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NO. 2

# SOUTH STAFFORDSHIRE LMC NEWS

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### ENHANCED SERVICES

The LMC has agreed that all the Enhanced and Local Enhanced Services for 08/09 will be rolled over into 09/10. There will be a 1.5% uplift and you should have received the first back payment for 08/09 from the PCT in your December 08 payment.

The Choose and Book LES will also be carried over and you will recall that the PCT has guaranteed a similar payment for 08/09 in comparison to the payment in 07/08.

The PCT has discussed with the LMC their proposal for the transfer of LESs to Practice Based Commissioning consortia that can be seen as secondary care services. The LMC has been supported by the GPC in its stance of caution and concern about the capacity of PBC to cope. We are also concerned about governance issues, ring-fencing of funds, PBC management of the process and future decommissioning of LESs. More financial details have been requested from the PCT who propose to make the transfer in the mid year of 09/10.

### LMC ELECTIONS

You will have received an invitation to stand as an LMC representative for your area. It is as important as ever for the LMC to be representative of its GPs and therefore hope you will give this some consideration. The LMC Secretary is available to discuss this with you.

### INSURANCE REPORTS

The GPC is aware of a few cases where instead of producing a report that includes the specific information/ facts required for the relevant condition, the doctor is down-loading the whole medical record onto a CD ROM and posting it in a normal brown envelope. They are then requesting the fee which would normally be paid for a written report rather than a dump of records.

The professional fees subcommittee will be producing some guidance on the correct way to write reports, however, in the interim they have provided some good key points to keep in mind when completing reports.

- The information should be provided in the manner requested and should be as complete as possible, providing a synthesis of essential details from the mass of undifferentiated information on the medical records.
- Reports may be completed electronically or by hand, provided the information is clear.
- The provision of paper or electronic copies of the medical record is not appropriate and is not covered by the patient's consent to the report.
- GPs are responsible for the content of their report and must sign them whether or not practice nurses or administrators have a role in their completion.

**Sending CDs by ordinary post is not a reasonable manner for a practice to undertake its responsibility to protect the confidentiality of patient data. Any loss may not only be the subject of legal proceedings but also significant adverse publicity.**

### IM&T COMPONENT 2 OF THE DES

Paula Ashfield has responded to LMC queries about the IT DES component 2 payments with respect to completion and money available:

1. A pre requisite for component 2 is that the practice are accredited for paper light initially. The evidence practices are currently submitting is to attain this

element and there is no payment for a practice to obtain paper light status.

Following successful agreement of paper light accreditation, the next stage is that practices will arrange a data accreditation visit, where their data and processes will be evaluated by a trained clinician and the data quality team. Recommendations will be put forward to the practice and an action plan generated. It is at this point practices will receive component 2 payment.

Currently all evidence submitted for paper light accreditation is being evaluated by a panel consisting of representatives from Primary Care, IM&T and data quality. Practices are being informed of any additional actions that they need to undertake if required.

2. The PCT have been aware of the timescales to complete component 2 and have therefore ring-fenced the funds accordingly into the following year, so we do not have a problem regarding funding being available once the processes for component 2 are completed.

**BMA SALARIED GPs' HANDBOOK 2009**

The BMA launched a new Salaried GPs Handbook 2009 last week. It is designed to give employers and employees comprehensive information of the legal and contractual issues facing salaried GPs. A hard copy of the handbook will be sent to all BMA's salaried GP members and is available to all BMA members on the BMA website.

Please see the following link for more information:
www.bma.org.uk/employmentandcontracts/employmentcontracts/salaried_gps/salariedgpbook.jsp

**CONFIRMATION OF DEATH**

You may have noticed that ambulance paramedics trained in the confirmation of death are now declining to carry out this function when we are busy in the surgery between 8 am and 6.30 pm and are saying it is the "responsibility of the GP".

The LMC was asked whose legal responsibility is it?

There is no obligation on a GP to attend an expected death under current law, in fact there is no statutory duty on anybody to confirm the fact of death. However the GP will want to bear in mind the feelings of the relatives in confirming death. An undertaker may remove a body so long as he is confident that the doctor who has attended the deceased in his last illness and has seen him within 14 days is prepared to sign a death certificate.

Please go to a helpful GPC West Midlands document on this matter via the link:
www.gpcwm.co.uk/pdf/deathincommunity.pdf

The LMC newsletter is a useful way of sharing everyday concerns and pitfalls in general practice.

**SPECIFICATIONS FOR PRINTING PRESCRIPTIONS ONTO PRESCRIPTION FORMS**

We have been asked by NHS Prescription Services for practices to be reminded that there are specifications for how practices should print prescriptions onto prescription forms. NHS Prescription Services uses information on prescription forms both to reimburse dispensing contractors and to attribute costs to PCTs.

Practices are urged to check that they are printing prescriptions in line with these specifications, so that forms are consistently overprinted to a high standard.

Things to look out for include:

- 'Title, initials, surname' matches the 'prescriber pin'.
- Only the information that is needed is printed in a particular area - for example postcode only in the postcode area, telephone number in the telephone field.
- Nothing is missing, for example PCT code.
- Information is up to date.

**MIND THE GAP ON INSURANCE**

GPs should ensure they are adequately covered for loss of earnings through accident and illness.

The BMA medico-legal committee says there is a shortfall between what we spend on personal insurance and what we need to spend to ensure adequate cover - what the committee terms 'the protection gap'.

