



Special points of interest:

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BMA Support your Surgery Campaign - Phase 2



The Support your Surgery campaign has so far proved to be a huge success. In just three weeks, practices across England collected almost 1.3 million signatures, demonstrating overwhelming patient support for NHS general practice. The petition was presented to Downing Street on 12th June and subsequently provoked a significant response from Ministers as well as debate in the national and local media.

Despite the success of Phase 1 of the campaign, the threat to NHS general practice remains. The Government still intends to introduce GP led Darzi centres throughout England. The threat is the destruction of high quality, patient friendly general practice and its replacement by large corporations. It is essential that practices continue to promote and defend their profession and

the Support your Surgery campaign has therefore been extended until the end of 2008 and beyond.

Phase 2 of the campaign will again focus on informing patients and the public of the implications of Government plans for primary care. On or around 19th September practices will receive a Support your Surgery campaign pack. The pack will contain advice on how best to contact the local media, MPs and local Overview and Scrutiny Committees. Contact details are also available on the LMC's website at <http://www.essexlmc.org.uk>

The BMA will continue to promote the campaign both nationally and regionally but if it is to be successful it is essential that practices continue to support the campaign. It is increasingly evident that patients are not being informed that in a system based on finite resources an inevitable consequence of the opening of expensive Darzi health centres will be the closure of existing practices that offer high levels of quality, value for money, continuity of care and patient advocacy.

In a command and control culture that is today's NHS, practices are one of a dwindling number of organisations that are able and willing to help patients better understand the implications for them and their families of what is being proposed. All practices are therefore strongly encouraged to participate in the BMA campaign and help prevent the destruction of the infrastructure that has supported the delivery of high quality primary care for the last sixty years.

Further information is available on the Support your Surgery website <http://www.supportyoursurgery.org.uk>

The LMC website at <http://www.essexlmc.org.uk> will shortly be updated to allow practices to access the campaign material electronically.



Extended Opening Hours for Practices - The DES



The final DH Guidance, Directions and amendments to the SFE relating to the Extended Hours Access DES have now been issued.

The key requirements are as follows:-

- The DES is effective from 2nd September 2008.
- PCTs must offer the DES to all practices no later than 29th September 2008.
- PCTs are not required to offer the DES to individual practices if they have already entered into an alternative arrangement with a practice(s) which is "broadly similar to the purpose of the DES", i.e. "to enable patients to consult a GP, face to face, at times other than during core hours..."
- Where alternative arrangements have been agreed, PCTs must review the arrangements no later than 2nd November 2008.

"PCTs are not required to offer the DES to individual practices if they have already entered into an alternative arrangement with a practice(s)."



• As a consequence of the review, and with the agreement of the contractor, existing local schemes must be varied so the following criteria are met:-

- ◇ The length of the agreement should be lengthened or shortened so that it terminates on 31st March 2010:
- ◇ The level of payment should not be less favourable than that set out in the SFE of £2.95 per registered patient (or contractor's registered population – CRP); and
- ◇ The scheme's requirements and obligations are of an equivalent standard to the DES.
- Where a practice is operating a scheme which does not comply with the three areas referred to above, and it does not agree to a variation to the arrangements, the PCT cannot insist on this. In such cases, the existing scheme will continue under the arrangements already agreed.
- Where PCTs do not need to offer the DES to individual practices (because an alternative arrangement has already been agreed with the practice concerned) they must let the SHA have details of the practices by 11th November 2008.
- Concurrent working is not a right. The PCT has "absolute discretion" to agree arrangements with practices taking into account local factors, DH Guidance, etc.
- Ensuring the safety and security of staff and patients is a priority for PCTs and practices. PCTs must look to mitigate any identified risks when agreeing arrangements with practices.
- Clinical sessions in extended hours must be in addition to those provided in core hours. "In order to ensure that there is no reduction in the overall availability of GP consultations and clinical care, PCTs should have established the availability of GP consultation times during core hours".
- Practices must provide information that the PCT "reasonably requires" in order to be sure that any proposal meets the DES requirements.
- Home visits are not a requirement of the DES. Home visits that are deemed necessary during extended hours will continue to be undertaken by the out of hours provider.
- There is no requirement that reception areas and/or telephone lines should be operational during extended hours.

