable to GPs and practices and we will be encouraging all of our CCGs to adopt our principles. The ability to influence and change practice behaviour, whilst not actually holding practice contracts, will be a major goal for CCGs and this will only occur if the relationship is based on accountability and trust. Changing the behaviour of the willing and supportive is possible, to attempt to achieve change without real practice sign up will be impossible.

One of the principles supported by both the Essex LMCs and the GPC is that all GPs in a CCG must be entitled to vote in elections of GPs to the CCG Board. This includes partners, salaried GPs and locums and is designed to ensure that all general practitioners have an investment in the CCG and therefore it is more likely that proposed changes in clinical behaviour will be successful. To expect to influence and lead a disparate group of highly independent clinicians, without allowing all of

them to participate in the creation of the organisation, would be foolhardy. How patients, other clinicians and practice managers will be involved is unclear, but it greatly increases the complexity of CCGs' "governance".

Although the LMC has spent a considerable amount of time with CCG leaders, and has put great effort into these early stages, it would be wrong to imagine that CCGs are going to function as democratic organisations. They will always be primarily accountable to the National Commissioning Board (NCB) and as statutory bodies must account for public funds. It is therefore an illusion to think they will constantly call for mandates from practices, or open up referendum style management by clinicians. That is why it is important that the initial set up of Boards has a fair and democratic foundation, and that said Board are ultimately accountable in a meaningful way to constituent practices and clinicians.

CCGs will have some

Special points of interest:

- ◆ Care Quality Commission
- ◆ CCG Accountability Agreements with Practices
- ◆ 2012/13 Contract Agreement

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responsibility for the performance of practices. It is not yet clear how this will be achieved, or how much of this task will be given to CCGs, but a "GP led" organisation which must address the performance of practices

will be a new challenge for the LMC.

LMCs have existed for 100 years and it will be interesting to develop relationships with these new organisations.

"It is not expected that a CCG will have the power to expel a practice and therefore at this time there is no place for this to be part of any local document"

CCGs – Accountability Agreements with Practices

There have been reports nationally of practices being required to sign Accountability Agreements with CCGs, the terms of which are onerous and in some cases totally inappropriate. One such Agreement contained a clause allowing the CCG to expel "failing" practices.

A meeting has been held recently between representatives of the DH and the GPC at which a number of commissioning issues were discussed and clarification provided as follows:-

◇ CCGs are in shadow form, are not statutory bodies and therefore currently have no legal status.

◇ CCGs are defined by the Health and Social Care Bill 2011, as a membership organisation. The members are practices and the practices should approve a constitution, Governance Framework and Accountability Agreement, and not have one imposed.

◇ The DH is currently developing a Governance Framework, which will give examples of constitutions etc, which can be adapted and adopted locally by CCGs.

◇ It is not expected that a CCG will have the power to expel a practice and therefore at this time there is no place for this

to be part of any local document.

CCGs are expected to work with practices and achieve a high level of clinical engagement. They should be supporting practices and it is intended that they will use support, peer pressure and peer review to improve quality and outcomes of clinical care. The GPC believe it would be inappropriate and a conflict of interest for a CCG to hold practice contracts. (These will be held by the NHSCB.) Any action which is taken in a formal way against a practice needs to be independent of the CCG and have strong involvement from the LMC.

Practice Nurse Indemnity



Following the announcement by the Royal College of Nursing (RCN) that indemnity cover for work undertaken by practice nurses as part of their employment will no longer be provided by the RCN indemnity scheme, practices are reminded to check their

indemnity arrangements, to ensure that the work carried out by their practice nurses and all practice staff is appropriately covered. This is particularly important if practice nurses carry out 'extended roles'.

The LMC Buying Group Federation approved supplier for insurance, MIAB is now offering indemnity cover for practice nurses and further information is enclosed separately.

Death Certification Reforms

The Department of Health is working with a wide range of organisations and groups to reform the process of death certification. These reforms, enabled by the Coroners and Justice Act 2009, will introduce a unified system of scrutiny by independent medical examiners of all deaths in England and Wales that do not require investigation by a coroner. The reforms, which are part of the Government's response to the Shipman Inquiry, are intended to strengthen safeguards for the public, make the process of death certification simpler and more open for the bereaved and improve the quality of mortality data.

Reforms proposed in The

Health and Social Care Bill will see responsibility for the appointment of medical examiners and related activities transfer from Primary Care Trusts to Local Authorities. The relevant regulations are expected to be published for consultation shortly, subject to the Bill's Parliamentary passage, and will be laid in Parliament in May / June 2012 with a commencement date of April 2013.

