The Humberside Group of Local Medical Committees Ltd

Newsletter March 2014

Message from Russell Walshaw, Chief Executive, Humberside Group of LMCs

The Secretariat of the Humberside Local Medical Committees Ltd is routinely contacted by practices for advice on many issues. It may be that a practice simply wants to clarify a point of regulation or confirm that requests for information from the NHS England Area Team, CSU or CCG and other bodies are obligatory or otherwise.

However, I am aware that there are a number of instances where individuals and/or practices do not consult the LMC at an early stage.

Remember that the LMC Secretariat has a wealth of experience. This includes pastoral care and together with colleagues we are able to provide personal and confidential support for individual doctors and practices in difficulty or experiencing major change.

I am especially keen that practices do not delay in contacting me if they are experiencing serious financial difficulties as a result of cash flow problems, for example where they are needing to make alternative arrangements either through use of existing contingency funds or bank overdraft arrangements

Your Local Medical Committee provides the representative function for GPs in Hull & East Yorkshire and North and North East Lincolnshire and also their practice teams and its role therefore is in contrast to that of CCGs which have a role in commissioning of care but no representative function.

If there is any issue with which you think we may be able to help, then please do not hesitate to contact the LMC Secretariat.

NHS Standard Contract 2014/15

There are changes to the NHS standard contract documentation compared to 2013/14 and are principally around governance, sanctions, payments, enhanced data protection and IG requirements, contract length and inflation/deflators to be applied.
In brief:

- There will be more stringent governance requirements that will require providers to have greater regard for lessons learnt, never events and complaints.
- There will be an increased number of sanctions with an emphasis on mental health which will be based on QP system with 'pick list' for local sanctions.
- Payment clauses will be updated to reflect National Tariff and Payment guidance system (previously PBR).
- Commissioners may offer up to a seven year contract where competitive procurement route is followed or three years where no competitive procurement. The commissioner must consider the contract length in relation to patient interests, context of benefits and procurement and the offer contract length is from the commissioner.

The National payment and tariff system sets the adjustments to prices which for non-acute services are minus 4% efficiency and 2.2% inflator and therefore the net is a 1.8% deflator. The application of the deflator will be determined as follows:

> Where a service that has not previously been contracted through the NHS Standard Contract is included in the NHS Standard Contract for the first time (for example on 1st April 2014) then the price will be the price offered by the CCG through whatever 'procurement' route they have chosen to use.
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> The inflator or deflator will then be applied from the first anniversary of the contract unless the contract is terminated or unless it is agreed locally not to do so and / or negotiate a new completely new price.
> It is most likely that the deflator will be applied from 1st April 2015 to the 2014/15 prices so that the prices for 2015/16 are deflated from those in 2014/15.
> What happens in subsequent years is yet to be determined.

The NHS standard contract is a ‘live’ document. The specifications can be changed throughout the duration of the contract. The range of services offered by a CCG will change and present opportunities and risks that will influence this process. There will be a dialogue with providers regarding this and changes will be via contract variation documents. Practices will have a choice whether to continue the contract but will have to give twleve months’ notice if not.

Care.data – delay to roll-out

NHS England has announced a six-month delay in the roll-out of care.data, with extracts now due to take place in autumn 2014. This follows concerns raised by GPC that the public awareness campaign has not worked, with many patients still unaware of care.data and their right to object to the extraction of data from their medical record.

GPs will welcome that NHS England has allowed more time to ensure that patients are made fully aware of the implications of care.data, how their information is stored and used, and their right to object. The BMA continues to support the use of anonymised data to improve and plan NHS services, but is seeking further assurances from NHS England around the scheme, working closely with them to ensure that the public is properly informed and that safeguards are in place before uploads begin.

The BMA will update LMCs and practices via GPC News and on the BMA website. GPs should continue to enter the objection code(s) to patient records where requested by their patients.