Extended Opening Hours for Practices - The DES Cont'd

- It is expected that six to seven GP appointments will be provided per 90 minutes of extended opening time.
- The payment is £2.95 per patient per annum, paid quarterly in arrears. The payment provisions only allow payments to be made to both GMS and PMS practices in respect of the period during which services are provided. Preparatory payments and or financial bungs are not permitted!
- PCTs are not required to offer the DES after 31st December 2009.

We believe that all the LES arrangements currently in place in the Essex PCTs can continue in their current form. Please notify the LMC office if this position is questioned by your PCT.



Choose and Book Paperless Pilot

Practices in South West Essex have been advised that with effect from 1st October 2008 Addenbrookes and Hinchingsbrooke will pilot paperless referrals in Urology and Geriatric Medicine.

North Essex LMC discussed this at their Committee meeting on 4th September and raised grave concerns that paperless referrals for these two specialities will no longer be accepted and that all referrals must be made via Choose & Book. Members questioned the legality of adopting this stance and also wondered who would be responsible for the patient if a written referral is refused? The view of the Committee is that Hospital Trusts are legally bound to accept all referrals,

irrespective of referral mechanism. It should also be noted that Choose & Book is not a contractual obligation.

Advice from GPC is that the national Choose & Book team have also publicly frowned on compulsory use of Choose & Book particularly where it has been done unilaterally and without consultation with referrers. The BMA also supports the view that it may be unlawful to do so. No system is 100% foolproof and given the problems that practices have experienced with the Choose & Book system it is completely inappropriate to insist on Choose & Book as the only vehicle for making referrals, for patient safety reasons more than anything else.

The Committee were strongly of the opinion that GPs should be allowed to continue to refer using paper referrals if they wish and requested that South West Essex PCT Choose & Book Team raise these issues with the Commissioning team in Cambridgeshire PCT.

"The Committee were strongly of the opinion that GPs should be allowed to continue to refer using paper referrals if they wish ."



The Future of Dispensing Doctor Services



"Dispensing practices are encouraged to submit a response and also to inform patients that their dispensing services are under review."

The Department of Health has recently published a consultation document on the future of dispensing doctor services in England; this can be accessed at the links below. The document contains four genuine options for consultation and these are as follows:

- 1) a pharmaceutical needs assessment with a reduced mileage criteria
- 2) the distance from the surgery (not the patient's home, as in the current regulations) to the pharmacy
- 3) the distance from the surgery to two pharmacies (in order to offer as much patient choice as possible)
- 4) no change to the existing rules as set out in the 2005 NHS Pharmaceutical Services Regulations as amended.

The consultation document contains 3 annexes and there are an additional 8 impact assessment documents, in addition to guidance on "how to respond". The deadline for

submissions is Thursday 20th November.

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_087324

<http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/index.htm>

The GPC and Dispensing Doctors' Association will be submitting responses arguing for the existing rules to be maintained, as set out in the Statement released on 8th May. A further statement is to be issued shortly.

North & South Essex LMCs will be discussing the documentation at their October meetings, following which a formal response to the consultation will be submitted. Dispensing practices are encouraged to submit a response and also to inform patients that their dispensing services are under review.

Listening Events

The DH has arranged a series of "Listening Events" around the country which

are detailed below:

Wednesday 8th October 2008 Business Design Centre, London, N1 0QH
9:30am – 1:30pm

Sunday 12th October 2008 Radisson Edwardian Marlborough, London, WC1B 3QD
9:30am – 4:00pm

Thursday 30th October 2008 Holiday Inn, Regents Park, London, W1W 5EE
9:30am – 4:00pm

Places can be booked online via the Primary Care Contracting website, www.pcc.nhs.uk/events

Places are extremely limited. Despite GPs not being referred to as part of the target audience, dispensing doctors are able to attend any of the events. The GPC has stressed the importance of dispensing doctors attending these events where possible in order to ensure their voice is heard.

