JUNE 2017

LOCAL MEDICAL COMMITTEE
LMC
GLOUCESTERSHIRE

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May saw the annual conference of LMCs taking place in Edinburgh, at which many burning issues were discussed – most notably that our colleagues in Northern Ireland are even now writing undated letters of resignation and preparing to take the enormous step of leaving the NHS. Particular points to note:

- Indemnity. For an explanation of the problem see the first main article below. Suffice it to say, the potential impact is vast and will need to be handled carefully at a national level. Conference agreed unanimously that the GPC should negotiate for full reimbursement of all indemnity costs.
- GPDF voluntary levy increases. The GPDF funds most of the GPC's expenses – a figure that amounts to nearly three million pounds annually. To keep in step with the increases in expenses they wanted to raise this voluntary levy from 6p per patient to 7p per patient this year and again in 2018 to 8p per patient. That would have been fine had they given sufficient notice, but we (like all LMCs) had set our annual budget before this announcement. Following heavy lobbying by this and other LMCs the GPDF have rescinded their demands for the moment, but they will be examined again in September.
- The Core Contract. Every year some LMCs seek to know exactly what is, and even more importantly what is not, in the core GMS contract, so that they can prioritise work and charge where appropriate. Conference again turned this motion down, largely on the basis that the current flexibility under the GMS contract was of more benefit to practices than a formal definition ever would be.
- Rationing. Two hours were spent in break-out groups to discuss the overall questions relating to the rationing of clinical care. By relatively narrow majority votes Conference demanded that the GPC engage with the country in debate on what care should be rationed, and to produce a discussion paper outlining alternative funding options for general practice, including co-payments.
- Non-NHS treatments. Conference voted in favour of allowing GPs to provide and directly charge their own patients for treatments not available on the NHS. Patients cannot understand how it can be otherwise. This will, however, require a major contract change.
- The survival of General Practice. Most practices are probably one unexpected resignation or retirement away from major difficulties. Conference was solidly in favour of preserving the independent contractor status, but suggested various ways in which GPs might be encouraged to become, and remain, partners.

- Working at scale. The debate on working at scale produced clear agreement that this offered opportunities to improve practice resilience but were less convinced that the GPC should produce 'blueprints' to achieve it.
- GP Forward View. Conference expressed a lack of confidence in GPFV since it had not noticeably alleviated the recruitment and retention crisis, nor had it made inroads in the unmanageable daily workload. Indeed, Conference demanded that the GPFV funding should be allocated directly to individual practices.
- Workload. The pressure was unremitting and could lead to mistakes being made. However, 'workload pressures' is not a defence in law to a resulting negligence claim. Interestingly, general practice (unlike hospitals and other clinical organisations) does not declare 'State Black' when things get overwhelmingly busy. Comparison with other nations and other professions suggested that the number of patient contacts a GP could safely make in a day should be less than 25 – not a situation recognised much in this country!
- QOF. To improve stability in general practice Conference believed that a non-capitation based basic practice allowance was needed, and payment also made to reward clinical management. Once again, Conference demanded that QOF should be evidence based and clinically relevant. New indicators should attract new funding.
- Forms and fees. The fees permitted for copying records were set by primary legislation. Although they are totally inadequate to cover the work involved the rates cannot be increased except by Parliament, which Government is unlikely to find the time to do. Conference tasked GPC at least to get the collaborative arrangements working again and to give clear information to the public on what documentation is not funded by the NHS.
- Transfer of work. The GPC's list of helpful template letters was generally deemed a good thing. 'Intermediate Care' needed to be recognised and funded. All extra work offloaded onto GPs must be properly remunerated.
- PCSE. The woefully inadequate performance of Capita in its PCSE role was well-recognised, but the motion that the job be handed back to the NHS was roundly defeated. In addition to obvious motions that general practice should be compensated for losses arising from PCSE's incompetence a motion was also passed that 'the Head of NHS England should be held to account for the continued failure of this commissioned service'.
- Premises. The issues of 'Last person standing', the lack of investment in premises and the way that NHS Property Services Ltd was trying to introduce very heavy service charges were all discussed.
- Clinical records. Conference agreed that, to promote efficiency, all clinical records should be held digitally, forwarded to a new practice digitally and that paper records be stored centrally. Once this is achieved it may also throw up extra consulting rooms.
- E-referrals. While agreeing that patients should be encouraged to ask the hospital rather than their GP about e-referral queries, Conference by a narrow majority voted against postponement of the implementation of 100% mandated e-referrals.
- CQC. Conference had no confidence in the CQC, which ran inspections in a subjective manner, seemingly unrelated to the practice contract or clinical evidence. GPs should have support in challenging the process and inspections, if necessary by appeal.
- Violent patients. Conference believed that unacceptable behaviour outside the practice should allow a patient to be categorised as 'violent'.
- GP Training. This was recognised as being very important for the long-term survival of the profession. Various suggestions were agreed to improve the existing system.