Its new advice calls on GPs to work out what they would be entitled to from the government and/or the NHS should they be unable to work and calculate whether this is sufficient to maintain their standard of living.

The guidance, Mind the Protection Gap, says 'Where a gap exists, and it is more likely than not that one will, you will need to make your own arrangements.'

GPs need to work out what they will be entitled to from the NHS occupational sick pay scheme, the NHS pension scheme - which could entitle them to an ill-health retirement pension - and statutory sick pay. The guidance provides figures and examples.

Any protection gap should be closed through an income protection policy that pays a regular tax-free income.

The full guidance is at www.bma.org.uk/images/mind_the_protection_gap_jan09_tcm41-181993.pdf

**GPC GUIDANCE**

Several guidance notes can be accessed on the BMA website at www.bma.org.uk.

**1. Focus on Seniority Payments**

Includes information on what seniority payments are, calculating your payments, claiming for work outside the NHS, appeals, salaried GPs, Sabbaticals, voluntary overseas service and PMS.

**2. GP Referral Incentive Schemes**

This guidance informs us what the GPC regards as appropriate practice.

**3. Patient Registration - Frequently Asked Questions**

The document covers a range of issues including eligibility, ID provision, allocated patients and removal of patients.

**Dr David Dickson**
**LMC Secretary**

**DATES OF NEXT MEETINGS**

South Staffordshire LMC - 23 April 2009, South Staffordshire PCT, Anglesey House, Towers Business Park, Rugeley

South East Staffordshire Sub Committee - 16 March 2009, Samuel Johnson Community Hospital, Trent Valley Road, Lichfield

South West Staffordshire Sub Committee - 19 March 2009, South Staffordshire PCT, Block D Beecroft Court, off Beecroft Road, Cannock

**LMC MEMBERS**

The following is a list of current members of the South Staffs LMC

| | |
|---|---|
| Dr M MacKinnon (Chairman) | 01785 813538 |
| Dr D Dickson (Secretary) | 01283 564848 |
| Dr C Pidsley (Vice Chair/Treasurer) | 01283 500896 |
| Dr A Parkes | 01827 68511 |
| Dr V Singh | 01543 870580 |
| Dr E Wilson | 01922 415515 |
| Dr A Yi | 01543 870590 |
| Dr A Burlinson and Dr O Barron (job share) | 01889 562145 |
| Dr P Needham | 01283 565200 |
| Dr M Murugan | 01543 870570 |
| Dr G Kaul | 01543 414311 |
| Dr A Selvam | 01543 571650 |
| Dr J Holbrook | 01543 503121 |
| Dr T Scheel | 01283 845555 |
| Dr S Dey | 01889582244 |
| Dr P Reddy | 08444 770924 |

**PTO**

**DR V SPLEEN**

Dear Reader

We are now approaching that time of year when our year end accounts are prepared. Our minds are exercised even more as to how to deal with the results of 3 years without pay increase. Once expenses are taken into account these are pay cuts. In our practice we saw a 3% reduction in profits for the year 2007 and are expecting a reduction of anything up to 10% for 2008. Most of us are operating efficient small businesses with little surplus in staffing, we have been contracting with the cheapest utility providers for years and have maximised our QOF, DES and LES payments. As I see it we have two options.

Option A involves replacing partners with salaried GPs, employed with the BMA model contract of course (this *is* a LMC communication). It involves the extended hours DES, and any other LES that comes along regardless of its clinical value and profitability. It may involve deferring premises upgrades and certainly avoiding investment in new equipment.

Option B involves continuing to replace partners with parity partners, only taking on work that is of clinical value and continuing to invest in the business to improve quality of services for patients and maintain job satisfaction.
What will be the result? My assessment of Option A is that the remaining partners will manage to preserve a small increase in profits, but at the risk of exhaustion and burn out, increased staff turnover and maybe poorer level of service.

My assessment of Option B is that the partners will continue to keep their sanity, some job satisfaction and continue to provide a good service to their patients. However they will take a severe drop in income on an ongoing basis.

Which of us is able to go for Option B? Even if we wanted to, we all have family to look after. University is getting more expensive and indirect taxation is escalating.
However think it through a little more carefully. As long as we return profits with little drop, the Pay Review body is unlikely to award any significant rise to our global sum and certainly not to any other payments. This means that in essence we are devaluing ourselves. We are doing more and more work for the same or less money. The QOF system already does this. When the number of diabetic patients doubles in a few years we will still be getting the same amount of money because our prevalence relative to the average will still be much the same!

If we stick with Option B and return significantly reduced profits there may be a chance-admittedly only a chance, of an inflationary increase in the global sum which will reduce the rate of devaluation of our services. There is also the sweetener with this option of the tax rebate. With taxation based on current year, there is the prospect of significant reduction in tax bill in the period after presenting the accounts to the tax man. Remember the opposite that occurred after our big pay rise and the huge extra tax bills that came our way. Superannuation payments will also reduce. Taking on outside work as individual doctors, such as locums and Occupational health contracts, would be a more effective way of keeping income level.
I know which I want to do, but Option B does depend on everyone doing the same. Unfortunately I think option A will herald the end of General Practice as we know it within 10 years. I say this because essentially the qualities that distinguish general practice from APMS will be eroded until the two become one and the same.

**Venture**

***The Views expressed in this column are those of the author and not necessarily those of the LMC.***