Warning from the GPC - Hidden Directory Charges

NOVACHANNEL AG

LMCs recently received correspondence from the GPC advising them to warn practices about certain methods being adopted by Novachannel AG which has been sending communications to UK practices about their publication "Physicians and

Therapists Guide".

Practices need to be aware that by returning the form enclosed with the letter they are signing up to pay for what is essentially an advertisement in this publication. Some practices have returned the form without noticing this, and have subsequently been invoiced for

the cost which is significant.

LMCs have been asked to alert practices so that they are fully aware of the position. Practices who have already signed such a form, are advised to consider cancelling the contract formally so that it does not roll over for a further twelve months.



PMS Contract Prices – IMPACT OF DDRB RECOMMENDATIONS

Background

The DDRB recommended that GMS practices should receive a 2.7% increase in Global Sum payments, but that there should be no increase in levels of protected income under the Minimum Practice Income Guarantee (MPIG). This would mean that most GMS practices will not receive any increase in contract payments. For most GMS contractors, the 2.7% increase in global sum would be matched by an equivalent reduction in correction factor payments.

The DDRB recommendations affect individual GMS practices differently. About 7% of GMS practices do not receive any correction factor payments under MPIG and would therefore receive a full 2.7% increase in their Global Sum payments. There is also a small category of GMS practices (around 2%) that receive a small level of correction factor payments under MPIG, but for whom the effect of the 2.7% increase would be to take their Global Sum payments above the level of their protected income. These practices would receive a net increase of somewhere between 0% and 2.7% and would no longer be covered by MPIG.

BMA Advice

PMS contracts are locally negotiated and agreed and are not bound by the

DDR B Report recommendations. The BMA advice has always been that practices should open negotiations with their local PCT with a view to agreeing an inflationary increase for 2008/9 of 2.7%

Letter from DH

In the context of discussions with PCTs practices do however need to be aware of a recent letter sent from the DH to SHA/PCTs highlighting the implications for PMS practices of the DDRB Report. The letter suggests that PCTs should begin discussions with practices. The extracts taken from the letter detailed below give a clear indication of the approach PCTs are likely to adopt.

PMS contract prices are a matter for local determination. However, in the interests of equity in the treatment of GP contractors operating under different contracts, PCTs will need to consider the implications for their PMS practices of the DDRB award for GMS contractors.

Given the differential effect of the DDRB award on GMS practices (as described above), PCTs will want to consider the implications for PMS practices on a case-by-case basis, with specific reference to the contractual agreement the PCT has with that practice. Most PMS practices have baseline funding that is based on historic GMS

income. This closely mirrors the effect of the Minimum Practice Income Guarantee in GMS. (It is these historic incomes on which Global Sum Equivalents and hence correction factor payments were derived for GMS practices). In addition to this baseline funding, PMS practices often receive "PMS growth" funding. For these reasons, we would expect that applying the DDRB recommendations to PMS practices (in an equitable way to that applied to GMS practices) would result in a smaller proportion of PMS practices receiving an uplift than in GMS.

In looking at this, PCTs may find it helpful to compare the funding that a PMS practice receives for delivering the equivalent of GMS essential and additional services with the equivalent GMS Global Sum funding (ie. the number of registered patients adjusted by the Carr-Hill formula that is used to calculate Global Sum payments in GMS). If the practice's income at 1st April 2008 (for these essential and additional services) is more than £56.20 per patient (after adjusting by the Carr-Hill formula), it is receiving more income than it would do under the Global Sum formula in GMS – and (if it were a GMS practice) would not receive any increase in contract payments under the DDRB's recommendations.



"The BMA advice has always been that practices should open negotiations with their local PCT with a view to agreeing an inflationary increase for 2008/9 of 2.7%"



Towards the best, together



"Towards the best, together" is a document detailing the East of England SHA's "strategic" vision for the local NHS for the next decade. The document confirms that change is needed but stresses that change must be based on the following six principles:-

"The proposals contain an undue emphasis on prevention. This is important but should not be at the detriment of diagnosis and treatment."