- BREXIT. Lastly, the uncertainty now felt by EU nationals working for the NHS was leading some to leave the NHS – a loss that the NHS could not afford. Conference called for them to be granted an immediate right of UK residence

Indemnity

A seemingly innocuous change to the discount rate to allow for investment return used in calculating lump sum personal injury pay-outs looks set to cause considerable financial upset. The discount rate is set by the Lord Chancellor and is used by courts to calculate future loss in personal injury cases. In layman's terms the reasoning behind the principle is as follows:

- A lump sum awarded by the courts to a victim of medical malpractice is calculated to pay for their care requirements for the rest of their anticipated lifetime. Consider the example of a 20-year old male rendered paraplegic by an error in the operating theatre. By consulting statistical tables an average life expectancy may be calculated which, let's say, is 84 years. This means that an estimate of his care requirements for the next 64 years needs to be made. For simplicity, if we assume the claimant's needs will amount to £50,000 each and every year until death, a total up-front lump sum in compensation of £3.2m would be appropriate. However, because over 98% of the award will not be needed in year one the sum is discounted by the return available by investing the balance in government gilts until it is needed (i.e. years 2 through 64). In this way, the insurer is not asked to pay more than is necessary to pay for ongoing care. Therefore, lump sum pay-outs in personal injury cases have, until recently, been discounted by 2.5% to take into account the income the claimant might receive by investing the sum in government gilts, which are seen as a relatively low but safe return. In other words, a claimant awarded £1000 would receive £975 which, when invested, would yield the £25 difference.
- However, since 2001 when the 2.5% discount rate was set, the return on gilts has plummeted to such an extent that real returns may even be negative. So, the new rate of -0.75% applicable from 20th March 2017 acknowledges this and in the above example the award of £1000 would be **uplifted** as opposed to discounted by £75 (£1000 x 0.75%) to reflect this.

Apart from surprising the industry, which had widely expected the rate only to fall to between 1.5% and 1%, the ramifications of what may seem to be a rather small and insignificant differential are very significant. The reason for this is that in high value awards made to those likely to live for many years the **annual compounding effect of even small percentages is quite dramatic** and the impact is profound. For example, the MDU has recently calculated that a claim that would have settled for £8.4 million on the previous discount rate would now settle for £17.5 million.

This more-than-doubling of potential liabilities has, according to Huw Edwards, director general of the Association of British Insurers, the unfortunate effect of "landing the NHS with a likely £1bn hike in compensation bills when it needs it the least".

A more insidious consequence is the potential effect on an insurer's solvency. Actuaries have been obliged to re-assess their increased liability in respect of claims 'Incurred But Not Reported' (IBNR) using a best estimate based on previous experience.

Those insurers having a mixture of short and long-tail business should be less exposed, and most importantly great comfort may be taken from the strict solvency requirements imposed on insurance companies by the regulatory authorities.

Because indemnity offered by Medical Defence Organisations (MDOs) is discretionary and not contractual, their solvency is not as strictly regulated, but of course, by their very nature they still need to operate with financial prudence. Moreover, as they indemnify on an "occurrence" basis the tail, or period after the event when they remain liable, is exceedingly long, which gives the IBNR liability figure added significance.

