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1. Editorial – The White Paper – Contracting Reforms



When it comes, where will the White Paper take us? Clearly any prognosis at this stage could be hopelessly wrong but there are some signs that could point in the eventual direction of travel for contracting

forms. Contractor commissioning is a separate, hugely complex subject which I will deal with in a later editorial.

We can be fairly confident that an NHS Board will oversee commissioning which will be carried out, at least to some extent, by contractors working in accordance with contracts issued by a number of statutory

Federations, each answerable to the Board. I believe that the Federations will be in a statutorily regulated form so as to ensure consistency across the country. I also believe that the contracts between the Federations and the contractors will be highly regulated, will contain a number of elements previously found in APMS Contracts such as KPIs and are likely to be for fixed or agreed terms. The work to be covered will probably be similar to the present essential and additional services found in GMS or PMS and will be paid on a tariff scale akin to the present GMS SFE terms. In addition to essential and additional services, it is likely that some other nationally directed elements will be included; perhaps the new terms will be called GMS plus or GMS 2012.

With this standardisation, I foresee an end to the present PMS arrangements with all contractors being required, for ‘core’ work, to move to the GMS 2012 regime. Locally negotiated work will continue but this will probably be carried out in the form of Service Level Agreements, many on AWP terms so as to avoid the need for an endless string of expensive procurement exercises.

What will this mean for contractors? Potentially less money for the same work or more work for the same money and very possibly a much greater degree of uncertainty about contract security and with it a disinclination to invest in future services. For some time now, £ per patient figures have been noticeably higher for PMS than GMS. To some extent, this results from a wider range of locally negotiated services being provided but there must be a great danger that elements of the wider PMS range will be pushed into the GMS 2012 arrangements at GMS prices. To counter this, it will be essential that there is a very much tighter definition of ‘core’ work so that all elements outside the ‘core’ are rewarded through SLAs.

From the stability point of view, any term contract will be very damaging to the future development of primary care services and their introduction may well accelerate the

move towards practice mergers and federated working so as to lay off individual risks. Lockharts are currently giving strategic advice to a substantial number of groups seeking to consolidate and to protect their operational future.

Alongside the full range of healthcare work for primary care contractors, I and my team will be very pleased to assist in this important area which will be necessary to secure the future. Needless to say, further comment will follow as soon as the White Paper is available.

Andrew Lockhart-Mirams
Senior Partner
csd@lockharts.co.uk

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2. Health Bill Forces GPs to Federate

The Government is to make it mandatory for GP practices to join federations in a new Health Bill being finalised by ministers.

The radical overhaul of commissioning will hand GPs control of over 95% of PCT commissioning budgets, putting them at the centre of plans to make huge efficiency savings.

Whitehall sources also confirmed plans, revealed by Pulse earlier this month, for the new NHS Board to hold contracts directly with GPs, replacing the existing role of PCTs. The NHS Board is set to have a contract with each federation, which in turn will have a contract with each member practice.

Health Secretary Andrew Lansley is due to present the bill next month and insiders made clear all GPs would be expected to sign up to joint commissioning arrangements, with practices expected to share back-office functions and human resources, and work to an agreed commissioning budget. 'Practices will have to work on a federated basis,' the source said.

The Government's plans are being widely compared to a return to the days of GP fundholding – but with the crucial difference

that this time the strategy will be mandatory.

With the health secretary having ordered a huge cull of PCT management in the operating framework, it is anticipated federations will employ many as business managers. But the source said: 'GPs will be in the driving seat.'

The news comes as a report by the Nuffield Trust, the National Association of Primary Care, the NHS Alliance, the NHS Confederation's PCT Network, the RCGP and The King's Fund welcomed Government plans to put GPs 'centre stage' – but warned the Government faced 'significant challenges in engaging more than an enthusiastic minority'.

The report called for incentives for GPs, suggesting commissioning groups could retain 100% of savings in return for them being re-invested in local services. It called for guarantees on management support and clarity over the possible risks to GPs. RCGP chair Professor Steve Field called the commissioning plans a 'new dawn'.

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3. Fears Over 'Fast-Track' GP Fitness to Practise Hearings

GPs who are called before fitness to practise hearings are to be subjected to a new fast-track process that medical defence experts fear will curtail their ability to defend their members.

The new Office of Health Professionals Adjudicator (OHPA) – which is taking over from the GMC in staging hearings - says it believes GPs' legal teams are deliberately stringing out proceedings and causing costly delays.

Stephen Shaw, chief executive of the OHPA, said new slimmed-down procedures would dramatically shorten hearings and cut GMC bureaucracy. He said there would be cost savings for the NHS and the potential for reduced GMC fees.

But the Medical Defence Union said it would fight any moves that diluted the ability of GPs to defend themselves.