A focus on prevention, health inequalities and timely intervention.

Services focussed on the needs of the individual and their carer.

Services localised as much as possible, but centralised where appropriate.

Services that are accessible and integrated, delivered by a flexible and skilled workforce.

Partnerships with others where possible, with patients always.

Outcomes that deliver

measurable and meaningful improvement.

North & South Essex LMCs both received presentations on the document from representatives of the SHA at their July meetings. Members had no objection to the key messages contained in the document but formally raised the following concerns:-

There needed to be much greater recognition of the role played by GPs particularly in terms of high level risk management and patient advocacy.

A degree of caution needs to be exercised when introducing an urgent care number. The use of an 888 number and NHS Direct have failed to ensure that patients are directed to the most appropriate service.

A number of the recommendations in the document could be

delivered by altering processes rather than structure.

Significant additional funding is required to support IT developments and clinical leadership training.

The proposals contain an undue emphasis on prevention. This is important but should not be at the detriment of diagnosis and treatment.

Concern was expressed that no mention was made of the high number of military personnel and their families in the Eastern region.

Support should be offered to existing primary care providers before creating or contracting with new provider bodies.

The Cameron Fund



The Cameron Fund is the profession's only charity providing help and support solely to general practitioners and their dependants, in poverty, hardship or distress. The Cameron Fund was set up in 1970, and named in memory of Sir James Cameron – a distinguished GP who led the profession at the time of the pivotal Charter for Family Doctor Services in 1966. Since then the Cameron Fund has distributed over £4 million in benefits and has assisted over 1,000 individuals or their families and dependants. The Fund is currently providing

much needed assistance to over 100 GPs or their dependants.

In order to continue to help GPs and their families who face such hardship the Fund needs to supplement its investment income. The Fund is reliant on donations from GPs for approximately half the income it needs.

At its meeting in May, South Essex LMC received a presentation on the work of the Cameron Fund from its Chief Executive, David Harris.

Consequently South Essex LMC has decided to set up a Charity Levy. This will be entirely voluntary for GPs. Funds will be deducted at source and will therefore attract tax relief in a similar way to the LMC Statutory Levy and the General Practitioners Defence Fund Subscription.

South Essex LMC agreed to write to all GPs in the area later in the year with further details and providing them with the opportunity of contributing to the Cameron Fund should they so wish.

Corporate Manslaughter Act

The BMA has recently produced guidance to alert GPs to the details of the Corporate Manslaughter Act 2007, which came into effect on 6th April 2008 and applies to organisations, including NHS bodies across the UK. It was introduced in response to high-profile disasters such as the Potters Bar and Paddington train crashes, which highlighted the difficulty of securing criminal prosecutions against large corporations. It takes into the area of responsibility such things as accidents when driving to work, MRSA cases and any work place fatality caused by the practice's "gross breach" of duty of care. The act will facilitate the prosecution of organisations as a whole and not individuals, whether doctors or other members of staff. Individuals remain liable under existing Health and Safety legislation and the common law of manslaughter.

What should practices do?

In light of the new legislation, it is important

for practices to take a number of steps:

Carry out a review of health and safety processes and documentation. Are current processes sufficient? Ensure that your practice policy on the Health and Safety at Work Act (HASAW) promotes a safety conscious culture.

Ensure that staff training and development is adjusted to promote awareness of the new legislation and its potential ramifications. Do not inappropriately delegate responsibilities to staff without proper health and safety training and ongoing backup and support.

Job descriptions for all staff will need to be reviewed to upgrade the emphasis on health and safety and the joint responsibility for all working at your practice to take a positive approach to health and safety.

Check that the partners' agreement/contract specifies health and safety responsibilities, which partner has the lead for any specific areas of health and safety including clear and specified sanctions for the neglect of these duties/responsibilities.

Review the management of hazardous substances – if a child were to die following accidental consumption of a toxic substance at a consultation, the absence of sufficient drug safety policy could mean vulnerability to a conviction.