Indeed, it was lack of attention to IBNR in a climate of increasing claims costs, which contributed to the insolvency of the largest MDO in Australia twenty-five years ago.

Historically mutual societies have been disadvantaged when needing to raise capital, being precluded from issuing shares in the same way as listed entities. However, times are changing and the long-awaited Mutuals' Deferred Shares Act, which received Royal Assent in March 2015, at least offers the possibility for mutuals to raise capital, should they need to strengthen their balance sheet.

Even so, annual increases in MDOs' members' medical indemnity costs are inevitable, and may be very large.

It may be that the Federation of LMC Buying Groups' authorised supplier of insurance broking (MIAB) may be able to offer alternative solutions, but please make sure that any policy they recommend does provide for an adequate 'tail', or 'run off' as it is often called.

Federation of LMCs' Buying Groups

Remember that every practice in Gloucestershire is also a member of the buying group Federation and entitled to take advantage of the savings its authorised suppliers offer. The current offers can be accessed at https://www.lmcbuyinggroups.co.uk/ and details of the latest supplier (NexPay) are at **Annex A**. We have already circulated to practice managers the noticeable savings to be made on oxygen supplies through the Federation.

PCSE problems

If practices are following the correct PCSE process but are having difficulty with performer lists changes please could these be raised with Joanna Berkeley, who is the PCSE Local Training Manager for Gloucestershire. Her email is joanna.berkeley@nhs.net. If problems then continue please ask her to take it to the Regional Liaison Manager, South West. Of course, if things get desperate you might consider looking at the GPC guidance online on:

- PCSE claims guidance - practices and individual GPs can claim for any other losses they have incurred as a result of Capita's failings. (The guidance is here.)
- Bringing a claim to the small claims court (available here).

Capita and the sessional GPs' pension arrangements etc - update

The deputy chair of the sessional subcommittee of the GPC, Dr Krishan Aggarwal, has posted an informative page here.

Passports

Good news! Doctors are no longer accepted as counter-signatories on passport applications unless, exceptionally, they state that they know the applicant well (e.g.as a good friend) and that they recognise the applicant easily from the photo.
A host of other professions can countersign applications: especially nurses (RGN or RMN), pharmacists and social workers; even the licensee of a public house! For a full list see: https://www.gov.uk/countersigning-passport-applications/accepted-occupations-for-countersignatories

The Cameron Fund

Circulated separately by email is the annual report from the Cameron Fund. The text of the speech given by the Fund's Chairman at this month's LMC Conference is at **Annex B**. It mentions the idea of a voluntary practice levy in aid of the Fund. We shall be discussing this at our next LMC meeting (in July) so if you have strong views for or against the idea then please let your LMC member known so that he can represent you properly at that meeting. You may like to know that personal donations at the Conference form those atte4nding the Conference amounted to £5,281.

GP Registrars - change of status

GP registrars are already on the National Performers List when they conclude their training but there are concerns that there may be delays in processing the change of status on the Performers List in a timely manner. Anecdotal information suggests that this is

compromising the ability of the GP to secure substantive independent work until the change in status is effected on the Performers List. It should not do so – see below:

- A GP Trainee legally cease to be a trainee when the GP registrar achieves their CCT and the GMC register is updated.
- NHS England policy requires GP Trainees to provide evidence that they have completed their training and to complete a change in status form, enabling Capita to update their status on the Performers List. If they have evidenced this, they have fulfilled their obligations under the regulations and NHS England policy.
- The change in status on the Performers List itself does not require MD/RO approval as this is a routine administrative process.
- During this period of time and in the event that an enquiry regarding their status is received from either the recently qualified trainee or an organisation wishing to use their service, MDs or their delegated officers should assure themselves that the trainee has completed their training by either checking the GMC register, and or liaising with HEE if they are a GP registrar. If the MD or their delegated officer can assure themselves via this route, there should be no reason why the trainee should not be permitted to practise independently whilst the administrative change in status is undertaken.