Local authorities will be able to use service models that are appropriate for their area; these models may include direct provision, commissioning the service from a healthcare provider, integration with existing related services and

collaboration with neighbouring authorities to provide a combined service. The new process has been piloted in several areas, including Mid Essex.

The Government is proposing to fund the new system of death certification by means of a single statutory fee chargeable for certification of all deaths that are not investigated by a coroner, irrespective of whether death is followed by burial or cremation. This statutory fee will be collected locally and will replace the existing fee charged by doctors for the completion of cremation forms, (forms 4, 5 and 10 will be removed).



GP Engagement with Substance Misuse LES

The Essex, Southend and Thurrock Drug and Alcohol Teams (DAATS) is seeking to increase the geographical spread of GP practices that provide shared care for substance misuse under the Local

Enhanced Service. Whilst they are keen to increase participation across the county, they have identified a particular need in South Essex and Tendring.

For further information, please contact Dipti Patel, Shared Care Co-Ordinator on 01376 302265 or forward your details to the LMC office, events@essexlmc.org.uk

"Drug and Alcohol Teams (DAATS) is seeking to increase the geographical spread of GP practices that provide shared care for substance misuse under the Local Enhanced Service"

Locum Agreements – BMA Guidance

The BMA has recently published Guidance which is intended to assist both locum GPs and practices who engage them. The Guidance assumes that the arrangements made will reflect the locum's status as a self-employed GP, and that the Agreement will be a

contract for services, rather than a contract of service which would apply in the case of an employee.

It recommends that when a locum is engaged by a practice both parties use a written agreement that sets out the terms of their engagement. The

Guidance aims to help both parties to draft such an Agreement. It outlines a number of areas that should be covered and provides guidance and examples regarding content in respect of each area. A copy of the Guidance can be accessed via our website.



Seasonal Flu Vaccine Strategic Reserve in England



In the October issue of *Vaccine Update*, the Department of Health (England) announced that they hold a strategic reserve of 400,000 doses of flu vaccine for use in England in the 2011/12 flu immunisation programme, which can be used as an 'insurance policy', in case there are problems with supply. The reserve will be available through the ImmForm website only if manufacturers have no supplies available to order. If practices have no stock of flu vaccine or are running out the DH advises the following steps:

◇ First try contacting suppliers to buy additional stock.

◇ If none is available, find out if this is temporary or permanent. If temporary, then place an order from that delivery date onwards.

◇ Work out how much stock is required to meet patient needs until supplies are available from manufacturers, or to the end of the flu season.

◇ Speak to local colleagues and the PCT flu lead or immunisation co-ordinator to see if any supplies are available locally.

◇ If the PCT confirms that no stock is available locally, order stock from <https://>

www.ImmForm.dh.gov.uk, to meet patient needs. Manufacturers advise the Department of Health on their stock levels and the reserve will only be accessible when there is no vaccine available to order from suppliers. Vaccines should be ordered sparingly to help prevent the stockpile running out. Vaccines will usually be delivered in one to two working days.

"...GPs will remain responsible for ordering their vaccine for the flu vaccination programme for the winter of 2012/13"

Flu vaccine procurement for 2012/13

The Department of Health has confirmed that even though a consultation has been held on the future

procurement of flu vaccination programme for the winter of 2012/13. GPs will remain responsible for ordering their vaccine for the flu

Care Quality Commission (CQC) Registration

In October 2011 the Care Quality Commission published "An introduction to registration with CQC" for providers of NHS general practice. The guide, which we circulated to Practice Managers and is also available on the LMC website, looks quite helpful and tries to dispel some of the myths

surrounding CQC registration.

If you want to get involved in shaping CQC's processes there is an opportunity for GPs and Practice Managers to join their Provider Reference Group (PRG) and the CQC would encourage you to join the PRG. The PRG tests key aspects of the

registration process and the CQC uses their feedback to inform changes.

In the meantime practices are reminded not to engage the services of any outside companies as the exact requirements are still unknown.



Contact the LMC

The LMC is routinely contacted by practices for advice on a variety of issues. It may be that a practice simply wants to clarify a point of regulation, confirm that requests for information from PCTs and others is within Contract or seek advice on QOF, Enhanced Services, etc. Some issues are more complex than others.

We are, however, conscious that there are instances when practices do not contact us at an early stage. There could be an issue or query which may have been relatively simple to resolve, but by the time contact is made, it has become more complex, resulting in stress and anxiety for practices.

The LMC has a wealth of experience and would like to remind you that we are a source of support and information for you. If there is any issue with which you think we may be able to help, then please do not hesitate to contact the LMC office.