DEP001 QOF business rules

Following a query regarding the QOF business rules of DEP001, where a practice had found that their performance on this indicator dropped following the upgrade by EMIS to v27.1 of the business rules, we have had the following advice from the HSCIC:

Originally indicator DEP001 was developed to follow the guidance which requires that the diagnosis of depression and the bio-psychosocial assessment (BPA) codes are recorded on the same date to meet the requirements for this indicator and that a patient would only have one BPA recorded for each new episode of depression.

The BPA code was a new code in April 2013, however it was found that some practices were recording the code again following diagnosis (as well as at diagnosis), which was a use that HSCIC hadn’t anticipated. It has since been brought to HSCIC's attention that a patient may have more than one BPA recorded in a given QOF year. This has been discussed with QOF stakeholders and as the numbers of patients affected was expected to be small any change to

the indicator was to be implemented in 2014/15, however this indicator will now be retired on 1 April 2014.
HSCIC have considered whether a change can be made to the business rules at this stage, however this is not possible as there will be an impact on GPES as all the suppliers would need to go through re-certification.
If practices feel that they have been unfairly disadvantaged for 2013/14 QOF they are advised to negotiate with their Area Team. Where a patient newly diagnosed with depression in the current QOF year, has received more than one BPA in the current QOF year the area team would need evidence that at least one BPA had been recorded on the same day as the depression diagnosis.
Alternatively, practices could delete the second offending code, and re-enter it as free text to preserve the integrity of their record.

Important information for GP practices – Quality and Outcomes Framework (QOF) 2013/14

The Health and Social Care Information Centre (HSCIC) sent an email bulletin out to practices last week on the QOF for the 2013/14 financial year. A step-by-step guide for practices will be issued in March by the HSCIC.
We recommend that practices read last week's bulletin, which explains how the General Practice Extraction Services (GPES) will operate for the QOF extraction. The bulletin also explains how practices should prepare for and participate in the QOF using the Calculating Quality Reporting Service (CQRS).
The GPC has emphasised to NHS England and the HSCIC the need for the necessary functionality and training to be in place so that practices can effectively use the CQRS with minimised disruption.
In the event that data is not available via GPES for all practices by the end of March, the HSCIC has provided some detail on their contingency plan – this is also set out in the bulletin with further information to follow.

Workplace pensions

Then LMC cannot give advice on pensions but would nevertheless draw to your attention areas of change in legislation which may have an impact on GPs or their practices..
Workplace pensions place responsibilities on employers including and GPs, both as practices and individuals (eg for nannies), to provide a pension.

• Workplace pensions, or ***'Auto-Enrolment'***, began rolling out in October 2012.

• Roll out will continue for several years through until April 2017 for the smallest businesses, and that extended timetable will deal with many LMCs and practices.

• The legislation requires all employers to enrol automatically some or all members of their workforce, depending upon age and wage level, into an employer organised pension scheme with certain minimum standards.

• The NHS pension schemes may not be the solution for all GP employers as some workers may be ineligible to join the scheme.

• An individual does not have to remain in the scheme and can opt out within one month of being enrolled.

• Every employer will be allocated a date from when the duty to establish a scheme first applies and this is known as the staging date..

• There is a particularly important consequence of Auto-Enrolment. It may lead to loss of fixed or enhanced lifetime protection already obtained with the possibility of a 55% tax rate.

The LMC urges you to begin by taking independent financial advice in so far as Auto-Enrolment is likely to impact you personally and your practice.. Planning is the key.
The BMA, NHS Confederation and Pension Regulator websites all provide very helpful further information.

Guidance on Named GP for patients aged 75 and over

The BMA has published guidance on the requirement for a named GP for patients aged 75 and over, which has been agreed as part of the GP contract changes beginning from April 2014. The guidance includes information on the responsibilities of the named GP and how practices should decide on the identity of each patient's named GP, and is available on the BMA website.