This has now been added here: http://pcse.england.nhs.uk/change-of-status-gp-registrar-to-qualified-gp/

Save the Date

The South West Maternity Clinical Network are holding a 'Supporting Normality in Birth - Safe and Personalised Care' Workshop on Thursday 6th July at Taunton Racecourse. All stakeholders in maternity services across the South West are invited. 'Stakeholders' might include: obstetricians, midwives, student midwives, delivery suite matrons and coordinators, practice development leads, obstetric labour leads, PROMPT/MDT training leads, birth unit matrons and managers, community midwifery matrons and leads, maternity support workers, commissioners and service users.

Speakers on the day will include Tony Kelly, National Clinical Director for the National Maternal and Neonatal Health Safety Collaborative, and Marie Washbrook, BirthRate+, with further speakers to be confirmed shortly.

Details of the day, along with a link to register for the event, will be circulated within the next couple of weeks. In the meantime, we ask that you please share this 'Save the Date' with any colleagues who you feel would be interested in attending and hold the date in your diaries.

NHS Property Services

NHSPS are still insisting on ruinously high charges. Practices affected would be well advised to set money aside against the day when an agreement is reached and something must then be paid.

Job opportunities

A list of recent job opportunity notifications is at **Annex C**. A full list of unexpired job adverts is at http://www.gloslmc.com/blog-job-vacancies.asp and links to them are also at Annex C for ease of reference.

Max's Musings

I write this the day after the suicide bomber took so many lives in Manchester and I find it hard to be objective. The wish for revenge is strong but frustrated since the bomber is dead and his confederates are, as yet, unknown. At this stage one can only wish solace to the bereft, successful medical care to the wounded, and good luck to those following up the incident. It certainly puts into perspective the little trials and tribulations we suffer daily in our practices.

No more this month – it is hard to be light-hearted in the face of this atrocity.

And finally,

Seen during a conference:
'FOR ANYONE WHO HAS CHILDREN AND DOESN'T KNOW IT, THERE IS A DAY CARE CENTRE ON THE 1ST FLOOR.'

This newsletter was prepared by Mike Forster and the staff of Glos LMC

ANNEX A TO
GLOSLMC NEWSLETTER
DATED JUNE 2017

FEDERATION OF LMCs' BUYING GROUPS – NEW SUPPLIER

New Supplier: Nexpay (Merchant Card Services)

The Buying Group's newest supplier, Nexpay, is a leading UK-based payment consultancy and management company, officially licensed by Visa and MasterCard for the provision of card payment services.

Nexpay can save GP practices thousands of pounds annually with up to 60% off monthly bills. The LMC Buying Group and NexPay have a joint aim to save members over £1M in card processing fees.

How it works

1. Send across a recent merchant statement to enquiries@nex-pay.co.uk or request a call from an account manager.
2. NexPay will review your existing account and show you the new tariff savings.
3. You decide if you'd like to start saving.

Merchant Management

Nexpay manage your payment environment by reviewing against market and industry changes on a monthly basis.

You will receive personalised reports evidencing the savings generated and have access to in-depth reporting confirming how your account continues to benefit along with comprehensive breakdown of activity.

Contact Nexpay on 01752 546266 or simply email a recent merchant statement to see how much you can save.

You must mention that your practice is a member of the LMC Buying Group to qualify for our discounts.

ANNEX B TO
GLOSLMC NEWSLETTER
DATED MAY 2017

LMC Conference Dinner 18 May 2017 - Cameron Fund Chairman's Speech

The Cameron Fund is the one Medical Charity that helps only GPs and not other members of the profession. We also support dependents of GPs and retired GPs, GPs undergoing retraining or on a phased return to work, and GP trainees.

We offer financial help to your colleagues in real financial need, which can arise totally unexpectedly. This year we have helped the spouse and young children, of a GP trainee who was killed in a car crash; a young GP and his family affected by a very severe physical illness such that he was unable to work for many months; a number of doctors off work with mental health problems; and some colleagues who have run into trouble with the GMC.