North & South Essex
Local Medical Committees Ltd
Promoting the interests, aspirations and welfare of general practitioners

Developing CCGs in Essex – Advice to Practices

All practices should have received a copy of the LMCs' latest Guidance "Towards Authorisation – A Guide for Practices and Emerging CCGs".

This Guidance is the latest in a series produced by the LMCs which includes:-

- ◇ Accountability and Rules of Engagement with Practices - July 2011
- ◇ Legislative Framework and Next Steps – A Factual Briefing for Practices - March 2011
- ◇ Commissioning for Patients – A Briefing for Practices

All guidance has been produced with the intention of updating practices on the Government's latest proposals regarding the establishment and operation of emerging CCGs. The LMCs are not in any way promoting or

endorsing this direction of travel. The introduction of CCGs is Government policy. The LMCs are adopting a pragmatic approach based on the premise that with effect from 1st April next year, membership of a CCG will become a contractual requirement for all practices.

At this time of change, the LMCs in Essex have an increasingly significant role as the local representatives of the profession. This role is not in any way diminished by the appointment of local GPs as clinical leaders of emerging commissioning groups.

The LMCs consider that their role in providing advice, information and support to all GPs is crucial. The legislation proposed a number of significant changes, some contractual, that if not handled sensitively and fairly at a local level,

could threaten the constructive working relationship between practices and between practices and commissioning groups. The LMCs will therefore continue to act as an "honest broker" and help ensure any arrangements that are put in place by emerging commissioning groups are developed in a way that is acceptable to local GPs.

It is important that the support and advice that the LMCs offer to all constituents is relevant and timely. Practices are encouraged to contact the LMC office if they feel that there are any particular issues that the LMCs should be addressing as part of their role in helping GPs and practices to prepare for the new commissioning arrangements.

"Practices are encouraged to contact the LMC office if they feel that there are any particular issues that the LMCs should be addressing ..."



2012/13 Contract Agreement



"In recognition of the general state of public finances and the efficiency contribution expected of general practice, there will be no uplift to GP net pay in 2012/13"

Following negotiations between the GPC and NHS Employers, agreement has been reached on changes to the Contract effective from 1st April 2012.

In recognition of the general state of public finances and the efficiency contribution expected of general practice, there will be no uplift to GP net pay in 2012/13. The Agreement relates to a number of areas of the Contract as follows: -

- ◇ Practice Expenses
- ◇ Certain QOF points, indicators and thresholds
- ◇ New Quality and Productivity Indicators in the QOF
- ◇ Choice of GP Practice
- ◇ Clinical and Extended Hours Directed Enhanced Services (DESS)
- ◇ Carr-Hill formula
- ◇ CCG membership

Practice Expenses

An increase of 0.5% to the overall value of GMS Contract payments has been agreed for 2012/13. This increase is intended to help practices meet the increasing cost of expenses including the pay award of £250 for all employed NHS staff with a full time equivalent salary of less than £21,000 per annum.

This increase will be delivered through an

increase in the value of QOF points to £130.51 for an average practice.

Quality and Outcomes Framework (QOF): NICE Recommendations

Two indicators (17 points) have been retired following recommendations from the National Institute of Health and Clinical Excellence (NICE) and a further 26 points in total have been removed from other indicators (BP4, BP5, CKD2, DM2, DM22, Smoking 3 and Smoking 4).

A number of changes to some of the current indicators have been agreed. Two new disease areas, osteoporosis and peripheral arterial disease, have been introduced.

The full details of the changes to QOF for 2012/13 are detailed on the LMCs' website at www.essexlmc.org.uk

QOF: Changes to Thresholds

There will be a number of changes to QOF thresholds from 2012/13 as follows:

- ◇ Raising the lower thresholds for indicators currently 40-90% to 50-90%
- ◇ Raising all lower thresholds for indicators currently with an upper threshold between 70-85% to 45%
- ◇ A number of upper threshold changes for indicators CHD6, CHD10, PP1, PP2, HF4,

STROKE6, STROKE8, DM17, DM31, COPD10

- ◇ Lower and upper threshold changes to BP5

QOF: Quality & Productivity (QP) Indicators

The QOF-QP prescribing indicators have been replaced with new indicators which aim to reduce avoidable Accident and Emergency (A&E) attendances. The new A&E indicators will be worth 31 points (28 points from prescribing and three points from other QOF changes). These indicators are for one year from 1 April 2012 until 31 March 2013. The guidance for these indicators will be available shortly. The QP indicators covering emergency admissions and outpatient referrals will continue for a further year until 31 March 2013.