Review whistle-blowing policy. There should be protocol for handling reports of any behaviour that could lead to prosecution under the Corporate Manslaughter Act.

Consider how to learn from significant events that did not, but could potentially have caused death. Ensure that all possible measures are taken to prevent the recurrence of such events.

Any expenditure on improvements to safety must be recorded and kept for future reference. Check that the practice insurance cover is adequate to protect for such events. This may well mean an increase in annual cover charges or the redrawing of your current insurance cover to include potential litigation claims and damages.



“Consider how to learn from significant events that did not, but could potentially have caused death. Ensure that all possible measures are taken to prevent the recurrence of such events.”

The Performing Right Society

Practices may have received letters from The Performing Right Society (PRS). For those of you who haven't, you need to be aware that **if you play music in your business to your employees or customers a PRS Licence is legally**

required. This is because the copyright for music is owned by the writer who therefore has the right to decide how and when it should be played. PRS manages these rights on behalf of songwriters, composers and music

publishers, which means a PRS Music Licence grants you the legal permission to play music on your premises. Further information can be found at www.prs.co.uk.





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Promoting the interests, aspirations and welfare of general practitioners

New Clinical Directed Enhanced Services 2008/09

NHS Employers and the GPC have agreed five new clinical Directed Enhanced Services (DES) as part of the 2008/9 contract negotiations. Joint GPC/NHSE guidance on the five new clinical DESs has been published and is available on the LMC website at <http://www.essexlmc.org.uk>.

The DESs are for:

Heart failure

Improving the treatment of heart failure and including incentives to provide beta blockers to appropriate patients. Practices will get £35.00 per patient treated under the DES. A pre-requisite for taking part in this DES is that the practice holds and maintains a register of patients with heart failure (HF), which is already rewarded through the Quality and Outcomes Framework (QOF). It is the responsibility of the contractor to demonstrate that they have systems in place to maintain a high quality register and PCTs will be expected to verify this, comparing reported prevalence with expected prevalence.

Alcohol

Helping to reduce the risks of adults, aged 16 years or over, drinking at 'hazardous or harmful' levels defined by the World Health Organisation. Practices will get £2.33 for each new registered patient that has been screened.

Osteoporosis

Encouraging practices to diagnose and prescribe appropriate pharmacological

secondary prevention for patients with Osteoporosis. Payment will be based on three criteria covering diagnosis and treatment. The payment per average practice that meets all these criteria is £588.21.

A pre-requisite for taking part in this two-year DES is that the practice holds and maintains a register of women aged 65 years and older with fragility fractures sustained after 1st April 2008.

It is the responsibility of the contractor to demonstrate that they have systems in place to maintain a high quality register and PCTs will be expected to verify this, comparing reported prevalence with expected prevalence.

Learning disabilities

Annual Health Checks for people on the local authority learning disability register. Practices will get £100 for every health check.

The pre-requisite for taking part in the DES are as follows:

Practices will have liaised with the LA to share and collate information, in order to identify the people on their practice LD register with moderate to severe learning disabilities. A practice providing this service will be expected to have attended a multi-professional education session. The minimum expectation of staff attending will include the lead general practitioner (GP), lead practice nurse and practice manager/senior receptionist. Practices may also wish to involve specialist LD staff

from the community learning disability team to provide support and advice.

Ethnicity

Rewarding practices for recording the ethnicity and first language of all the patients on their list. Practices will get 5.6p per registered patient.

These DESs were due to run from April '08 but were delayed as a result of the GPC dispute over the 2008 D D R B recommendations. All of the DESs will run for two years with the exception of heart failure which is a one year DES. It is the intention of the DH to publish Directions and Amendments to the Statement of Financial Entitlements to underpin the DESs in October 2008. PCTs have been advised not to enter into Local Enhanced Service arrangements until the DES directions and amendments have been published.

Practices are advised to read the guidance and decide if they are of interest to them. All of the DESs achievement payments are made at the end of the year.

The guidance suggests that practices wishing to take up any of the DESs can begin working on the basis of the specifications and record what they have done in their clinical systems, to be used as part of the evidence of achievement at the end of the year.

