North Staffs LMC Newsletter

September 2017 – issue 36

North Staffordshire LOCAL MEDICAL COMMITTEE

Update

This is a quick update on a few ongoing key issues –

- The need to print and sign paper copies of map of medicine referrals will steadily be removed.
- Map of medicine itself continues to interfere with EMIS functionality.
- MDDUS have frozen their premiums for this year (after increasing them) and we await the outcome from MDU/MPS and the government's offer to cover the huge indemnity increases created by the decrease in discount rate, which will through the legal system substantially trigger increased compensation awards. The consequent overall multiplier in premiums costs is thought to be of a factor of between 2 and 5. The Winter OOH cover arrangements are still to be announced.
- We are chasing the CHP/NHSPS local lease offer and still await the national offer.
- We will be challenging two major issues with UHNM - the increasing complexity of some of their referral forms and the inaccessibility of their referral portals.
- There is still some lack of clarity about the bare minimum required to qualify for being technically open on Thursday afternoons (in order to qualify for the extended hours DES), but it would involve having the phones and an open reception. We are awaiting practices' choices and the subsequent potential alternatives that could be negotiated with NHSE and the CCGs.
- We have fed in to the new QIF 2018/19 proposals to make them both useful and realistic.
- We have fed back to the National Audit Office regarding the STP's progress and will be liaising with key representatives in the coming months.

Dr Paul Scott
LMC Chair

Electronic prescriptions – future requirements

NHS Digital are **asking users about future enhancements** to the Electronic Prescription Service (EPS).

Prescribers and dispensers have told NHS Digital which enhancements are required, now they need to understand which are most important to you so they can prioritise them to use the resources and time available most effectively.

For example, would you prefer private prescriptions or personally administered prescriptions to be included in EPS first and would you prioritise adding an alert about urgent antibiotics to the script over automatically cancelling all outstanding repeat dispensing regimes when a patient leaves your practice?

The **survey** should take around 10 minutes to complete depending on your answers.

Helping you meet your training obligations

The BMA's new guidance on training is now available online. **Click here for the link**

This is mainly aimed at practices in England due to the specific issues they have faced with inappropriate training demands/requests from CCGs and CQC, but it should be of interest to all practices.

Transfer of Private patients to NHS

We still hear stories of consultants in private practice asking GPs to transfer/refer patients to NHS care. This is NOT a GP's responsibility. If a patient has been referred to a consultant privately for a first outpatient appointment and the patient wishes to be transferred to NHS care, then it is the responsibility of the private consultant to refer the patient directly into the NHS. At this point in time, the patient will enter the 18 week pathway at the date that this decision was undertaken, not on the date that the original referral was made and patients will be subject to NHS waiting times. In addition, the surgery/treatment/diagnostics required must be routinely commissioned by the CCG.

CQC - Registered Manager checks

It's been brought to the BMA's attention that CQC is investigating compliance with its registered manager requirements in GP practices. The BMA have been advised that letters have been sent to a number of practices in CQC's central region, and that it is CQC's intention to look at all regions in due course. It is unclear at this stage if the practices affected received previous communications from CQC regarding its intentions prior to these letters being sent out.

For background, under the regulations all providers must have a registered manager, except where the service provider is an individual who manages the service day-to-day and who is fit to carry on the service. Some single handed GPs will meet this criteria and will not need a registered manager. Any GP practice registered with CQC as a partnership or as an organisation is required to have a registered manager. Further information is available on the **CQC website**

Whenever a registered manager leaves/is replaced, CQC **must be notified**. A practice must apply to register a manager within 12 weeks of the previous manager leaving.

Practices are reminded of their legal obligations relating to registered managers.

Below is information provided to the BMA by CQC showing the number of GP practices in each CQC region that do not have a registered manager where one is required.

	No Registered Manager
Central	95
London	54
North	113
South	67
Total	**329**

This table below shows the length of time and numbers of GP providers that have been in breach of this condition of registration.

	3 years +	**2 - 3 years**	**1 - 2 years**	**6 – 12 months**	**3 – 6 months**
Central	5	11	30	28	21
London	6	10	11	10	17
North	8	21	21	27	36
South	4	8	10	14	31
Total	**23**	**50**	**72**	**79**	**105**

CQC's Central region is ahead of other regions in validating its lists to make sure its data is correct, so its letters went out before the other three regions. North, South and London regions are currently validating their lists and at the end of the process the remaining providers will receive a letter by **mid-September**.

CQC have advised the BMA that:

- Each region will validate its list to make sure the provider needs a registered manager – any that should not be on the list will be excluded.