Funding redistribution

NHS England has recently published guidance on funding redistribution for both PMS and GMS practices, as highlighted in last month’s edition of YORLMC News.
It is now known that £325m of "premium" PMS expenditure has been identified by NHS England as the amount by which PMS expenditure exceeds the equivalent items of GMS expenditure.
The premium will reduce to £235m over the seven years to 2021/22 as GMS correction factor funding is phased out and global sum funding increases.
Area Teams will have up to two years from April 2014 to review their local PMS contracts, with

the pace of change on the redeployment of funding following the reviews being left to local judgement. They are expected to invest the premium funding in GP services according to criteria set by NHS England, with local discretion within these criteria about how the funding should be invested. For GMS practices, NHS England sent a letter to its Area Teams shortly before Christmas about outlying practices caused by the phasing out of MPIG. The letter refers to 98 national outliers whose details have been sent to relevant Area Teams. It provides some options for Area Teams to consider in dealing with these practices - for example, encouraging collaboration or agreeing a new contract type with the practice. It is likely that many practices not identified in the 98 outliers may have equally strong cases for local support because of significant funding cuts. Nationally, Area Teams have also been encouraged to engage with LMCs in finding solutions for practices that are disproportionally affected but who are not one of the 98 outliers and the LMC has already offered its assistance to the Area Team when supporting affected practices.

There are problems with NHS England's approach for both GMS and PMS practices, not least the inequity that will be caused by the amount of discretion being left to Area Teams by both sets of guidance. The GPC and the LMC believe that the PMS premium expenditure should have been redistributed to core GP funding, providing greater certainty for practices and allowing them to invest for the future with greater confidence. The GPC has made our shared concerns clear to NHS England.

King's Fund report

The King's Fund has published a new report entitled *Commissioning and Funding General Practice: Making the Case for Family Care Networks*. The report argues for increased collaborative working between GPs and increased funding for practices to meet the demands on primary care, but within a new contractual framework.

In response to the report, Dr Chaand Nagpaul, has said:

“It is important that we constantly look for ways to improve the way we deliver care to patients. The King’s Fund are right to recognise the unique contribution general practice makes to the NHS and that we need more resources to be allocated to GP practices so that they can continue to deliver the high quality service patients have come to expect. We do also need to encourage more collaborative working to help GPs take on the role of providing new services in the community, including the care the government wishes to move out of hospitals. “However, general practice does not need another reorganisation on the back of the incredibly time consuming and costly restructuring GPs have only just undergone. Instead we should be

focusing on tackling the serious workload and financial challenges facing GP practices, and supporting them to evolve and develop rather than wasting resources rearranging the NHS' already complicated bureaucracy. "There is also no evidence that changing wholesale the contractual basis of general practical would deliver any real benefits to patients. In its current form, the GP contract enforces nationally agreed standards of care across the country while allowing practices the flexibility to tailor their services to the demands of their local community. The King's Fund alternative would see GP services subsumed into wider commissioning budgets that would both make it more difficult to guarantee national standards and hinder the ability of local GPs to truly manage the services they deliver. "While we need to be bold in addressing the problems facing general practice, we must ensure that we don't implement needless, disruptive policies that focus more on structures than patient outcomes. The BMA's GP Committee's own vision for the future of general practice shows how we can achieve many of the King's Fund aspirations by building on practices' current contracts, and focusing on supporting innovation, such as through the pooling of resources under a federation system. We also need to back general practice with targeted funding in the areas that really need support."

Changes to pension arrangements for GP locum appraisers in England and Wales

The NHSPA (NHS Pensions Authority) has stated that freelance GPs who carry out appraisals can now choose to pension that income. Until now, only salaried and partner GPs appraising other doctors could do so. This move comes after continued lobbying of NHS England by the GPC sessional GPs subcommittee.

GP locum forms A&B will be updated by the NHSPA in the coming weeks to reflect this change, which comes into effect from 1 April 2014.

Changes in pensions arrangements for salaried GPs in England and Wales

The NHSPA has also announced changes that mean all the practice income of salaried GPs will now be pensionable. Practice-based overtime is not currently pensionable for salaried GPs - for example, if they work a Saturday morning that income is not pensionable if it is outside their contracted hours.