Those are not events we can anticipate, or necessarily insure against. I sometimes think, as I read an application, that 'there but for the grace of God go I'. So in 2016 the Cameron Fund gave financial help amounting to £375k to 226 beneficiaries, 30 more than in 2015.

More than half of our income comes from our investments set up by Sir James Cameron after whom we are named. But the rest needs to come from donations, from you the LMCs and from individual donors. Many LMCs contribute substantial sums to the Fund. In total 49 LMCs make contributions.

The best way of all to help us is to set up a voluntary levy, and Wessex LMCs are a shining example of that, with many practices signing up to a 3p per patient levy that brings in about £35k for the Fund - by far the largest donation, and several other LMCs have followed their example.

We can help you set this up if you would consider doing so, and practices can set the levy rate at whatever level they wish. The Cameron Fund is here to help your colleagues in real difficulties. One day it could be you or your family, as none of us can be sure that we will avoid a disastrous event such as some of our beneficiaries have faced.

We are, as our strap line says, the GPs' own Charity, set up by the conference of LMCs in 1970. So I would like to ask you to put this on your next LMC Agenda to consider what you can do to help us to support your colleagues in real financial need.

Thank you for your support in the past. With the increasing stress of General Practice we are seeing more young doctors who need the help of the Cameron Fund. So in 2017 we need your support more than ever.

Dr Stephen Linton

Chairman, the Cameron Fund

ANNEX C TO
GLOSLMC NEWSLETTER
DATED MAY 2017

JOB VACANCIES

The full list of current vacancies is at: http://www.gloslmc.com/blog-job-vacancies.asp.

GLOUCESTERSHIRE			Date posted	Closing Date
Tewkesbury Choice Plus	Gloucestershire	Choice+ rota	9 Mar 16	Open
Partners in Health	Gloucester	Partner/Salaried GP	20 Jul 16	Open
White House Surgery	Moreton-in-Marsh	Salaried GP	25 Aug 16	Open
Dockham Road Surgery	Cinderford, Forest of Dean	Partner or Salaried GP	26 Aug 16	Open
Gloucester City Health Centre	Gloucester	Salaried GP leading to partnership	31 Aug 16	Open
Coleford Health Centre	Forest of Dean	Salaried GP/partnership	31 Aug 16	Open
Newent Doctors Surgery	Newent	Newent Doctors Practice, Sabbatical Locum	26 Oct 16	Open
GP Retainer Scheme	Gloucestershire	GPs (plural)	22 Nov 16	Open
Church Street Practice	Tewkesbury	Maternity Locum required	13 Dec 16	Open
London Medical Practice	Gloucester	1 / 2 Salaried GPs 8-10 sessions per week	11 Jan 17	Open
Royal Crescent Surgery	Cheltenham	GP Partner (Part-Time)	11 Jan 17	Open
Church Street Medical	Tewkesbury	Salaried GP	15 Feb 17	Open
Springbank Surgery	West Cheltenham	Salaried GP	15 Feb 17	Open
Cam & Uley Family Practice	Uley	Full or part time Salaried/Partner GP	15 Mar 17	Open
Regent Street Surgery	Stonehouse	4.5 sessions for a Partner, salaried GP	23 May 17	Open
ELSEWHERE				
Roseland Peninsula	Cornwall	Salaried GP	25 Oct 16	Open
Pensilva Health Centre	Liskeard Cornwall	GP Partner	02 Nov 16	Open
Burnham & Berrow Medical Centre	Somerset	GP Partner or Salaried GP	21 Dec 16	Open
Burnham & Berrow Medical Centre	Somerset	GP Partner or Salaried GP 4-8 sessions per week	26 Apr 17	Open
Air Balloon Surgery	Bristol	Assoc. GP with view to Partnership	10 May 17	12 June 17

REMINDER: *If you are advertising with us and fill the vacancy please let us know so we can take the advert down.*