- An inspector will check the system to make sure that no application is currently being processed for a Registered Manager – if there is they will be excluded.
- The majority of providers will have had a conversation with an inspector either at an inspection to remind them to register a manager, had a letter or were told by registration when they originally registered to do this or will have a telephone conversation with an inspector at some point reminding them of this. CQC expects practices to have had a phone call once the lists are validated before a letter goes out.
- Once a response is received CQC will hold a management review meeting and decide next steps.

The BMA has raised their concerns regarding the language and tone of the letters being sent out to practices and will do so again when they next formally meet with CQC.

Income Tax/Annual Allowance

Please see below article by Wessex LMC.

Everyone should read this!

As an LMC we meet every 3 months with the specialists Medical Accountants and Solicitors and also Chartered Surveyors. This is really helpful in terms of discussing topics of mutual interest in their specialist areas and allows the LMC to provide information relating to a number of key issues that are going on in general practice.

General practice finance is more complex than it has ever and practices and individual GPs would be wise to have an accountant that specialises in general practice.

The following was prepared for the LMC by two of our specialist Accountants - Sally Sidaway from RSM UK Tax and Accounting Limited and Roger Morgan from Sandersons.

"One of the main topics of conversation at GP practice meetings this year should be unfortunately, the 'Tapering of the Annual Allowance limit' with regard to pensions. New rules from 2016/2017 are leading to huge increases to many GP's tax bills from January 2018 onwards. GP's ignore this legislation at their peril!

2015/2016 in contrast saw the majority of GP's escape an Annual Allowance tax charge but the goalposts have now moved and this should be a clear message that you have taken and understood from your accountant or IFA.

2016/2017 saw the introduction of tapering of the annual allowance limit. Those earning over £110,000 may well see their annual allowance limit reducing from £40,000 down to a possible £10,000 depending on individual levels of total income. When this happens unused relief that may have been generated in 2015/2016 and earlier years is likely to be used up in full in 2016/2017 which may mitigate a tax charge but very often will not remove it altogether. This is real extra tax that will need to be paid for no extra growth in pension when a GP retires. The extra tax for 2016/2017 is payable in January 2018 and the position will be potentially worsened due to the knock on effect to the first payment on account towards 2017/2018 tax.

The tax year 2017/2018 gets worse as most higher earners will by that point have no unused relief left to offset and the CPI rate which will be used as part of the dynamising calculation is based on the September 2017 factor. September 2016 saw a factor of 1%, it is largely expected September 2017 will be higher thus giving more growth to pension pots. As an extra point it should be noted that the growth rate in the new 2015 scheme is in fact faster than in the 1995 scheme so individuals in this scheme will see pension growth at a faster rate. A small growth in inflation with no other changes can have a large effect on annual allowance growth.

We are advised by the Specialist Medical Accountants acting for a number of our GP's that the increases in tax liabilities that they are seeing as a result of these rules are often staggering in size and this is an area that must be looked at very carefully.

If you have not been asked to already your first step is to download a Total Rewards Statement from NHS pensions website. You will need a government

gateway login first to enable you to do this. Make sure this has been forwarded to your accountant for careful review. The Total Reward Statements will not be fully up to date they are likely to be live to 31st March 2015 but your accountant should be able to extrapolate forward from this with your last two years' pensionable earnings.

Whereas Life Time Allowance planning may well be a conversation that you need to have with your IFA, your accountant has a duty to review your Annual Allowance position if information can be obtained in order that your Income Tax Return can be prepared as accurately as possible. It is not advisable to await statements setting out your position from NHS pensions agency as under the current system these will be sent out after the date at which your Income Tax return has to be submitted. As always if with hindsight extra tax is found to be due, HMRC will charge interest on late payment of tax and there could be the possibility of penalties.

Eventually NHS pensions Agency should advise you of your Annual Allowance breach although this cannot be relied upon without request.

Self Assessment tax is clear that the individual remains responsible for declaring all tax due, NHS pensions agency will not be in any way responsible . Beware also:

The NHS pension saving statement setting out any breach will not have considered any non NHS pension contributions made.

b) Will be potentially many months after the tax is due giving a nasty shock of tax effectively payable immediately.

c) This is retrospective, once a tax charge has arisen it cannot be reversed if you know in advance what is likely to happen you have a chance to take mitigating action.

d) In a number of cases the tax numbers are enormous and facility to pay this tax will need careful planning.

e) These rules are not only a problem for GP's with big pension pots who are near end of career, many young GP's are also being hit where earnings are high.

If you are not getting the right advice on this area of your tax and pension affairs please consider your position very carefully. There are ways to mitigate the tax and you need to consider if any of these are appropriate to you.