Now all practice income can be pensioned, even if it takes salaried GPs over their working time hours.

Updated enhanced services guide 2013 / 14

The enhanced services guidance for 2013/14 has been updated following the October 2013 read codes release and is available on the practice funding pages on the BMA website.

The Information Governance Toolkit

Version 11 of the Information Governance Toolkit for general practice went live in June 2013 and the deadline for final submission is **31 March 2014**. The toolkit encompasses 13 requirements against which general practice should self assess. The Health and Social Care Information Centre (HSCIC) states that completion of the toolkit is necessary in order for practices to ensure that their HSCIC services, such as the N3 connection, continue to be provided. This is because every practice receiving these services needs to sign up annually to an Information Governance Statement of Compliance and the only way this can be signed or submitted is through the IG Toolkit online assessment.

One person from a practice will have been nominated as the IT lead and they will register for a user account and complete the online self-assessments on behalf of the practice. We recommend that practices submit their 2013/14 self assessments by the deadline.

Death certification

Death certification reforms in England and Wales have been expected for some time now, and while delays continue, the GPC remains positive that implementation will occur. Ministers are committed to reform in all the countries of the UK, although the details may vary. Implementation is expected in October 2014. The new process will involve the introduction of a new role of medical examiner, commissioned by local authorities. Scrutiny of deaths by the medical examiner will effectively replace the existing cremation system involving three different doctors (two medical attendants signing the MCCD and cremation forms, and the medical referee).

In England, a training programme for medical examiners has been produced by e-Learning for Health in collaboration with the Royal College of Pathologists. A number of issues relating to local authority recruitment, and to cost, are still under consideration. The BMA Forensic Medicine Committee continues to be a part of the Department of Health's Implementation Board and will provide updates to members as and when further information is available.

Partnership changes

The government intends to make significant changes to the taxation of partnerships and partners therein from 6 April 2014. The draft Finance Bill 2014 was published on 10 December 2013 and contained further detail on the proposals. Under current legislation, all partners in an LLP (known as 'members') are regarded as self-employed for tax and national insurance contribution (NIC) purposes.

Limited companies and dispensing practices

The GPC has been informed that some practices have been advised by accountants that they should put their dispensing income into a limited company, distinct from the practice, to avoid breaching the pension taxation limit.

In order to have the rights to dispense to patients, a practice must hold a Primary Medical Services Contract with the NHS. Any practice divorcing their dispensing rights from their NHS contract as suggested will risk losing their rights to dispensing altogether, so the GPC is advising practices to take appropriate legal and accountancy advice before making any changes to their dispensing arrangements. The GPC is also contacting AISMA to make accountants aware of this issue.

DH estates & facilities alerts

With regard to the above which are issued from time to time to remind providers of healthcare to the NHS of the requirement to report defects and failures involving plant, infrastructure and non medical devices, practices are advised that the requirements on general practice should be reasonable and proportionate. From a CQC viewpoint the GPC advises that practices should comply with any health and safety related legislation to meet the CQC outcome on premises.

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The Cameron Fund - The GPs' own charity

The Cameron Fund is the only medical charity which provides help and support solely to general practitioners and their dependants. It aims to meet needs that vary considerably from the elderly in nursing homes to young, chronically sick doctors and their families and those suffering from unexpected and unpredictable problems such as relationship breakdown or financial difficulties following the actions of professional regulatory bodies.

Anyone who knows of someone experiencing difficulties, hardship or distress is urged to draw attention to the Cameron Fund's existence or alternatively to contact Jane Cope, the Services Manager.

E-mail: janecope@cameronfund.org.uk Phone: 020 7388 0796

Address: Tavistock House North, Tavistock Square, London WC1H 9HR

The Humberside Group of LMCs Ltd
Albion House
Albion Lane
Willerby
Hull
HU10 6TS

01482-655111
humberside.lmcgroup@nhs.net