In order to ensure that prescribing improvements continue, the following joint statement with NHS Employers has been agreed: -

"Although the prescribing element of the quality and productivity scheme will be replaced with A&E attendances in 2012/13, we agree that all practices in the UK should continue to ensure cost effective prescribing when compared to peers, building on the progress achieved in 2011/12. Those practices who remain significant outliers would also be expected to



2012/13 Contract Agreement

continue to participate in external peer review during 2012/13."

Choice of GP Practice

The GPC continues to oppose the complete removal of practice boundaries and instead proposed greater local flexibility to allow patients to remain registered with a practice when they have only moved a short distance outside the practice area, and a modified temporary resident scheme to allow practices to provide primary medical services to commuters.

It has been agreed that practices will agree with their PCT an outer boundary where they will retain, where clinically appropriate, existing patients who have moved into the outer boundary area and want to stay with the practice. There will also be a pilot to test two different models enabling commuters to receive primary medical services when away from home. It will allow patients in two or three cities (or part of cities) to visit a practice, either as a non registered out of area patient, or as a registered out of area patient in a number of voluntary practices in those areas. The funding to pay for patients who use surgeries on a non-registered basis will be capped at £2m which will therefore limit the size of the pilot. The pilot will be subjected to an independent evaluation.

The Department of Health has agreed that the results of that evaluation will be published and results considered before any further implementation. Detailed guidance on both the establishment of outer boundaries and the operation of the choice pilot will be developed and published shortly.

Clinical DESs

The osteoporosis DES in England, Scotland and Northern Ireland will no longer be available from 1 April 2012. In England, the GMS element of the funding for the osteoporosis DES will be reinvested in the global sum with no corresponding increase to correction factor payments. Any money released through reductions in correction factor payments is to be reinvested back into the global sum.

The following existing directed enhanced services are to be re-commissioned by PCTs for the twelve-month period ending on 31st March 2013:-

- ◇ The alcohol reduction scheme
- ◇ The learning and disabilities health check scheme.

The requirements of these two clinical DESs remain the same and the payment scheme will mirror the payment scheme at the same rate that applied for the period 1 April 2011 to 31 March 2012.

Extended Hours Access

Directed Enhanced Service

The extended hours access directed enhanced service is to be re-commissioned by PCTs for the twelve-month period ending on 31 March 2013. The requirements of this DES remain unchanged.

Carr-Hill formula

It has been agreed in principle to explore how the Carr-Hill formula might be adjusted from 2013/14 onwards to give greater weighting to deprivation factors. Such work will refer to the Formula Review Group recommendations from 2007 and Professor Roy Carr-Hill's original work in 2001-03.

Risk profiling and case management

Subject to confirmation of the evidence base, it has been agreed to explore how risk profiling and case management of patients might be introduced from April 2013.

Clinical Commissioning Group (CCG) Membership

Agreement has been reached in principle that, subject to the successful passage of the Health and Social Care Bill, all GP practices will be contractually required to be a member of a CCG.



"The GPC continues to oppose the complete removal of practice boundaries..."





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New Community Pharmacy Services

The BMA has published information in connection with the introduction of two new Community Pharmacy services – New Medicine Service (NMS) and nationally targeted Medicines Use Reviews (MURs) – which came into effect on 1st October 2011. This guidance is available on the LMC website at www.essexlmc.org.uk.

The new services are designed to lead to improved health outcomes for patients, support better utilisation of community pharmacy expertise and resource and provide value for money for the NHS, supporting the QIPP programme. It is anticipated that the changes will ensure that patients are able to use their medicines more effectively and they should be less likely to present to their GP with medicines related problems. In delivering the NMS,

pharmacists are required to contact local GP practices about the service, which can be provided to patients who have been newly prescribed a medicine for asthma and COPD, type 2 diabetes, antiplatelet/ anticoagulant therapy and hypertension. A list of medicines has been agreed for each of the condition/therapy areas and these plus further details of the service can be found in the guidance referred to above.

The aim of MURs is to improve a patient’s knowledge, understanding and use of their medicines and patients who have an MUR are likely to have been taking the medicine for a period of time. From the 1st October pharmacists must ensure that at least 50% of the MURs they provide are “targeted” on patients who are taking high risk

medicines, have been recently discharged from hospital with an amended medicines regimen or have respiratory disease. The MUR will continue to cover all the patient’s medicines and not just those that fall within the target group.

Both the LMC and LPC are keen to make sure this process runs as smoothly as possible to ensure that patients can get the most benefit from the new services and it is important that effective communication and reporting processes are agreed between pharmacists and GP practices.