Below is a real example of Dr Smith (name changed to protect identity)

In 2016/17 it was estimate that Dr Smith had unused pension relief brought forward of £14,017. However, her tapered annual allowance for the year is calculated at £18,189 and it was estimate her deemed growth in her pension at £65,857. She therefore has 'excess' contributions of £33,651 (calculated as £65,857 less £18,189 and less £14,017) which gives rise to a tax charge of £13,460 for that year.

For 2017/18 (assuming she remains a member of the scheme for the whole year) and estimating CPI at 2.5% (we won't know this figure until September) the position is worse. She has now exhausted any unused relief from previous years. Her accountant estimated her deemed pension growth ay £72,202 and her tapered Annual Allowance at £15,485. If she had done nothing her excess for the year will be £57,717 resulting in a tax charge of £23,086.

Some of the AA tax charge can be paid by the pension scheme but not all. The GP partners do not receive any extra drawings to cover this tax and it is therefore a direct hit on the cash available to them to draw. The NHS pension scheme cannot advise the value of their pensions at the beginning and end of the year (and many GP's are unable to access their Total Reward Statements at all at present) so all of these figures are our best estimates based on the information known to us at this time. We have to make an entry on their tax returns to declare the potential liability and as you can see we are talking some very significant figures. Dr Smith's views are similar to most partners reactions that we are getting at the moment so I am sure you will be hearing a lot more about this over the coming months.

Quality Improvement – open event on 26.09.17

The first cohort participating in the Productive General Practice Quickstart (PGPQ) programme will soon be

completing their 2 work modules and you are all invited to come and see the results at the Bet 365 Stadium, on Tuesday 26th September between 2.35p.m. and 4.30p.m.

The Practices have reviewed a variety of internal processes and systems with some amazing findings and results. For example

- one Practice looked at their prescription process and as a result identified 11 changes they could make to improve it, make it more efficient and save time (200 hours admin time p.a. and 99 hours GP time p.a.).
- one Practice looked at workload and task allocation and this has improved productivity, provided additional time to train staff in new duties and improved staff morale.
- 2 or 3 Practices have identified those patients who are frequent attenders at their practice. At one Practice 26 patients attended for 745 appointments in a 12-month period (average of 28.6 per patient) which represents 11% of available appointments. They are now working through the full list (114 patients) to address attendance, where appropriate, and to navigate patients to other services. One early success is a mum with 2 young children who was attending the Practice or OOH almost every week. She has been referred to the Health Visitor and has so far not made another GP appointment.
- a Practice will save 338 hours p.a. of medical secretary time by not chasing hospital appointments for patients. They have produced a poster for patients providing appropriate telephone contact details for the hospital and now direct patients to do this for themselves.

There are lots more very positive outcomes for all the Practices involved in the programme and it's really important that all this excellent work is shared with everyone so that all Practices can benefit from the findings. So come along, talk to the people who have done the work, see their posters and process charts and discover for yourselves what's possible.

There is no need to book to attend this event – just turn up on the day. You don't need to be there for the full 2 hours as there is no timed, structured agenda. It's for you to get as much out of it as you can simply by chatting and asking question so you can drop-in at any point from 2.35p.m. onwards (to 4.15p.m.) The session is open to any member of the Practice team.

PCSE Claims Guidance

GPC England are aware that practices and individual GPs continue to experience unacceptable incidents relating to PCSE (primary care support services in England), commissioned by NHS England and provided by Capita. The issues have been ongoing for some time and GPC England are aware of cases where practices have not received payments, or have received incorrect payments. It is never acceptable for payments to be delayed and GPC England advise practices to follow the below process to ensure incorrect payments are corrected. Similarly, GPCE are aware that practices or individual doctors may have suffered losses due to the failing of these services.

We advise following the **claims guidance** if a practice or individual has experienced an issue due to PCSE. Please share this guidance with any members who are experiencing issues with PCSE. Please contact the GPC at **info.gpc@bma.org.uk** if the issue is not resolved through this process in a timely manner, and they will take up your claim with NHS England.

PHE guidance on treating common infections – dental

Updated BMA guidance **on prescribing in dental conditions** on the BMA quality first pages

1. There is a useful **article** which references GPs prescribing unrequired antibiotics for dental infections, with a suggestion that it may be contributing to antibiotic resistance.
2. And **here** is some helpful guidance from prescribing matters for dental practitioners, on page 4 which states very clearly that dentists should not be routinely asking GPs to prescribe in dental related conditions.

Spirometry registration/training is not mandatory

In some areas of the country commissioners are demanding registration and/or evidence of training with regards to spirometry delivery. Spirometery is delivered voluntarily by practices and so

commissioners have no contractual rights to demand such requirements. Whilst the below letter was seeking to clarify the obligations of practices in the delivery of cervical smears, the principles of the letter hold true. Practices may find the letter useful should local commissioners ever make similar demands.