Under the new arrangements GMC panels will be replaced by a three-person tribunal, similar to those used for solicitors and architects.

Mr Shaw said the legal detail allowed to dominate hearings was completely out of line with other professions: 'We're determined to provide a quicker, more proportionate, less costly system. We need to bring the medical profession in line with other professions. The drawing out of proceedings that goes on at the moment won't be allowed.'

He said there would be strict rules to clamp down on legal delays, under which he said 'only the lawyers get rich'.

Mr Shaw denied the process would mean less rigorous assessment of the facts but insisted it could substantially reduce the £85m a year spent by the GMC on the existing adjudication process.

Under the new system, the GMC will still decide which doctors face fitness to practise hearings, with 2009 figures showing a 30% increase, with 100, or 37%, involving GPs. There has also been a surge in the number of doctors being struck off, with 68 struck off in 2009 against 42 in 2008.

Mr Shaw said: 'Speedier proceeding is fairer for doctors because it will not be hanging over them for so long.'

But Mary-Lou Nesbitt, the MDU's head of external and governmental relations, said: 'We're surprised to see the OHPA's assertion. It's simply not correct and the GMC's own published data does not support it. The MDU's role is to provide a robust defence for our members and we'll continue to do so, whatever the adjudication process.'

Dr Krishna Korlipara, a GP in Bolton, Lancashire, and a council member of the GMC for 25 years, said it was 'extremely important' that GPs were given adequate time to prepare their cases for defence.

'What is paramount is that justice is done. If they are being fast-tracked, doctors will not have sufficient time to get their case together.'

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4. Pay Freeze For GPs

Following the Government announcing a two-year pay freeze for all public sector staff earning more than £21,000, GPs may be set for three pay freezes in a row.

The Government has yet to confirm if the freeze will apply to GPs as independent contractors, but previous public sector pay freezes have been applied to GPs.

The Conservatives had already pledged to freeze pay for everyone in the public sector earning over £18,000 a year in 2011/12, as part of a package of tough pre-election pledges on the economy but Chancellor George Osborne has gone further in his emergency budget, by pledging to freeze pay for the next two years.

The announcement means GPs are likely to face three successive pay freezes in 2010 and 2011, and 2012, making six freezes in seven years for many GPs.

It also casts doubt on the role of the Doctors and Dentists' Review Body, whose recommendations on this year's pay award were ignored by the Government due to demands from the Treasury.

Nigel Edwards, NHS Confederation acting Chief Executive, said: 'All NHS trusts are aware of the collective £15-20bn of efficiency savings that are required over the next five years. The pay freeze for public sector workers announced today will play its part in achieving this, but VAT increases mean a simultaneous rise in the cost of goods and equipment.'

'Although the NHS budget has been largely protected, it is likely that over the next five years cuts to other areas, such as local authorities, may impact on health expenditure. So although health spending will continue to rise year on year, all NHS trusts will find they are challenged to do more for the money they have.'

A DH spokesperson said: 'Everyone who works in the public sector will need to play their part in helping to reduce the deficit.'

This includes GPs and proposals for GP pay will be outlined in due course.'

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5. National Health Service (Performers Lists) Directions 2010

In accordance with the National Health Service (Performers Lists) Directions 2010, which came into force on 23 March 2010, each PCT must review its procedures for processing applications and these are to include the requirement that PCTs satisfy themselves that any applicant has the knowledge of English necessary to perform services which those included on a performer's list perform in that area.

Further, PCT's must review their procedures for keeping their performers list up to date and the review must include procedures for the removal from a performer's list of performers who cannot demonstrate that they have performed the services, which are included in the relevant performer's list within the area of the PCT, during the preceding 12 months.

These reviews have to be completed by 1 July 2010. Following such reviews, PCT's must also consider whether, in the light of the review, their procedures need to be amended with the object of minimising the risk to the public from performers.

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6. Summary Care Record 'Saving Lives' Say Out-Of-Hours GPs

GPs working out of hours in areas covered by the Summary Care Record access it on a daily basis and believe it has made patients safer, new findings reveal.

A survey of 53 out-of-hours GPs by computer firm Adatastra, which provided them with access to the care record, found 69% had used it on the day they were questioned, and 35% that it had 'informed clinical decisions today'.

Overall, 61% of respondents thought the care record had improved safety for

patients, with information on repeat medication and allergies considered most useful.

The results were released as clinical leaders for out-of-hours care attacked the UCL report's negative findings, and insisted the care record was having clinical benefits and needed to be retained.

Dr Simon Collins, clinical lead for out-of-hours provider Meddoc in Kent, said his organisation was part of a pilot rolling out the care record to 130,000 patients.