LMC Elections 2012

LMC representatives hold office for a term of four years. The following constituencies are due for re-election in March 2012:

North Essex

- Colchester
- Epping
- Tendring
- Ophthalmic Medical Practitioner

South Essex

- Basildon
- Billericay, Brentwood & Wickford
- Thurrock
- Ophthalmic Medical Practitioner

LMC membership is open to GP principals, salaried GPs and locum/sessional GPs. Nomination papers will be posted to GPs in early January. Locum/sessional GPs may wish to check with the LMC office that we hold the correct contact information for them to ensure that they are included in the process.

If the number of nominations received for any constituency exceeds the number of places available, an election will be held.

If you require any further information regarding the election process or would like to discuss the role of an LMC representative, please contact the LMC office.





LMC Buying Group Indemnity Cover For Practice Nurses

Changes are being made by the RCN regarding the withdrawal of malpractice cover for nurses from January 2012. The LMC Buying Groups Federation and its approved supplier for insurance, MIAB, are aware of this situation and are now offering indemnity cover for practice nurses...

Currently the RCN provide malpractice cover for their nurses to indemnify a patient, should something go wrong when the patient is in the nurse's care. This will cease on 1 January 2012.

Instead the RCN are looking to GP practices to provide professional indemnity insurance for their nurses, by adding them to a policy that some (but not all) GP practices may currently have. This indemnity policy protects against Vicarious Liability and is not to be confused with the more common Public and Employers Liability insurances found in a surgery policy.

It is an insurance taken by a practice to cover the errors and mistakes of their staff (both clerical and medical and excluding GPs) when dealing with and treating patients. The purpose of such cover is to protect the business against the costs of being sued for malpractices resulting from staff in their employment.

Your GPs will have their own Malpractice Insurance that they pay for individually. Nurses currently have similar cover through the RCN but this will cease. Without insurance to protect against vicarious liability or standalone nurse cover, a practice becomes personally liable for any instance of malpractice alleged against a nurse in the practice's employment.

So what should you do now?

Working with the LMC Buying Groups Federation as its approved insurance provider, MIAB can supply a range of solutions to practices of all sizes. This includes providing cover for just your nurses or if you prefer, full vicarious liability protection for all staff.

Alternatively if the GPs have a **group** malpractice policy with the MDU or MPS it may be possible to extend this cover to include nurses; however depending on the scheme this may incur an additional charge and practices will still be required to insure nurse practitioners and nurse prescribers separately at an additional cost.

MIAB are here to help. If you need further detail or simply have an enquiry about how to take the situation forward, contact Tristan at MIAB on 01438 730213.

ESSEX 2012 PRACTICE MANAGER CONFERENCE



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Ivan Clark - Managing Change
Andy Edwards - Motivational Speaker
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Tuesday 21st February 2012
Ivy Hill Hotel, Margarettin,
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9.30 - 4.00pm

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Working Without the Default Retirement Age

Objectives:

By the end of this practical and interactive one day workshop designed specifically for general practice, delegates will have gained a thorough knowledge of the impact of the loss of the Default Retirement Age and how this will impact upon management within the practice. Practices will need to focus much more closely on the effective management of performance and develop policies and protocols to achieve this.

Performance Management

A Guide for General Practice

Objectives:

This workshop has been specifically designed for managers in primary care to help them establish and maintain high standards of performance in the team. Every team member must contribute to the overall effective running of the practice and to the team. Managers will learn how to create systems and processes to create this and how to engage and motivate the team to perform well.

Recruiting the Right Person

Objectives:

By the end of this one day workshop, delegates will have gained a thorough knowledge of the recruitment, selection and appointment process. They will understand how to avoid discrimination and to interpret the law into best practice. Delegates will have tested out a variety of tools designed to make the process effective and simple and will have many ideas on how to implement good recruitment practice in the workplace.

When and Where:

17 January 2012
9:30 - 16:15

Churchill Room,

Pontlands Park
Hotel, West
Hanningfield Rd,
Great Baddow,
Chelmsford
CM2 8HR

When and Where:

25 January 2012
9:30 - 16:15

Churchill Room,

Pontlands Park
Hotel, West
Hanningfield Rd,
Great Baddow,
Chelmsford
CM2 8HR

When and Where:

1 February 2012
9:30 - 16:15

Churchill Room

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Hanningfield Rd,
Great Baddow,
Chelmsford
CM2 8HR

£85.00
per delegate
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Booking and Enquires to:

Annette or Sarah, Tel: 01245 383430 or email: events@essexlmc.org.uk
The agendas for each of the above three courses are available on request.