Hakin letter re cervical cytology training for GPs

Potential fraud scam re locums

The GPC has been made aware of a scam where two GPs had been subject to an attempt to gain their bank details through contacting practices where they had been working. The man attempting to gain their details called himself James Keith, who phoned the practice reception team stating the name of the Doctor working there and claiming that he worked for a locum agency "down south" but their systems were down so they needed the doctors bank account details so they could pay them.

The practices involved did not give out any details and swiftly informed the GPs and also the GPC of the attempt. The GPC has since reported this incident to the Action Fraud Team and the police are dealing with it.

Palliative Care

Practices are reminded that they are not required to complete a 'Care in Last Days of Life - Adult services' booklet which had not been agreed by the LMC but may well be in circulation after being unilaterally produced.

Post CCT Fellows

Health Education England have announced a new round of recruitment for Post-CCT fellowships within the West Midlands. The West Midlands GP Fellowship programme has been developed jointly between NHS Health Education England, University of Worcester, Taurus Healthcare (Hereford), Modality Partnership (Birmingham), Royal Wolverhampton NHS Trust and GP First (Staffordshire). For further details, please **follow this link**

GP contract: Identification and Management of patients with frailty

Please follow the below link for a reminder of BMA advice on your practice's contractual obligations with regards to the identification and management of patients with frailty:

Focus on identification and management of patients with frailty

Wessex LMC Practice Healthcare Diagnostic Tool

Wessex LMC has developed a toolkit to help their practices, and as part of the development they discussed this with other local LMCs and shared ideas.

The toolkit has now been endorsed by the RCGP and NHS England and has been made available via their website for any practice to use. The link is below.

Wessex LMC Practice Healthcare Diagnostic Tool

Collaborative Fees

GPs are professionally and statutorily obliged to complete medical reports for social services, education and public health. Payment for these reports falls under the collaborative arrangements, the current fees for which are subject to review by the CCGs after they have taken on delegated commissioning from NHSE. We are waiting for the outcome of this review but we would suggest that you use the current fee list when invoicing for this work until further notice. Recently added to this are also the safeguarding reports at £28.06.

The current fee list is on the next page.

NHSE Collaborative Fees calculation	Form	Staffordshire wef 1.7.12	DDRB Uplift 13/14 1.50%	DDRB Uplift 14/15 1.60%	DDRB Uplift 15/16 1.34%	DDRB Uplift 16/17 0.70%	TOTAL 16/17
Exams & Reports in a form recommended by the British Agencies for Adoption and Fostering (BAAF)							
Adoptive (Parents)	F001-0	£33.50	£0.50	£0.54	£0.46	£0.25	£35.25
AH2 (health assessment on prospective carer)	F001-1	£95.00	£1.43	£1.54	£1.31	£0.69	£99.98
AH2 (supplemmentary to AH)	F001-2	£40.00	£0.60	£0.65	£0.55	£0.29	£42.09
M/B	F002-0	£60.00	£0.90	£0.97	£0.83	£0.44	£63.14
M/B (forms M/B Obstetric/Neonatal reports)	F002-1	£60.00	£0.90	£0.97	£0.83	£0.44	£63.14
AME	F003-0	£120.00	£1.80	£1.95	£1.66	£0.88	£126.28
Form C	F003-1	£120.00	£1.80	£1.95	£1.66	£0.88	£126.28
Form D (forms AME:C:D detailed med exam to report on child	F003-2	£120.00	£1.80	£1.95	£1.66	£0.88	£126.28
IHA initial health assessment for looked after children)	F003-3	£75.00	£1.13	£1.22	£1.04	£0.55	£78.93
YP (detailed med exam to report on child)	F003-4	£120.00	£1.80	£1.95	£1.66	£0.88	£126.28
Case Conferences							
Attendance over 1hour requires certification by Social Services- GP	F004-1	£120.00	£1.80	£1.95	£1.66	£0.88	£126.28
Other Reports Requested by Social Services							
Occupational Therapist Assessment	F010-0	£25.15	£0.38	£0.41	£0.35	£0.18	£26.47
Referral/Assessment Form GP2 (only if med exam carried out)	F012-0	£33.50	£0.50	£0.54	£0.46	£0.25	£35.25
Certificate of Visual Impairment (exam in consulting room)	CV1	£70.70	£1.06	£1.15	£0.98	£0.52	£74.40
Certificate of Visual Impairment (re-exam in consulting room)	CV1	£47.47	£0.71	£0.77	£0.66	£0.35	£49.96

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