He claimed among the third already covered were concrete examples of benefit, including prevention of penicillin treatment in an allergic elderly patient, and a chronically constipated young man who turned out to be on co-codamol.

Dr Collins said: 'The Summary Care Record can and has saved lives. In years to come, doctors that block it will be seen as Luddites and out of date.'

He claimed to be at a loss to understand why Professor Greenhalgh's report had been so scathing about the care record: 'Because of the fuss over confidentiality it was rolled out half-heartedly and some doctors have been slow to see the benefits.'

GP Dr Liaqat Natha, clinical lead for the Summary Care Record at NHS Bolton, one of the original pilot sites, said there had been a series of benefits for terminally ill patients and their families through having end-of-life templates uploaded.

Giving one example, he said: 'When the patient died, paramedics and police attending contacted the out-of-hours service and were quickly able to establish it was not an unexpected death.'

The Greenhalgh report did find some evidence out-of-hours call centre nurses had found the care record useful and 'anecdotal' reports of benefit in medication information.

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7. Changes to the List of Notifiable Diseases

Changes to the Public Health Regulations came into force on 6 April 2010. The new legislation adopts an all hazards approach, and, in addition to the updated list of infectious diseases, there is a requirement to notify cases of other infections or contamination which could present a significant risk to human health. Some additional data items, including ethnicity, are also required to be reported.

The updated list of notifiable diseases is available in Schedule 1 of the Regulations. The following diseases have been added:

- Botulism
- Brucellosis
- Enteric fever (typhoid or paratyphoid fever)
- Haemolytic uraemic syndrome
- Infectious bloody diarrhoea
- Invasive group A streptococcal disease
- Legionnaires disease
- SARS

The following diseases have been removed:

- Ophthalmic neonatorium
- Relapsing fever.

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8. GPs Risking Security Breaches With Email Consultation

GPs are putting confidentiality at risk by sending medical information to patients' personal email addresses and failing to use encryption software, general practice IT experts are warning.

A Pulse survey reveals GPs are increasingly making use of email as a means of consulting with patients – nearly one in five say they have already consulted over email – but many are not taking adequate security measures.

The survey of more than 500 GPs found 18% had provided email consultations in response to requests by patients, and a further 1% after an email consultation had been offered by a practice colleague.

The great majority - 77% of those who had given email consultations - had used a

secure NHS email address. But 50% admitted they had sent information to patients' personal email addresses, which could risk security breaches.

Only 12% of GPs said they used encryption tools when emailing patient identifiable information, just 8% had used a security function provided by their practice computer system, and only a tiny minority – 1% - had used 'Connecting for Health's Communicator function'.

GPs remain uncertain of the benefits of email consultation. When asked if the benefits outweighed the drawbacks, 12% said yes, 24% said no and 53% were unsure. But IT experts said pressure was likely to grow for email access to GPs – a key pledge of the Liberal Democrat election manifesto – and that it was essential GPs got to grips with security measures.

Dr Manpreet Pujara, clinical director of Connecting for Health's electronic prescription service and a GP in Rochester, Kent, said: 'One of the reasons some doctors may be hesitant is that email consultations are not generally recommended. Apart from NHS mail, for sending email clinician to clinician, there's no recommended facility.'

'We need a wider rollout of Communicator because without doubt we're going to have to look at new ways of communicating with our patients - coming to the surgery doesn't suit everyone.'

Dr David Lloyd, medical director of out-of-hours IT at Connecting for Health and a GP in Harrow, Middlesex, said an enhanced version of Communicator would be piloted later this year in an effort to boost uptake, saying it needed to be 'quicker and simpler'.

'I'm gratified to hear 78% use an NHS email address - that shows GPs are aware of security issues,' he added.

But many GPs remain sceptical. Dr Nick Bunting, a GP in Boston, Lincolnshire, said: 'Email consultation will increase workload and not increase patient benefit or safety.'

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9. Agency Workers' Directive

The Agency Workers' Directive is one of the most important pieces of new employment law to be introduced for a considerable time. It will have major implications for employers, and as such organisations need to be preparing for this change immediately.

The new Directive will provide 'equal treatment' for temporary and agency workers, giving them equal rights to permanent staff after 12 weeks with an employer.

This new legislation which is planned to be implemented by October 2011 will affect over one million temporary agency workers in the UK. Therefore it is imperative that both public and private sector employers get to grips with the implications of the Directive, in order to have enough time to prepare and adapt their temp, agency and contract staff policies and procedures to avoid costly mistakes.

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Contacting Lockharts

Lockharts Solicitors
Tavistock House South
Tavistock Square
London WC1H 9LS

Tel: +44 (0)20 7383 7111
Fax: +44 (0)20 7383 7117
Email: csd@lockharts.co.uk
Web: www.lockharts.co.uk



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